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An Investigation into the Practice of Forced Drugging/Medication in California's Detention Facilities and Transcript of Hearing Held at Los Angeles California on July 28, 1976

California Assembly Select Committee on Corrections, Sacramento

Dec 76

AN INVESTIGATION INTO THE PRACTICE OF FORCED DRUGGING/MEDICATION IN CALIFORNIA'S DETENTION FACILITIES

Report Prepared By:

THE ASSEMBLY SELECT COMMITTEE ON CORRECTIONS

CHAIRMAN

ASSEMBLYMAN RICHARD ALATORRE

December, 1976

Assembly
California Legislature

Select Committee on Corrections

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December, 1976

The Honorable Leo T. McCarthy
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Mr. Speaker:

Transmitted herewith is a report from the Assembly Select Committee on Corrections. This document has been prepared in compliance with your mandate to this Committee upon its creation in February of this year.

This initial report concerns a subject of direct concern to the broader topic which the Committee was directed to consider, that being the quality of health programs for residents incarcerated in California's prisons. The Committee believes that the issue of forced drugging/medication is not only timely in light of recent disclosures of alleged drugging abuses in state mental hospitals, but it is also relevant due to the tragedies which occur to human beings as a direct result of the negligent and improper use of psychotropic drugs within prisons.

I call your attention to the fact that the Committee's report contains one important additional aspect. In the contents of this document you will find a copy of legislation which will be introduced as the new session of the Legislature convenes on December 6, 1976. This legislation was created as a direct result of the Committee's inquiry into the question of forced drugging/medication within this State's penal institutions.

Should this Committee be able to provide you or any other member of the Legislature with additional information on this subject, please feel free to contact me.

Sincerely,

RICHARD ALATORRE
Chairman

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Assembly Select Committee on Corrections

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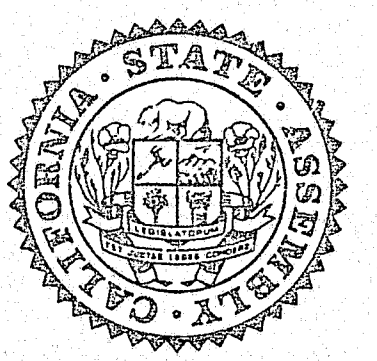

December, 1976

ASSEMBLYMAN RICHARD ALATORRE, CHAIRMAN

Assemblyman Frank Murphy (Vice-Chairman)
Assemblyman Julian Dixon
Assemblyman Terry Goggin
Assemblyman Kenneth Maddy
Assemblyman Bill McVittie
Assemblyman Floyd Mori
Assemblyman Paul Priolo
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INTRODUCTION

Early this year, Assembly Speaker Leo T. McCarthy created the Assembly Select Committee on Corrections. Under the direction of Committee Chairman Richard Alatorre and members - Assemblymen Frank Murphy, Julian Dixon, Terry Goggin, Kenneth Maddy, Bill McVittie, Floyd Mori, Paul Priolo and Alan Sieroty - the Committee began operations on March 1, 1976.

The mandate issued by the Speaker directed the Committee to involve itself in the following activities: Evaluate existing educational programming within state penal institutions; study conditions at the California Institution for Women; provide a comprehensive examination of county jail facilities; and conduct an investigation relative to quality of medical care currently being offered in California's state prison system.

Shortly after the Select Committee commenced its work, staff began to receive numerous letters which contained allegations that inmates at California Mens Colony East, the California Institution for Women and the California Medical Facility were subjected to forced drugging. Due to the heavy volume of mail received by the Committee raising an issue with such serious consequences as forced drugging, it was decided that a preliminary investigation would be conducted to refute or verify the accusations which were being made.

The initial investigation by Committee staff consisted of extensive interviews being held with inmates' families, former inmates, psychiatrists and personnel from the California Department

of Corrections. Additional information and background was provided by CONTACT 7, a public service television program affiliated with ABC News in Los Angeles.

The preliminary work undertaken by the Committee on this issue yielded enough information so that a broader more comprehensive investigation was found to be warranted. This report contains data compiled by the Assembly Select Committee on Corrections during its investigation into the subject of forced drugging/medication within the walls of California's state prisons. The investigation was conducted from June, 1976 to October, 1976.

Specifically, the contents of the report include: A transcript of the Special Hearing on Forced Drugging held in Los Angeles on July 28, 1976; a list of findings and recommendations, including suggested legislation designed to prevent possible instances of forced drugging from occuring in the future; and a summary of the status of forced drugging in the California state prison system.

The Committee would like to express its sincere gratitude to those who have assisted in making this report possible. For without concerned individuals making the effort to bring information relative to forced drugging before the Committee, and without individuals taking the time to be interviewed by staff as well as appearing as witnesses at hearings, many at great personal risk, this tremendously important subject would not have received the attention and public scrutiny that it so justly deserves.

"SUDDEN, UNEXPECTED AND UNEXPLAINED DEATHS HAVE BEEN REPORTED IN HOSPITALIZED PSYCHOTIC PATIENTS RECEIVING PHENOTHIAZINES"

-Physicians' Desk Reference
Medical Economic Company
29th Edition

*See Appendix C

COMMITTEE FINDINGS

I. Findings

The following are the findings of the Assembly Select Committee on Corrections with respect to the subject of forced drugging/medication. These findings were compiled through the intensive efforts of the Committee by the use of investigations, interviews and testimony taken during open hearings.

The majority of abuse was found to exist at the California Mens Colony at San Luis Obispo. The existence of forced drugging/medication was discovered to be most prevalent in the infamous D quad at C.M.C., East.

The term forced drugging/medication as referred to within the text of the report, specifically pertains to the employment of major tranquilizers. (See Appendix A).

A. Forced drugging/medication is a widespread phenomena affecting state prisons, major county jail facilities as well as local juvenile detention centers.

B. Insofar as the state prison system is concerned the practice of forced drugging/medication was found to be in existence at the following prisons; California Mens Colony East, California Institution for Women and the California State Prison at Vacaville (C.M.F.) and to a lesser extent, at other major institutions throughout the system.

C. Residents who have been classified as psychotics are being housed in correctional institutions which lack sufficient mental health care staff to effectively treat these individuals.

D. There is a pronounced lack of proper therapy for individual residents who have been classified as psychotic. The major emphasis is placed simply on the administration of drugs.

E. Major tranquilizers have been employed for extended periods of time, greatly exceeding recommended time limitations for use. The Committee discovered that in some cases major tranquilizers were being administered to certain residents for up to 3 or 4 years straight.

F. Serious question arises as to whether individuals have received adequate treatment and rehabilitation upon their release, inasmuch as they have been forceably drugged or medicated during the majority of their time in prison.

G. Forced drugging/medication is being utilized as an indirect threat to the general prison population as a form of management control. i.e. resident displaying a non-conforming type of behavior may be subjected to forced drugging/medication.

H. Testimony from hearing indicates some residents are being released from custody of the California Department of Corrections with as much as three month prescriptions for major tranquilizers.

I. Currently residents have no legal recourse or appeal in order to refuse forced drugging/medication. The sole determining factor as to whether or not resident is placed on medication is the prison psychiatrist.

J. Current C.D.C. Administrative Manual procedures, Section 346 (D), are totally inadequate in terms of enforcement, inasmuch as C.D.C. personnel have not followed established policy concerning the question of the medication of residents. (See Appendix B).

K. Outside consultants have not been brought into review cases of residents who have been placed on forced drugging/medication.

L. Various degrees of coersion is employed relative to residents in order to place them on medication. Examples; threats of transfer and/or the issuing of disciplinary reports which influence members of the Parole Board when evaluating a resident's fittness to receive a release date.

M. Abuses were reported arising with regard to the amount of dosages of major tranquilizers being prescribed by C.D.C. psychiatrists.

N. Interviews with residents and staff indicate that there exists a marked increase of homosexual attacks on residents who are on medication.

O. Due to a general lack of mental capability to function normally there are increased instances of extortion involving residents who have been placed on medication. In most cases the incidents involve a resident's canteen supplies, i.e. cigarettes, etc.

P. Cases have been reported where the administration of drugs was in direct retribution for inmate's past behavior; i.e. residents who might outwardly express anxiety within the prison setting.

Q. The number of budgeted positions for psychiatrists by C.D.C. is forty. These individuals are responsible for serving a total resident population of 20,000 plus.

R. Initial psychiatric reports are developed at the guidance and reception centers. This is an inappropriate atmosphere within which to develop any type of psychiatric report due to the fact that the individual is undergoing a period of severe anxiety, inasmuch as he or she is about to enter prison.

S. In many cases unqualified personnel are conducting the initial review and development of recommendations regarding the status of the mental health of individual residents.

T. An insufficient amount of time is utilized for the purpose of diagnosing a resident's psychological needs. In some instances, a fifteen minute interview is used to determine the psychological necessities of a resident.

U. Few, if any, residents and former residents on forced drugging/medication were ever told the reasons for being placed on the drug or medication, or the ramifications of the use of the particular drug or medication.

V. In some institutions inmates and staff report that prescribed medication may be obtained from psychiatric staff by simply requesting the drug without a psychiatric evaluation.

W. There appears to be an overabundance and abuse of legal drugs in some of the major institutions. The Committee has heard testimony that these drugs are being used for illegal purposes by some residents.

X. In some instances there is a possibility that forced drugging/medication has been employed solely as a form of management control.

Y. Hearings and investigations conducted by the Committee were unable to obtain a consensus of opinion from psychiatrists as to the long range effects of the use of psychotropic drugs. (See Appendix C).

Z. There exists a possibility that the State of California, due to neglect and abuse of drugs which are being utilized in prisons, could potentially be sued by residents or former residents for the indiscriminate use of neuroleptics or major tranquilizers.

COMMITTEE RECOMMENDATIONS

II. Recommendations

The following recommendations of the Select Committee on Corrections reflect areas which in the Committee's opinion, are in need of immediate attention if abuses in forced drugging/ medication are to cease.

These recommendations were formulated on the basis of Committee hearings, staff investigations and interviews conducted with residents, staff and prison administrators.

The majority of the Committee's recommendations are embodied in legislation which was developed by the staff of the Select Committee for the purpose of being introduced in the State Legislature.

The recommendations are offered in the spirit of cooperation and as constructive criticism of current policies and procedures.

A. No phenothiazines or major tranquilizers should be used for administrative or custodial purposes within C.D.C. or county dentention facilities.

B. Major tranquilizers should not be used for non-psychotic residents. Only residents with a diagnosis of psychosis should receive major tranquilizers in conjunction with psychotherapy.

C. Residents should have the right to refuse medication, and can only be given such drugs after which time they have given their informed consent.

D. Subsequent to the administration of any major tranquilizers a resident must sign an informed consent form on a voluntary basis with the exception of the resident who lacks the capacity to give informed consent and the withholding of the medication threatens substantial physical and mental harm to themselves or others.

E. Every effort should be made to secure the voluntary consent of patients for necessary and appropriate medication. In those cases where sustained involuntary medication (over 72 hours), is necessary to prevent substantial physical and mental harm, a consultation with an outside practicing academic or community psychiatrist should be obtained. The consultant's opinion will be binding on the prison psychiatrist. If involuntary medication is given for over ten days, where its use has been approved by an outside consultant, a court order to proceed with such forced medication must be secured by the warden or superintendent that authorizes the continuance of the drug for an additional ten days.

If a resident lacks the capacity to give his or her informed consent, they shall be given a court hearing to determine the lack of capacity.

The only time that major tranquilizers can be used without the residents informed consent or court order is in a case of extreme emergency. In this instance the medication should not be utilized for more than 72 hours without the approval of an outside consultant.

F. By and large all prison residents who are thought to be, or diagnosed as psychotic should be reviewed by the courts and transferred to a specialized mental health facility which has staff with the capability of handling such cases.

G. An outside board of consultants should be utilized to review all cases where residents have been classified as psychotic. This body should then make recommendations as to the proper course of action to be taken in each individual case. This outside review board should have final authority with respect to their recommendations.

H. Psychiatrists functioning in prisons should be made liable for malpractice suits the same as their fellow professionals who practice on the outside, to insure that prison psychiatrists are not abusing their powers.

I. Until such time as specific psychotropic drugs have been proven as to their effects, they should be banned from all prison, jail and juvenile facilities within the State of California.

J. Psychiatric medication should never be given in a covert or disguised fashion. Residents should be advised as to the type of medication he or she is being given, as well as to its possible side effects and long range implications.

K. Any major tranquilizers which are administered within the prison should be done in conjunction with psychotherapy.

L. A "Due Process" should be established for residents being placed on medication. Legal review must be provided to the resident on request.

M. Any and all prescriptions for major tranquilizers should conform to the standards contained in the Physicians Desk Reference, 29th Editions, 1975.

N. Reception/Guidance Center psychological work-ups should only be utilized as a preliminary evaluation. Then once a resident has been assigned to an institution, they should then be given a complete psychological evaluation.

O. Each individual resident should be allowed free access to his or her own psychological records.

P. Whenever there is a possibility for resident misuse of prescribed medication, a liquid form should be used. Misuse may include the accumulation of medication, transfer of medication to another inmate or other improper use.

Q. There should be no retaliation carried out by prison authorities on any resident who refuses to take medication.

R. Original legislation concerning residents' civil rights exclude the utilization of chemotherapy. Any subsequent legislation of this type should be inclusive of chemotherapy. See P.C., Section 2670.5, Organic Therapy.

SUMMARY

This report has focused attention upon the practice of forced drugging/medication of individuals incarcerated in California's state prisons. The question of forced drugging/ medication of prisoners is a highly serious issue which contains potentially disasterous consequences for its recipients as well as for practitioners. By utilizing forced drugging/medication, prisons run the risk of ceasing to function within the purview of their intended purpose. The act of sending a person to prison is designed to serve as punishment for a violation of the law. With the introduction of forced drugging/medication into the prison environment, the penal institution then becomes armed with an additional tool for punishment.

The Committee has discovered that the forced drugging/ medication of prisoners does exist within state prisons in California. Those institutions most affected are: California Mens Colony East, the California Institution for Women California State Prison at Vacaville. (CMF)

The primary objective of each state prison in California is for the custodial care of its residents. For this reason, the facilities under the jurisdiction of the California Department of Corrections have proven themselves to be inappropriate and inadequate areas within which to administer proper mental health programs. Therefore it is unrealistic to continue to call upon these institutions to engage in rehabilitative efforts with those in need of extensive

psychological assistance and services.

It is obvious that the current administrative regulations of the California Department of Corrections are woefully inadequate with respect to providing individual residents reasonable protection against the possibility of becoming victims of forced drugging/medication. During the course of its investigation the Committee encountered numerous instances in which even the minimal C.D.C. regulations on forced drugging/medication were not properly adhered to by prison authorities.

Every attempt was made by the Committee to conduct as broad based investigation as possible on this issue. A conscientious effort was put forth in terms of representing the opinions of numerous individuals who are directly or indirectly affected by the question of forced drugging/ medication. Viewpoints of these people were actively sought and compiled in this report. Opinions of line staff, current residents, outside psychiatrists, former residents, prison psychiatrists, medical technical assistants, prison administrators, community organizations and families of residents are reflected in the transcripts of hearings as well as in the documentary film produced in conjunction with ABC news.

The input of ex-offenders, some who have experienced forced drugging/medication, as well as the legal assistance offered by Committee interns, has done much to facilitate as balanced an evaluation of the issue as possible. Therefore, Committee findings and recommendations, in addition to the subsequent

legislation to be introduced on this subject, is not the product of a select homogenous group of individuals, but rather reflects a combination of the diverse elements that have contributed to making this report possible.

Assembly
California Legislature

Select Committee on Corrections

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AGENDA

FORCED DRUGGING IN
CORRECTIONAL INSTITUTIONS
July 28, 1976

Opening Statement, Chairman Alatorre

Showing of documentary on Forced Drugging prepared by Eyewitness News in cooperation with the Select Committee on Corrections.

California Department of Corrections:
Response to Documentary

Dr. Paul Lowenger, San Francisco

"Mel", former resident, C.M.C.

Dr. Lee Coleman, San Francisco

Wade Hudson, N.A.P.A., San Francisco

Eleanor Gardner, C.I.W.

Dr. Isadore Ziferstein, Los Angeles

Mr. Tafolla, former resident, C.M.C.

Lunch Break

Mr. Mike Quinn, Citizens Commission on Human Rights

Gordon Cook, Project Involvement

Yvonne Rice, concerned citizen

William Harris and Stan Hervey, former residents

Manuel Ramos, former resident

Peter Calagna, N.A.P.A., Los Angeles

ASSEMBLY SELECT COMMITTEE ON CORRECTIONS

Los Angeles, California
July 28, 1976

CHAIRMAN RICHARD ALATORRE: Good Morning. It is a pleasure for me to welcome you to this special hearing being conducted by the Assembly Select Committee on Corrections.

Today's hearing is concerned with a most serious and important topic: the subject of forced drugging in state prisons. The questions which we seek to answer are: How are psychotropic drugs being utilized in California penal institutions? Are they being employed for psychiatric medication, or for management control problems?

Through today's testimony, the Committee hopes to obtain information necessary to stop any abuses in the administration of psychotropic drugs. If, in fact drugs are employed as a psychiatric tool, the question arises as to whether this activity should fall within the jurisdiction of the Department of Corrections. We are concerned that inmates who need psychiatric help be afforded the necessary services in the proper medical atmosphere. It is our opinion that C.D.C. was not created for this purpose.

If, on the other hand, drugs are being utilized for management control, this Committee will work to see that such activity is discontinued as soon as possible.

Before we commence, on behalf of the entire Committee, I would like to extend our appreciation to those of you who have taken time out of your schedules to testify today. I am most impressed by the credentials of our witnesses.

The initial portion of the hearing will feature a short documentary film which was produced by CONTACT 7, KABC-TV Los Angeles. They have brought many of the concerns relative to the issue of forced drugging in prisons to the attention of the general public.

Part of the responsibility of this Committee is to look carefully at the quality of medical services which are extended to inmates throughout the prison system. Within this context we are most disturbed by the charges of forced drugging which have been raised in connection with the California's state prisons.

As I have indicated, the first phase of this hearing will focus upon the information which has been compiled by KABC Television relative to the subject of forced drugging. Channel 7 has been running a series for the last six days on this issue. In order to give some of the members of our audience an opportunity to become acquainted with the problem of forced drugging, those responsible for the documentary have consented to show us the film which they have produced.

So, Steve may we start now?

(Documentary film shown)

This Committee and CONTACT 7 may be criticized by some for being biased. However, I want to make it clear that a representative from the California Department of Corrections was requested to be present today. This request was made to their legislative representative, as well as to the Director of the Department. Obviously, unless an individual from the Department is present, C.D.C. will not be represented. I am sure they feel the presentation made here this morning was somewhat biased, but the information compiled was not only obtained from inmates, but also from the prison psychiatrist or the head of the medical unit. So, in my opinion, the documentary is not biased. I believe that there is a problem, and this is the purpose of the hearing.

The first person that will be testifying today will be Dr. Paul Lowenger from San Francisco.

DR. PAUL LOWENGER: My name is Paul Lowenger. I am a medical doctor, specializing in the practice of psychiatry. I hold a position in Associate Clinical Professors of Psychiatry and Community Medicine at the University of California, San Francisco. I am currently Director of the Psychiatric Residency Training Program at Highland General Hospital in Oakland.

My concern for prison health and psychiatric problems in prisons rose out of long participation with the medical committee for human rights both before and after I moved to California. The statement which I am making reflects the views of the Bay Area

Chapter of the Medical Committee for Human Rights Prison Task Force.

CHAIRMAN ALATORRE: Let me ask, who composes your task force?

DR. LOWENGER: The task force is composed of a number of people, but this statement was primarily prepared by myself while I was working for the prisoners health project in San Francisco, caring for people in the county jails, in contact with those in the state prisons. Dr. Phil Shapiro, Dr. Louise Miller, and Dr. Richard Fine; we are the ones that are responsible for this statement; of course, we have contact with ex-prisoners and with prison rights groups as well. We have tried to address the issue of forced medication; involuntary medication on prisoners in state prisons. We have tried to establish some definite guidelines, and we have prepared this statement for possible use as legal regulations in the state prison system in California. I have copies of it which I will make available to people who want it. I want to explain very briefly why some of these major issues are mentioned.

1. No major tranquilizers or neuroleptic drugs should be used for administrative or custody reasons. By major tranquilizers or neuroleptic drugs, we are referring to phenothiazine drugs or haloperidol or the major tranquilizers that are commonly used as you saw in the previous film.

2. All psychiatric medication should be prescribed by licensed physicians, preferably psychiatrists. The use of other personnel giving medication, including forced medications, has occurred in prisons and jails.

3. Minor tranquilizers should be available to the doctor for the treatment of anxiety and depression. Major tranquilizers, that is the neuroleptic drugs, should not be used where minor tranquilizers give adequate relief. Concurrent use of more than one major tranquilizer should require consultation, as we refer to in Point 9, with an outside professional expert. In other words what Point 3 is saying is that if a prisoner or patient is anxious or depressed, he shouldn't be given a large dose of a heavy major tranquilizer like chlorpromazine. He should have the same kind of treatment by and large, that people would get in private clinics or office practices in the community.

4. Wherever there is a possibility for prisoner misuse of prescribed medication, a liquid form should be used. Misuse means, or includes, accumulation of medication, transfer of medication to another inmate or other improper use.

5. Psychiatric medication should never be given in a covert or disguised fashion. We constantly run into situations where we hear about medication being given in the food or the drinking material of inmates. This should be specifically forbidden.

6. Patients should be given thorough information about their psychiatric medication, including its purpose and side effects. Prisoners rarely have this information, and clearly are unsure whenever they take any medication, especially psychiatric medication.

7. Major tranquilizers. Once more, neuroleptic drugs should not be used for non-psychotic patients, only patients with a diagnosis of psychosis should receive a major tranquilizer.

What we are saying here is that the people who are anxious or depressed or neurotic should not be given chlorpromazine or other heavier potent tranquilizing drugs.

8. Major tranquilizers should be given to psychotic patients only on a voluntary basis with the exception of the prisoner whose condition threatens substantial mental or physical harm to themselves or others. This is probably the most controversial of our points and I call your attention to that fact.

9. Every effort should be made to secure the voluntary consent of the patients for necessary and appropriate medications. In those cases where sustained involuntary medication, that is over 72 hours, is necessary to prevent substantial physical and mental harm, a consultation with a practicing academic or community psychiatrist should be obtained. The consulting psychiatrist should be chosen from a panel of community and academic psychiatrists selected by the California State Department of Health in cooperation with the Department of Corrections. The consultant's opinion would be binding on the prison psychiatrist, except when an appeal is made to the Chief of the Medical Services of the Department of Corrections who may then request additional consultation. If the consultant to the prison psychiatrist decides involuntary medication should not be used, the medication will be stopped until the appeal to the Medical Services has been decided. If involuntary medication is given over ten days where its use has been approved, an additional consultation will be required for each ten days of involuntary medication. If the psychiatrist has reason to question

the patient's ability to give or withhold voluntary and informed consent for psychiatric medication, he is required to request consultation. The same requirement for consultations shall apply if another professional member of the prison psychiatric treatment staff has reason to question the patient's ability to give or withhold voluntary and informed consent to psychiatric medication. I think this is a major safeguard which is clearly not present as things are currently organized.

10. Regular medical education about psychiatic medication and related topics will be available for all staff involved in these treatments.

That is the full text of the statement, which I offer to the Committee. I would be glad to answer any questions if there are any.

CHAIRMAN ALATORRE: Have you had an opportunity to go into the Men's Institution at San Luis Obispo? And, to your knowledge, is there any forced medication that has gone on or is going on?

DR. LOWENGER: My personal experience is limited to observations made by visits to the California Medical Facility at Vacaville. Talking with prisoners who have been in Vacaville and other state facilities and who have returned to the county jail, where I was working for almost two years, I have heard numerous accounts of forced medication without safeguards, information, precautions or consultations with the prisoner about his own opinion or his opportunity to give consent or to withhold consent. So it is personal information from prisoners and from talking with the medical staff who work in those

institutions that leads me to believe that this is a common and daily practice in many of the institutions, but particularly Vacaville.

CHAIRMAN ALATORRE: You have testified that you had the opportunity of discussing this with some of the medical personnel at Vacaville. Is that correct?

DR. LOWENGER: Yes.

CHAIRMAN ALATORRE: Can you give us your observations as to the competency of the medical personnel at Vacaville?

DR. LOWENGER: I found the competency quite variable. Some professional and medical staff there are well trained, conscientious, and hard working. Others appear primarily punitive and not well motivated or interested in the health conditions of their patients. However, even the well trained and conscientious doctors are at a disadvantage because the environment of the institution emphasizes security, and institutional rules don't permit them to practice good medicine even where they know how, and want to do it.

CHAIRMAN ALATORRE: Now about C.M.C. East. Do you think that institution should be involved in medic. ion or d you feel that people they diagnose to be psychotic should be transferred to a medical facility before they are given medical treatment?

DR. LOWENGER: I think by and large all prison inmates who are thought to be, or diagnosed as psychotic should be transferred to a specialized facility such as California Medical Facility at Vacaville, for definitive diagnosis and for treatment

or simply to not be treated if they are not psychotic. We have emphasized in our statement that specialized trained personnel should be used wherever possible and that can nearly always be the case if the system becomes flexible enough to rule in or out the diagnosis of a serious mental condition such as psychosis where the prisoners are out of contact with reality.

CHAIRMAN ALATORRE: Do you think that the medical facility at Vacaville is the best location, or do you think a mental health facility would be preferable?

DR. LOWENGER: I think you can say in general, a mental health facility would be preferable since removal of a emotionally disturbed, mentally troubled person from the prison environment is often a major step in overcoming whatever problem, issue or illness that is troubling them. We certainly found that to be true in our two years of work with prisoners at the county jail in San Francisco County, where removing the prisoner from the prison, treating him in the hospital, the San Francisco General Hospital, which has some capacity for psychiatric as well as medical treatment, is often very important, so I would agree with that plan. If at all possible, and it should be possible if legislative directive is given, prisoners should be taken from the prison to a mental health facility.

CHAIRMAN ALATORRE: To you knowledge is there any forced drugging going on in county jails?

DR. LOWENGER: Yes. This is quite variable. We have had reports of this from prisoners and unfortunately we don't

have as much information about this in terms of its frequency or severity as we would like, but the repeated reports from prisoners about their experiences in one or more county jails leads us to believe this is the case. I think what the Committee and the Health Department and the Department of Corrections really needs is some direct observations of these matters inside the walls using the kind of legislative authority and technical and professional assistance that can be assembled to find out how frequently it occurs and how extensive it is. For example, what types of drugs are used and for how long?

CHAIRMAN ALATORRE: If you were to go to the Legislature to try and seek legislative relief, what types of things would you be requesting from them to control the forced drugging problem?

DR. LOWENGER: I think one major area would be the kind of regulations having the force of law that I have identified in this statement. After this has had a chance to be subjected to legal and administrative review, I think that kind of authority over doctors and corrections officials is important. Clearly, the administrative structure here has to involve the Health Department, it cannot rest solely or primarily with the Corrections Department even though they are administratively responsible for the prisons. In other words, the health conditions of the prisons have to be related to the line of authority of the Health Department.

CHAIRMAN ALATORRE: Do you see this as a custodial problem,prison problem or do you see this as a problem that should be dealt with in the health area?

DR. LOWENGER: I see it primarily as a health problem. Although people from a variety of prospectives want this done, I think it is of importance to the legal profession who get clients in court situations or in conferences where the prisoner is so heavily drugged that he can't participate adequately in some legal action involving his case. But I think it is primarily a health problem, it has to be solved within a health context and the lines of authority to the Health Department from Corrections have to be clarified. The regulations have to have the force of law or they will be ignored or simply subverted in some way.

CHAIRMAN ALATORRE: Do you think that an institution like C.M.C. East is capable of providing these types of services?

DR. LOWENGER: I am not sufficiently familiar with C.M.C. East. I have not visited there, I have only talked occasionally with prisoners who have been there and there clearly seems to be major problems in that institution. I think that Vacaville is capable of carrying this out if there is continued surveillance from health and legislative components of government under the authority of law.

CHAIRMAN ALATORRE: Do you think that surveillance at the present time is adequate?

DR. LOWENGER: No.

CHAIRMAN ALATORRE: Thank you very much, Dr. Lowenger.

CHAIRMAN ALATORRE: Yes, Mel. Let me ask you, to get some clarification for the record, are you here voluntarily or did you come here at my request?

MEL: I came at the request of the Chairman.

CHAIRMAN ALATORRE: How long, and in what facilities have you been incarcerated?

MEL: I have been in C.M.C. East, and a month and a half at Vacaville.

CHAIRMAN ALATORRE: How long were you in C.M.C. East?

MEL: Well, almost four years except for the month and a half at Vacaville.

CHAIRMAN ALATORRE: What are the reasons that you are hesitant in giving your full name? Is it that in giving testimony, you are afraid of retaliation?

MEL: Yes.

CHAIRMAN ALATORRE: Can you just give us your observations at the time that you were actually in C.M.C. East as to the problem that we are addressing today?

MEL: Well, I saw on the news that they say you arrive one day and the next morning you get a slip under your door saying report at eight o'clock to the psychiatrist and you go in there, and they start handing out the drugs.

CHAIRMAN ALATORRE: Now the following day when you saw the psychiatrist how much time did he spend with you?

MEL: About 5, 10, 15 minutes. No longer.

CHAIRMAN ALATORRE: Were any tests given to you?

MEL: No.

CHAIRMAN ALATORRE: Was a consultation given to you?

MEL: No.

CHAIRMAN ALATORRE: So, it is your testimony that after about

5 or 10 minutes you were given a prescription of drugs.

MEL: Yes, I was given quite a few.

CHAIRMAN ALATORRE: What were you in the institution for?

MEL: Well, it is a violation of probation which was for forging dangerous drug prescriptions. I had a back injury and the doctor did not believe me, so I made my own prescriptions for medication. I wrote my own. Like I say it was my fault, I realize that, but I had no mental problem but that's what they kept driving into me.

CHAIRMAN ALATORRE: What medication did they prescribe for you?

MEL: Thorazine, stelazine, artane, placidyl and meprobamine.

CHAIRMAN ALATORRE: Were you ever told why they were prescribing those medications to you?

MEL: Not really, they just, whenever I go to the board they said I was crazy. That I keep flipping out.

CHAIRMAN ALATORRE: So, to your knowledge at any time, did they ever tell you why they were prescribing and giving you those medications?

MEL: No.

CHAIRMAN ALATORRE: Can you describe to the Committee some of the reactions that you had to the drugs?

MEL: Well, I had that shuffle, I couldn't stand still, and my wife and kids was coming up to see me. I couldn't stand still and I stayed two and a half years locked up in my cell because I was so drugged out and doped, the only time I got out was when I ate. The medication which I had to take or else it is tough.

CHAIRMAN ALATORRE: Now at any time during your stay at C.M.C. East did you refuse to take the medication?

MEL: No. I heard too many stories and I seen too many things happen.

CHAIRMAN ALATORRE: What type of stories did you hear, and what types of things did you see?

MEL: Well, if you refuse the medication, they take you and lock you in the PC Cell.

CHAIRMAN ALATORRE: What is a PC Cell?

MEL: Protective Custody, or lock up which is nothing but a concrete bed. It has a thin mattress, no shelves, nothing. They take your clothes away from you, all the blankets, everything and the guards would hold you down, about three guards or four whichever it took, and the MTA's would put the stuff in your rear and they would give you five milligrams extra for punishment because you had refused it.

CHAIRMAN ALATORRE: Now when they gave you injections, you're saying that they gave you an extra dosage?

MEL: Yes.

CHAIRMAN ALATORRE: Now, what was that supposed to be for?

MEL: For punishment, for refusing.

CHAIRMAN ALATORRE: Now would they tell you the reason they were giving you the extra dosage was to punish you for refusing to take it orally?

MEL: Like I said, it never happened to me because I never refused it, but I heard it was told to the other inmates.

CHAIRMAN ALATORRE: Did you ever see any of the inmates being taken?

MEL: Yes.

CHAIRMAN ALATORRE: Did you see any of the inmates when they returned?

MEL: Yes, quite a few.

CHAIRMAN ALATORRE: And they told you basically what you have just said?

MEL: Well, it's just, they give them that stuff to just keep them quiet, to keep them locked up in their room, so they won't give them any trouble. They just quiet them up.

CHAIRMAN ALATORRE: What section of C.M.C. East were you at?

MEL: In D Quad.

CHAIRMAN ALATORRE: When you entered the institution were you sent immediately to D Quad?

MEL: Yes.

CHAIRMAN ALATORRE: How long did you stay in D Quad?

MEL: About 2 1/2 years, then I went to Vacaville for 1 1/2 months in 1974; and came back 1 1/2 months later. I went up there for observation, for my back and a neurosurgeon came in from Travis Air Force Base to check my back out to see if I needed another operation. He said that the first one did not do any good, and the second one would not help either so he would not operate.

CHAIRMAN ALATORRE: Were any of the drugs that they gave you for your back condition?

MEL: No, my back was forgotten.

CHAIRMAN ALATORRE: Now when you left the institution, did they give you a set of prescriptions?

MEL: No, because when I went to Vacaville, I refused to take

it up there and told them that I didn't want anything and they said well, if you won't take it then we're not going to force it on you. I have been off medication since 1974.

CHAIRMAN ALATORRE: You have been off medication since 1974?

Mel: Yes.

CHAIRMAN ALATORRE: Have you had any side effects as a result of the medications that you took while you were incarcerated at San Luis Obispo?

MEL: While I was taking them?

CHAIRMAN ALATORRE: No, when you came back..afterwards.

MEL: Afterwards, no, they just had me locked up in my room too. They kept me locked up there, so I just laid in bed.

CHAIRMAN ALATORRE: Have you had an opportunity since the time you left the institution to seek private consultation to determine whether or not you are insane?

MEL: No. Because I know I am not.

CHAIRMAN ALATORRE: Have you had any problems since you left the institution?

MEL: No.

CHAIRMAN ALATORRE: Are you currently on parole?

MEL: Yes.

ASSEMBLYMAN JULIAN DIXON: Can you tell me how the drugs were administered to you?

MEL: They were handed out through the window. Sometimes you'd get pill form and sometimes you'd get liquid. Sometimes you'd get the right one, sometimes you'd get the wrong one. I mean I have had things and have gone 50 feet or 50 yards and hit

the ground and had to be carried to my cell.

ASSEMBLYMAN DIXON: So they were administered orally never through an injection?

MEL: No. never.

ASSEMBLYMAN DIXON: Were you receiving any other kind of medical treatment while you were at C.M.C. East?

MEL: No, I went for my back. They gave me heat for my back. They refused to do anything about my back.

ASSEMBLYMAN DIXON: Were you in any type of therapy?

MEL: I was in group therapy.

ASSEMBLYMAN DIXON: How often did you see a psychiatrist or a physician?

MEL: I think it was once a week.

ASSEMBLYMAN DIXON: Did you ever ask the psychiatrist why you were being administered drugs?

MEL: You don't ask anything. You just take it.

ASSEMBLYMAN DIXON: You indicated the reason that you took them was because of some punitive action that might have been taken if you did not take them. Can I ask you how you became aware of that knowledge? Was it through the grapevine or did someone tell you that?

MEL: I seen it, I heard it..that was PC Cell, 7 building, 1st floor.

ASSEMBLYMAN DIXON: As it relates to any personnel involved at C.M.C. East did you ever, for any reason, register any complaints to them about taking drugs?

MEL: Yes, I complained about it to the psychiatrist.

I don't want to mention his name but everybody here knows him anyway. Instead of cutting anything down they would say you just go ahead take what you get, and then we'll just give you something else to counteract it.

ASSEMBLYMAN DIXON: Do you recall what he said in response to the fact your registered a complaint? Did he say anything at all?

MEL: No, he just said I needed it.

ASSEMBLYMAN DIXON: Do you have anything else you want to say?

MEL: No, I can't think of anything. On, they say you have an opportunity to work. I filed for work many times and they turned me down because you're so medicated. They won't cut the medication off, so that's it. I mean you just lay there, that's all you got to do.

CHAIRMAN ALATORRE: Now it was my understanding in the conversation that we had with the superintendent, as well as the psychiatrist, the chief medical officer of the institution that D quad was the best section of the institution because there was an opportunity to go to educational classes or to work on different trades. Did you have the opportunity to work?

MEL: No, because I just wasn't in shape and your mind isn't that good to do anything. They'd tell you to go, but you can't do the work because you're so medicated it's something else. There's something else I want to say, up there in D quad on Mondays, Wednesdays, and Fridays they always walked us out of our building and made us sleep on the ground outside

from eight o'clock in the morning until eleven o'clock count time.

CHAIRMAN ALATORRE: 11:30 a.m.?

MEL: In the morning, yes.

CHAIRMAN ALATORRE: What was the purpose of this?

MEL: He said we needed fresh air and exercise.

CHAIRMAN ALATORRE: Now to your knowledge did any friends that you had at C.M.C. East have the opportunity to take any classes?

MEL: Sure there were some because they were not on medication.

CHAIRMAN ALATORRE: Do you have any knowledge of how many people were medicated in D quad? Were they roughly about 300?

MEL: I'd say that many or more. There are two buildings of 600 guys in D quad. In every quad there are two building and there is 300 in a building.

CHAIRMAN ALATORRE: To your knowledge, aside from D quad, are there any other quads that practice the use of medication?

MEL: I heard B quad did, C quad did and a few in A.

CHAIRMAN ALATORRE: Do you have any personal knowledge of whether the problem in A quad and B quad was the same as in D quad concerning medication?

MEL: No. I don't think it was as bad. D quad was just a special quad.

CHAIRMAN ALATORRE: Thank you very much. I would appreciate your keeping us informed of any problems that arise from your testimony.

MEL: Okay.

CHAIRMAN ALATORRE: Dr. Lee Coleman.

DR. LEE COLEMAN: My name is Lee Coleman. I'm a psychiatrist and I live in Berkeley. I just want to give you very briefly, my background and why I'm involved in these issues and how I come to be here. Since coming to California in 1971, I have been involved in the issue of prisons and particularly the whole relationship between the rehabilitative, treatment or correctional philosophy which underlies the present system as well as the laws governing the system, most particularly the indeterminate sentence and because that is based on a rehabilitative rationale which in turn rests on psychiatric principals, and because I have seen that the indeterminate sentence is the most abusive thing about prisons. I felt I had to get involved because if for no other reason, I felt it was a very bad reflection on the profession that I'm a part of. I have subsequently been involved in a variety of areas which I think touch on your concerns this morning, that is, the prison issue. I'm deeply involved in the whole issue of involuntary psychiatric treatment of which forced drugging is the whole issue of long-term psychiatric control through conservatorships, the use of a treatment rationale for increased oppression of juveniles. These are all areas I have been involved in and I want to try to give you that broad perspective in some of the things I am going to say this morning. Now in what I'm going to say it may appear that I am really going far afield,

but I beg of you to stay with me and I'll try to be brief. I just don't feel that you can adequately deal with the issue of drugging and prisoners unless you take at least some look at the background of the whole problem. What I mean by that is, the whole issue of psychiatric drugs in general, not just if you are a prisoner, the whole backdrop of control in prisons. I don't think I need to go into great length as far as prisons because you are all quite familiar with that through your work on the Committee. But let me say just briefly, a little bit about what's happening in psychiatry, what seems to be happening more and more all the time and I urge you to keep this in mind when you are trying to decide what kind of legislation would be appropriate.

In my experience, psychiatry is in a midst of an incredible biological orientation, a bandwagon in the direction of biological psychiatry. Psychiatry I think, partly because it is being threatened by non-psychiatric competitors in the therapeutic market place is withdrawing into a medical orientation, a biochemical orientation, in which they are the only one to have goodies supposedly if you believe in this. It gives them a special identity and also financial security which they wouldn't have if they didn't have this medical framework to fall back on. The result is, and because of the relationship with the drug industry which I'll mention in a minute, is that psychiatry is more and more tending to conceptionalize people's problems as biochemical abnormalities in their brains and therefore the response is more and more pills, and more chemicals. The number

of pills that are being prescribed and utilized is vast, and I don't think I need to go into numbers, they're available, but everybody knows from experience how everybody is being given drugs for one thing or another. The relationship between psychiatry and the drug industry is a most unholy one in which each side is scratching the other's back. The drug companies need the doctors, because without that signature on the prescription pad the drug companies don't make any money, and the doctors need the drug companies in many ways. One outstanding example is they can't support their journals without advertising money from the drug companies. That's why you see example after example of these horrendous advertisements in psychiatric journals. Neither side seems willing to look at the conflict of interest that's inherent in that situation.

Just a couple of examples of the way this thing is mushrooming; the very powerful tranquilizer thorazine or the phenothiazines has, for years, been considered to be most appropriate for psychotic conditions, and I'll get into it a little later, the whole problem of using any of those labels particularly in a prison setting, but even if you leave that aside, it's now being felt that thorazine could be useful in non-psychotic individuals as well. That takes in everybody psychotic and non-psychotic, everybody is potentially available for it. Likewise for another equally powerful drug in terms of dangerous side effects is lithium, a very dangerous drug which has side effects on virtually every organ system in the body. Initially, it was said to be useful in the manic phase of depressive illness, that is when you're

hyper in those phases. Now they're talking about if you don't manic and you just get depressed it's also useful there. So what I'm saying is that there is a tremendous bias towards giving pills for people who come in with psychiatric problems. That's going on in psychiatry in general and I think its well to keep that in mind when you then try to focus in on what is likely to happen in a particular kind of situation that is a prison. Let's then ask a few questions and look at a few issues with regard to a prison keeping that kind of thing in mind. It's been said that people shouldn't get these drugs against their will especially unless they are psychotic, we shouldn't give it to them if they are neurotic, anxious, or have a character disorder.

CHAIRMAN ALATORRE: Well, what does that mean?

DR. COLEMAN: I would suggest to you that it means nothing. A psychiatric diagnosis doesn't mean very much anyway because it has an awful lot to do with subjective bias of the psychiatrist and the situation. But in prison it means even less and I am speaking from my own personal experience of being involved in cases, and I am sad to tell you that I could pull out a dozen cases from my own file in which the diagnosis was used in the most clearly inappropriate and destructive manner, and I will just give you one example because you can read about it in a public format and that's the case of Rodriquez, which the California Supreme Court reviewed. The case of a man who'd been in prison for 22 years for molesting a little girl. Now, I am not condoning such activity or saying that shouldn't be a crime. My point is that he was in prison and initially,

of course, he got his psychiatric workup and it showed he was clear and rational, there was no evidence of delusions or hallucinations, and what do you think the diagnosis was? Schizophrenia, despite the fact that nothing had been said in the body of the workup that would indicate that. He was forced to take medication at various times throughout his 22 years, but very importantly is that those psychiatric reports and particularly the diagnosis was used by the Adult Authority as justification for keeping him in prison year after year after year. "We 'd let you go Mr. Rodriguez, but you don't have psych clearance." That's typical of the kind of thing that would happen. So, what I'm saying is, you have to keep in mind that in addition to the backdrop of the way drugs are being abused in psychiatry in general, the inherent coercion in a prison which is going to be there anyway by the very fact that it is a prison and is multiplied many times over because of the indeterminate sentence and the incredible power that it gives to the people who run the prison, including the psychiatrist. The Board reports have a very great influence on what the Adult Authority is going to do. That then takes us to the problem of this morning, and that is the issue of medication and prisoners. Because as long as you have the backdrop that what the psychiatrist thinks and writes on a piece of paper can hint to us how long you are going to be in prison, then you refuse medication at very great peril, not just the peril of what will be forced on you physically as we heard this morning and as I'll document a little bit later. But even greater peril is the fact of spending longer time in prison. Let me quote an

example to show you what is happening and tne thinking of the psychiatrist. This letter is written by Dr. Pickett who's the same psychiatrist who was interviewed in that tape at C.M.C. East. He says in part of his letter "there were cases of repeat exacerbation of the man's symptoms after he's been taken off medication, requiring that he again be placed back on medication. In these cases we require a maintenance dose so as to prevent such recurrences. Mental illness should not be a contrite indication to parole unless the man's criminal behavior is related to his illness. If this is the case, then it is important for the man to realize one of the conditions of his parole would be that he take the indicated medications if necessary in controlling his behavior. Now the key phrase there is, "if the man's criminal behavior is related to his illness." I don't know if you are aware of it, but the Adult Authority requires the psychiatrist in his report, in every one of them, to state whether they feel that the illness is related to the crime. This is absolute hocus-pocus from any psychiatric point of view.

CHAIRMAN ALATORRE: Let me ask you, do you think that the psychiatrist spends enough time to be able to make a definitive determination on that particular question?

DR. COLEMAN: That's a loaded question, they don't spend enough time to do anything meaningful, but if I were to stop there I'd be doing you all a disservice and most of all the prisoners a disservice. I don't care how much time you spent with them, there is no such thing as an illness which is related to crime in that way, there is no such thing. So that would be like saying that...

during the Inquisition they used doctors to testify in witches' trials, and they would testify to whether or not they found witches' marks. Now if you were to say, well, doctors maybe you didn't spend enough time and if you looked harder you might of found the witches' marks, well you'd obviously be supporting the notion that there are such things. Well, that's exactly the same thing here, there is no such thing as any psychiatric condition which is related to crime. That's a mythology which goes back years and years and is based on class distinctions and race more than anything else. So the prisoner he knows that the psychiatrist is thinking on those terms, he knows that's required and he knows that if he gets in this bind where the psychiatrist says, I think your illness is related to your crime. That if he doesn't take the medication it's very clear from this letter that he is going to be in bad shape as far as what the Adult Authority is going to think. Now obviously that gives you a backdrop of the coercion which is inherent in giving of drugs in prison, and one of the main points I want to emphasize this morning is, do not restrict yourself in any legislation that you write to the issue of those people clearly and obviously being forced to take drugs because you are not going to be touching the biggest part of the problem.

CHAIRMAN ALATORRE: What else?

DR. COLEMAN: The biggest number of people are typical of the individual who just testified. He didn't complain and he gave the reasons why. He knew he would be forced to take them physically and I would be very safe in saying that he was also

concerned about...how it would affect his standing with the Adult Authority. So yes, we've got to take care of those grievous examples where people are physically forced to take it, who physically refuse it. But that's only the icing on the cake.

CHAIRMAN ALATORRE: In other words, what you are saying is that we should not be limited to those individuals that are being forced to take drugs, but also look at the process and look at the individuals who voluntarily are taking medication because he knows what the system is about and knows what the consequences are of not taking it.

DR. COLEMAN: Voluntarily in quotes that's right, and I am going to say more a little bit later about my recommendations as to how to get to that problem, but that's the biggest part of the problem. Let me just briefly read from a letter to give you an indication of what some other prisoners have said about their own experiences.

This is an individual who wrote on May 30, 1975, "on April the 25th I was called to see the chief psychiatrist, we had a five minute talk in which he stated that he thought I should...I was becoming overly fond of the Valium and it should be discontinued." I'll just paraphrase parts of this, he, the individual, agreed with this but he was asked if he'd being hearing voices, and he said I'm not hearing any voices, I have in the past but that hasn't happened for several years. That night I was shocked that I found myself having been put on medication four times a day without any warning or mention to me of this the fact. When I asked the MTA

if it was a mistake, it was checked and I was informed it was true. I asked if I could refuse it, and was told if I refuse it we have an order and you'll get an injection and will be taken by force if necessary to a P cell. Then I asked the MTA what I was being given and he said he was not at liberty to say, so I took it and made the statement that I was taking it under duress. On the 28th of April I requested to see a doctor, I asked him why I was put on medication, he said your behavior had been erratic on Friday and this is why. I asked him to be specific. He said your whole behavior is erratic. I replied, I did not want any of the medication. As a matter of fact, I did not feel I needed any at all and I would resist taking it. He said this was all right since he had put an order to cover just that attitude and I could do what I wanted. He first said he'd see me in a month and I should appreciate the people who wanted to help me."

Well, I would say in my experience this is typical of the way people get put on medication and that is there is something that goes on in the institution which is troublesome. It may be a kind of a interview with a psychiatrist has some friction, it may be a problem with another inmate, but it's clearly that you're sort of a pain in the neck and it get conceptualized as a psychiatric disorder. I have other letters here, individuals saying, "I'm being forced to take medication, Prolixin is a really mind killing drug. At present I'm all right, I don't want or need drugs, especially Prolixin."

I think this is the issue, is that the control of prisons

particularly the indeterminate sentence. Against the backdrop of the general abuse of drugs by psychiatry means that coercion is inevitable, if you know enough about those two things you can't miss. As far as concrete data, I don't think very many people have very much and that gets to two of the recommendations I want to make to you as to how to deal with the problem. First of all, let me say I don't think you can separate this problem from a responsibility which your Committee is also involved in and that is the indeterminate sentence. As long as we have the indeterminate sentence, you are going to have abuses of this kind. You can cut them down, but ultimately the abuse stems from the fact that the prisoner knows he has too much to lose in terms of time. And so I urge you, don't make strict separations from these two things.

CHAIRMAN ALATORRE: If the indeterminate sentence were abolished and fixed terms were set, do you think that there would continue to be abuses?

DR. COLEMAN: Oh, yes. There will be and I'll address myself to those now, but I think there would be far far fewer abuses. The inherent abuses in the woodwork I think would be a lot less because the psychiatrist would cease to have a lot of the power he has now.

All right, I think what I would then recommend that what you do is to impanel a commission with the authority to really find out what is going on. Right now nobody has any information which the people who are in a position to change the laws and to administer the laws are finding very creditable or choose

to find creditable. I find it highly creditable, letters from prisoners, talking to prisoners, direct experience with the prison scene but you are in a position to generate information which people will not be able dismiss, because of the authority of your Committee. And I would urge you to establish a blue-ribbon commission, and I'm going to describe what I mean by a blue-ribbon commission, to go in and gather the kind of information that I've been talking about. Find out how many people are clearly forced to take drugs and find out about the much larger group who are taking drugs who really do not want to take them. When is that done? How often is it done? Under what kind of conditions? Now, what I mean by blue-ribbon commission would be a commission which has very few professionals on it. Just one or two maybe. A group which would be represented by convicts, a group which would be represented by minority groups, which truly would be representative of those people who have the most to gain or lose by this situation. But clearly one which could not be dominated by those entrenched in a medical viewpoint. I would say, you know trying to look ahead from that, ultimately there's got to be some sort of review process. Now in my personal view, I don't think you should ever have any forced drugging, ever, with a capital "E" ever. I don't think it's necessary and I think for every individual who the psychiatrist will prescribe, who's going to be slowly destroyed by not getting his medication, we could come up with a hundred who are being destroyed and who are going to be destroyed by forced medication. Since we don't have the luxury of doing anything which will get rid of every problem, we've got to ask, what can we do that will minimize the problem? In my experience both as a psychiatrist

in the private sphere, and involved in prison matters, hospitalization for psychiatric problems I have no question whatever that we would have far far fewer problems if no patient could ever be forced to take medication. I'm aware of all serious psychiatric disturbances and all the things that can happen. But in prison of all places with that kind of security they shouldn't need drugs for the control of people. There aren't any psychiatric emergencies for which you have to have drugs. I think what you'd find is suddenly the individual who becomes addicted to their medication would gradually find that they can withdraw from it, it's happened other places. You go to a lot of state hospitals, they used to give shock treatments in huge numbers, now they don't give it in a lot of those hospitals. I was recently at Sonoma State Hospital and they don't give any shock treatments there any more. They used to give it all the time, but what happened? The decision was made that they weren't going to do it and so they learned to get along witnout it, and that's what would happen with forced drugging. I realize that's probably not going to happen next week or the week after, but I'm telling you that here's at least one individual's experience, it's not really necessary to ever force people to take drugs and you are actually harming them far more. As long as any forced drugging does exist you've got to have an outside review board that is not part of the prison system and I think the regulations that are now in existence are clearly a flop. They have the power to overthrow the outside consultants, there is nothing in there talks about how the outside consultants are going to be appointed,

you've going to have a review board that has some teeth in it. But I feel that's down the line. As a matter of fact, I feel that at first you've got to get a commission of the kinds of people I've recommended to go in and really find out what's going on, so that when you get to the point of writing the legislation you've got some findings that nobody's going to be able to dismiss, and I think you have the power to do that. That's my strongest recommendation. I'm finished.

CHAIRMAN ALATORRE: Let me ask you a couple of questions. Do you have any knowledge as to who prepares the psychiatric work-up?

DR. COLEMAN: Are you talking about the initial work-up at the Reception and Guidance Center, or board reports every year?

CHAIRMAN ALATORRE: I'm talking about the psychiatric work-ups done at the Reception Center when the person enters the institution, and any other work-ups that are done.

DR. COLEMAN: Well, it's a joint effort. In my experience from reading them the social worker does most of the work, because they compile most of the background information. The psychiatric reports are nothing more than rehash of information you can find somewhere else. So the social worker does the longest writeup. The psychiatrist also has something in there, as does the psychologist, but I'm not sure where you are going with that question. It's a joint effort of several people.

CHAIRMAN ALATORRE: Basically, a non-professional doing the work-up on a person; what effect does that have?

DR. COLEMAN: Well, that gives me the same reaction of which you asked me earlier about whether the psychiatrist spent enough time to...first of all, I would consider the social workers probably as professional as a psychiatrist. I think in many ways they would be preferable because they are use to having less power and therefore they get less carried away with themselves, less arrogrant in terms of their position. So I consider them professional, but the real point is; it really doesn't matter whether the psychiatrist is putting in 80 percent of the time and the social worker 20 percent. The point is that the whole thing is a sham and most of all the prisoner knows it.

The point is you are there for a work-up which is supposed to determine what prison you go to and it is then used to determine how long you stay in prison. In part, I mean, these work-ups that are done initially, at reception and guidance centers stay with you in board reports in coming years. They get quoted over and over again. Now the prisoner knows inherently, he may not be able to write a paper about it for a journal, but he or she knows that this is a lot of B.S. There isn't anything that this professional is doing which really tells anybody anything about how long they should be in prison, or what is going on inside their head, and that engenders a lot of feelings. Anger, frustration, powerlessness, despair and that only is just like... starts the seeds of problems later on in many cases. So the real problem is not an issue of who does it, it is the issue that it is done at all. The reason it is done is because we have an indeterminate sentence which is based on a rehabilitative

rationale and that is a sham itself. So that is the core of that problem as I see it.

CHAIRMAN ALATORRE: Let me ask you something else. Can you explain to the Committee how the process works, and how a person ends up being give a combination of drugs, whether it is Stelazine, Thorazine, or whether it is one of the others?

DR. COLEMAN: I think I can, and I would again remind you that in many ways it is the same thing that is going on outside. Many, many times people are given 3,4 and 5 different kinds of medication. I would say that if you're a prisoner and not causing anybody too much trouble, and you want some medication, you can probably get it. A lot of medications are taken because the prisoners request it. They may have a background where they will take just about anything you will give them, because they have a drug abuse problem of their own. Or they just take a lot of pills, you know Valium, Librium, Meprobamates, you name it. Just put in their time to space out a little bit, whatever the reason maybe to try to pawn some off for a few cigarettes from somebody else, they will request it and there is a lot of abuse there and sloppiness of giving out medications. So that is one way you can get it. If you're not too big a trouble maker and you're not clearly standing out in anyway, nonetheless it may be prescribed for you by the psychiatrist. Now, when you start getting into the heavier drugs, it is either that you have received a diagnostic label indicating a psychotic condition, schizophrenia or something, which, as I tried to indicate, may not mean very much. Rodriquez was not psychotic, he had a language problem, he came

from a different racial background, he couldn't talk too well to these people. They called that psychotic. That happens to a lot of people, so if for some reason you get labeled that way or you have had some serious mental problems, or you are a problem in the prison for one reason or another, the heavy tranquilizers get used as agents of control, there just isn't any question about it. Thorazine, Stelazine, Mellaril and of course, the wonder drug of them all Prolixin because you can inject it and you only have to go back two or three weeks later to inject it again. You know the psychiatric and drug professions are proud of this. They advertise the advantages of certain drugs. For example some of the liquid forms, they advertise how convenient they are because they can be placed in the clients food, or the prisoner's food and they won't know it. You don't taste it, you don't smell it and so you avoid any problems of hassling with the person. So the way it happens is one of those methods. You get that label put on you, you're considered to be troublesome in someway or you have had some mental problems then you get put on a variety of medications and if the result is not what they want they then juggle them. You know they will try you on Thorazine and then they increase that and then they drop that, and try Prolixin or Stelazine and so forth and so on.

CHAIRMAN ALATORRE: We have heard testimony and have seen in the presentation of CONTACT 7, a number of inmates said that they did not know why they were on medication. Another area that troubles me is the fact that I could be eating and drugs could be put in my food. How much of that is happening and how

true is it that inmates often do not know why they are being given these medications?

DR. COLEMAN: I think I can safely say, that in a lot of cases they don't know why, and the reason I would say is that in mental hospitals the patients usually don't know why. I would think with the degree of control and the close setting being even more extreme in prison, that my feeling is that it is much more often that they would now know why. As far as how often people are given liquid forms of medication, I can't document that, and that is one of the reasons I am urging you to set up a Committee with some teeth that could find out exactly that." But I can quote to you briefly or I will just paraphrase it, if you will trust me that I have it right in front of me, an individual who, well I can't find it, off hand anyway what they would do there, is that they would crush up a pill in the food and you either eat or you either take your medication in your food or you don't eat. That is it.

CHAIRMAN ALATORRE: Now do they tell the inmate that the medication is in the food?

DR. COLEMAN: Yes, they do that. They can put it in juice, that is a very common form, you see what typically happens is that they put you on the pills, they don't particularly want to give everybody shots because that is just a lot of work. They will put you on the pills, Thorazine, Stelazine, Prolixin or something like that, if you don't take it, or you're troublesome, if you check it, or you try to spit it out, put in the toilet, throw it away or something, they will start giving you the

a side effect called tardive dyskinesia, something which was ignored for years and years that people in state hospitals would be sitting there smacking their lips like this; funny movements of the tongue, protruding of the tongue, this was just dismissed. It has now been found that some people, particularly those that have been on drugs for a while, can get this condition and it is irreversible, you stop the drug, it doen't go away, there is no other drug you can give to treat it. I think that it is basically that those people didn't care enough to really look. There are other side effects even for those people who do not get ones I've described, that fortunately doesn't happen too often. These other side effects that I am about to describe happen a lot, some of them happen all the time. Dry mouth, it drys up all the different systems of your body so you may get constipated, you have trouble reading, you can't focus your eyes, you get blurry vision and you get what was described earlier the shuffle. If you don't mind I will give you a little demonstration; although I am happy to say I haven't ever had to go through this myself, but you see people that walk like this. (A DEMONSTRATION OF WALKING) I think you can see from that, what kind of condition their minds are going to be in, they are dazed out, they can't think,they can't concentrate, they are just not with it. There are others less common, but very dangerous side effects in terms of the blood forming system of the body, the liver, but far and away. One that I didn't mention is muscle cramps and spasms which can be very disturbing, people can't sit still. These are the kinds of things that people often

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concentrate because they can stand there and watch and they can insist that you open your mouth and if you don't have any liquid in your mouth they know that you have taken it. If you refuse to do that, then you get the shot of Prolixin which lasts for a couple of weeks and you're chemically controlled for that period of time. I consider someone being forced to take a drug to be the ultimate nightmare. It is bad enough that you're locked up, and that is the whole issue of who gets locked up and why and so forth, but to have somebody make you take a drug in which your thinking, your feelings, your mind are not your own, it is a horrible nightmare and I think that it just can't be condoned any longer, I can't really give you anymore than that in terms of numbers. Nobody can, I am confident of that, I have talked to a lot of people, in preparation of the hearings, people who are extremely knowledgeable or the prison scene, they don't have much data either, because it isn't around. I think you can get it if you really want it.

ASSEMBLYMAN DIXON: Dr. Coleman, can you tell me about other effects of these drugs. Is there a build up of either a psychological or a physical dependency on these drugs?

DR. COLEMAN: There is not a physical dependency in the sense of what we usually think of in drugs like Heroin and the Opiates, but there are some very, very bad side effects. First of all, Phenotiazine, and the major tranquilizers which include Thorazine, Stelazine, Prolixin which are used most often when they really want to control someone or when they feel somebody has a major psychiatric disorder, these drugs have been found to have

a side effect called tardive dyskinesia, something which was ignored for years and years that people in state hospitals would be sitting there smacking their lips like this; funny movements of the tongue, protruding of the tongue, this was just dismissed. It has now been found that some people, particularly those that have been on drugs for a while, can get this condition and it is irreversible, you stop the drug, it doen't go away, there is no other drug you can give to treat it. I think that it is basically that those people didn't care enough to really look. There are other side effects even for those people who do not get ones I've described, that fortunately doesn't happen too often. These other side effects that I am about to describe happen a lot, some of them happen all the time. Dry mouth, it drys up all the different systems of your body so you may get constipated, you have trouble reading, you can't focus your eyes, you get blurry vision and you get what was described earlier the shuffle. If you don't mind I will give you a little demonstration; although I am happy to say I haven't ever had to go through this myself, but you see people that walk like this. (A DEMONSTRATION OF WALKING) I think you can see from that, what kind of condition their minds are going to be in, they are dazed out, they can't think,they can't concentrate, they are just not with it. There are others less common, but very dangerous side effects in terms of the blood forming system of the body, the liver, but far and away. One that I didn't mention is muscle cramps and spasms which can be very disturbing, people can't sit still. These are the kinds of things that people often

describe. So they are very upsetting to many, many people.

ASSEMBLYMAN DIXON: Is there any dependency that would carry over after once being released from the institution?

DR. COLEMAN: Again, not in any physical addiction sense. I would say the main way it could be is that, people are often told, if you don't take these drugs for the rest of your life, you are going to have another psychotic breakdown, or you're going to be a chronic hospital patient, this goes for both Lithium and Phenothiazine. People are being urged to take these drugs for the rest of their lives. There is no feedback as to when it should ever be stopped because if the person does well then the doctors are claiming it is because you're on the drug, so how do you know that you shouldn't take it any longer? That is the kind of side effect that I see most as a dependency in terms of, I need it, and a fear that if I don't take it I will be in deep trouble, that is the most common thing I have seen.

ASSEMBLYMAN DIXON: I assume that you belong or are active in some professional associations here in California.

DR. COLEMAN: Yes.

ASSEMBLYMAN DIXON: Has your profession given any attention by way of papers or discussions or symposiums on the use of drugs in prisons, and if so can you characterize what the attitudes are, and where the psychiatric field lines up on the issue of abusive drugs?

DR. COLEMAN: I would not expect much help from them. There are a few individuals who are critical of what is going on, but the vast majority of psychiatrists and their official organizations,

such as the American Psychiatric Association are well entrenched in the kind of biochemical medical model that I have been describing. They feel that we made great breakthroughs in the biochemistry of some of these disorders, they feel that drugs are the wave of the future, I don't think that you are going to get any help. Everything that we can learn from past events has been that they will view this as another interference from the outside within the discretion of the doctor and the patient and they absolutely refuse to recognize that psychiatry cannot be viewed that way because they have power given to them by the state. They are not acting as physicians, and in prison of all places, they are acting as custodians. But I don't think that the psychiatric profession will help you very much.

ASSEMBLYMAN DIXON: Is there no discussion within the profession as to the validity of the use of these drugs in a prison environment?

DR. COLEMAN: Not very much. No. I haven't seen it.

CHAIRMAN ALATORRE: Are you familiar with stress programs?

DR. COLEMAN: I am.

CHAIRMAN ALATORRE: Do you see any relationship between the stress programs and the whole medication problem that we have?

DR. COLEMAN: I don't know how much medications are used in the stress program, so I can't answer that in a specific way. I think part of the whole problem is that medication is part of the treatment process which is then tied in with release and so is the stress assessment unit. So that it is one more situation where you have to participate in a way in which they feel you're doing the right thing before they are going to let you out. I can't answer that in terms of how medications are used,

or the way they are used in the stress program. I don't think they see that as the primary focus, I think that they see it as; we are going to test you out under stress and if you pass we will give you a good recommendation. The Adult Authority uses it as a way to pawn off their responsibility because if they don't want to let a guy go, they want the doctors to take responsibility to say, well, we will let you go if we get an okay from stress, so they will send you there and then if they do release them and something happens, they can always say well, see the doctor said he was okay, so you can't put all the blame on us.

CHAIRMAN ALATORRE: You see any usefulness in the stress program?

DR. COLEMAN: Absolutely not. It is not just a matter of usefulness, I mean if it wasn't useful, but it didn't do any harm, we would have a lot smaller problem. It is tremendously destructive, as any part of this indeterminate sentence rehabilitative framework is destroying people. It is the major factor behind all the violence we had in the prison. It is obvious. They start giving people dates mainly because the Adult Authority is trying to save its own existence, and the files went down what else can you say, I mean it is just obvious. Of course stress assessment is part of that, so it has all got to go. What I said to Senator Nejedly and the people who are considering the bill that he wrote is, if you want to find out if any programs are any good, there is only one way to do it, and that is to put these programs on the free market; that is, let the consumers

decide what they want and if there programs can't compete and get business from people who don't have time to lose or gain by playing games with it then you will find out whether it is any good. You wouldn't find one guy in the State of California who would go to the stress assessment unit if he didn't have to.

ASSEMBLYMAN DIXON: Are you familiar with the California Institution for Women?

DR. COLEMAN: I have never been there, but I have read documents coming out of there, particularly a program called the Intensive Program Unit.

ASSEMBLYMAN ALATORRE: Do you know whether C.I.W. practices forced medication or engages in abusive drugging?

DR. COLEMAN: I don't have any direct knowledge of how much or when or what reasons.

ASSEMBLYMAN ALATORRE: Are there any other institutions with which you are familiar where they used forced drugging?

DR. COLEMAN: Well, I would be very surprised if it is not being used in virtually every institution. The Department of Corrections is not trying to deny that they use forced medications. It is policy. So I know that it exists at San Quentin, Vacaville, San Luis Obispo, Folsom, I mean they do not try to say that we don't do it, but what their basic rationale is, well look, yes we do it, but it goes on in every hospital because we have some patients that are so disturbed that they need it. Now they will try to claim that they don't abuse it, but they don't try to say that it doesn't go on.

CHAIRMAN ALATORRE: Do you see any difference in custody

problems between C.M.C. East and Vacaville? Some of the reasons they use to justify the giving of medication to prisoners is that they are psychotic and dangerous to themselves, dangerous to the institution, or dangerous to other inmates. Obviously that is a custodial problem. Now, do you see any difference in the custody problem, say at C.M.C. East or Vacaville? Vacaville supposedly, you have a large concentration of people that are alleged to be medically disturbed.

DR. COLEMAN: I have not had enough exposure at C.M.C. East to compare the two. I would guess where they would be able to make their best case for needing to use forced medication, would be at Vacaville, that is where people are supposed to go who are in that kind of shape. My impression, however, is that they do it a lot at C.M.C. East anyway. In fact, Dr. Pickett, in the letter that I read from him earlier, states that they had 800 out of 2,400 people on medication so that is 1/3 of the entire institution.

CHAIRMAN ALATORRE: We will probably be doing some other things as we are interested in the stress program. Part of it is not just the issue of forced drugging, but it is really a question of what has happened or what is not happening as far as the extension of the medical services to inmates throughout the Department of Corrections. So I am sure we will have an opportunity of getting your expert testimony in the future. Another question from Mr. Dixon.

ASSEMBLYMAN DIXON: Do you practice privately?

DR. COLEMAN: Yes, I do.

ASSEMBLYMAN DIXON: Can you tell me, in general terms, what percentage of your patients receive drugs from you?

DR. COLEMAN: Virtually none. About the only prescriptions I write are when my kids get sick and they need cold medications. Nine out of ten times when I get into the issue of medication is when somebody has been on it and wants to get off of it. They may have been to other people, and they have been told they must take it and they question that and they have heard I take a different position, or maybe it is people who come in and ask to be put on it, and I say I won't do it, I don't feel it has anything to offer you. I think I can help you in some other way. So I say if I write a prescription or two a year that would be it.

ASSEMBLYMAN DIXON: Could you characterize the percentage of other psychiatrists in California practicing privately who have patients on medication? Is it a large percent, over one-half?

DR. COLEMAN: Rampant. You know drugs are becoming the tool of psychiatry. They have whole clinics which are being set up for example, which do nothing but prescribe Lithium to people on a lifetime basis. People come in and get Lithium and they are supposed to take it for the rest of their life. That is the whole purpose of the clinic. Community Mental Health Centers are becoming the focus for drugging of large numbers of people, and I know that in Los Angeles and I am sure in other places, some people are being put on conservatorships because they refuse to take their medication. Even now that is illegal.

ASSEMBLYMAN DIXON: Could you, perhaps give me some criteria that you would use as a rule of thumb before you administered drugs to one of your patients?

DR. COLEMAN: Well, the biggest rule of thumb is that I would never do it if the client doesn't want it. That is No. 1 I would say that the only time I ever would even bring up the subject that medication might be useful would be with somebody who is in an acute psychotic breakdown. Somebody who is delusional, who is flipping out, going crazy, whatever word you want to use, mad. What the powerful tranquilizers like Thorazine, Stelazine, Prolixin, what they can do I think is, you know you pay a price, they basically slow you down and zonk you out. Now in some cases the person is so upset and they are in such distress that they feel that it is useful to them, even though they pay that price, the balance to them is worth it and to get a certain grade or degree of calmness inside. So what I would do is I might recommend it to them and then say let us try this for a few days, or a week, to see how it affects you, and then I feel the ultimate indicator far and away is the reaction of the feeling of the clinic. This is something that psychiatry does not accept. They feel that the reaction of the patient is part of their disease. But they don't like what they are giving, that is just an indication of how disturbed they are, so what I would say is that you may try it, and in those cases where a person is actually going crazy, not long term, but right now, and is just new, or a person is very, very, anxious--tremendously anxious and they feel they just need some relief, occasionally I think that will be useful. It will happen more often if you're in a hospital kind of practice of course.

ASSEMBLYMAN DIXON: Has your opinion on this question come to you out of some study or some observations that you have made, or have you always felt this way?

DR. COLEMAN: Well, I would say, as a resident in training which in my case was '65 to '69; I had some questions and doubts about what was going on, but it wasn't as bad then as it is now. By the way, this biological orientation is growing. Plus the fact that you know I wasn't with it in terms of what was going on, I wasn't questioning as much. I would say the big difference came when I began to work in a community mental health facility in Marin County, but they are the same everywhere. I began to see how drugs were being overused and then I began to get involved in the actual practice of psychiatry and to see how the drugs were being abused. The relationship between the drug industry, you can see that all the way from medical school, the gifts they give to people to try to subtly influence their prescribing their drug. So it has been a gradual evolution, I would say.

ASSEMBLYMAN DIXON: So this orientation you feel comes from the medical school and it is the popular movement within the psychiatric field now?

DR. COLEMAN: Absolutely.

ASSEMBLYMAN DIXON: Thank you very much.

CHAIRMAN ALATORRE: Yes, Mr. Hudson.

MR. WADE HUDSON: My name is Wade Hudson. I represent the Network Against Psychiatric Assault, San Francisco Branch.

My experience with psychiatry began about 15 years ago as a psychiatric orderly. Since that time, I have worked in a number of different institutions, studied psychology, went to seminary for a couple of years, and in 1971 I was hospitalized in two different psychiatric institutions. I would like to speak briefly about my experience in the first institution which was in San Francisco because I think it is very typical and very illustrative.

I was flipping out, I was very crazy, I attacked my roommate, I thought he was an FBI agent. While I was in the hospital I thought my roommate was J. Edgar Hoover. I experienced an atomic war, I felt the painful heat of the war, but I did not need to be treated the way I was treated and the way I was treated was not helpful to me. I was taken to a crisis clinic, and upstairs to the psychiatric unit and locked in a secluded room. For the next four days I was basically confined and drugged and ignored. I was not given any human attention by anyone except fellow patients. I was discharged from this institution, I was injected with Prolixin, and for the next two weeks I went through hell. This was very excruciating and it got worse and worse. At the end of two weeks, my tongue was so swollen that I could barely speak, my mouth was dry, my myscles were twitching, and my whole body felt like it was wrung up tight, like in a wringer. I went back and I got some medication to counteract the side affects and like within ten minutes it was just this incredible wave of relaxation that went over my body It was one of the most wonderful experiences I have ever had because part of that time

the whole two weeks was just so excruciatingly painful. I was in no different condition than when I went in, and a couple of weeks later I ended up at another psychiatric institution in Dallas.

Now the question of whether or not my experience is unusual, or whether it is typical I think is very important. There is a recent study that was done by Julian Silverman, who works at the Eslan Institute, and Maurice Rappaport, who works at Langley Porter Institute in San Francisco. According to them, no other study has been done with this model, that had a three year follow-up and that had an enriched program where people were given considerable amount of human attention and warmth while they were hospitalized. They compared people who received the placebo drugs, to people who received the real drugs. Three years afterwards, the people who received the placebos had stopped taking their pills and only 8 percent were rehospitalized. Of the people who received the real drugs and were continuing to take their drugs, 73 percent were rehospitalized so 8 percent of those who had gotten the placebos were hospitalized, and 73 percent of those that had received the real drugs were hospitalized. Dr. Lowenger, who spoke earlier, did a similar study on an out patient basis, and there was no basic difference between the people who received the placebo and the people who received the real drugs.

CHAIRMAN ALATORRE: May I interrupt you just a minute, Mr. Dixon has a question.

ASSEMLBYMAN DIXON: On that issue is there some conclusion that is drawn from this study?

MR. HUDSON: Yes. I think that is a very good question. Their position is that the administration of the drugs interrupts a natural process. It interferes with the resolution of whatever is troubling the person, because it pushes down feelings, so if instead you allow the person to get out of their system whatever they are doing or going through, they can more easily learn from that and reintegrate a balanced life.

CHAIRMAN ALATORRE: Can I try and get you to direct your testimony to prisons, because that is really the focus of the Committee. I know that you have had some experiences at C.M.C. East and I would appreciate it if you could direct your testimony in that direction.

MR. HUDSON: Yes, well, we have corresponded with a great number of people, but I did want to comment about the alleged effectiveness of the treatments and the whole medical model and the presumption that people with MD's and psychiatric credentials are especially able to help people. I think that most people believe that the doctor does know best. That any time a physician states that something is a scientific fact, it is assumed to be the case. But I urge you to analyze these claims very critically and consider the position of many of us, that in fact psychiatrists are no better able to help people than any of us in this room. And certainly so long as they treat people as objects that need to be manipulated with technological tools, such as drugs, I think their power needs to be questioned.

I would like to address the ethical and constitutional

questions related to forced drugging and forced psychiatric treatments in general because I believe that the question of whether or not another person's mind should be tampered with against that person's will under any conditions, is a very fundamental ethical question. I believe, in fact, that forced drugging is tantamount to chemical rape and no kind of rape, no kind of invasion into the sacredness of another person's body should be justified by the state. The state should not have that kind of power under any conditions.

I mean that's only ethical and constitutional. Then on the practical level, you're faced with a question of whether or not there should be a mechanism for forced drugging in prisons or anywhere else. I submit to you that there is no practical way of establishing that kind of mechanism that would restrict forced drugging to only those cases where it really helps people, because you are not talking about a scientific method where you can predict what the results are going to be. Any criteria that you establish for forced drugging if it's going to be subject to the arbitrary interpretation of the people who have the power to administer the drug forcibly so that any bureaucracy you establish, any institution the state is going to set up, is going to end up making decisions on the basis of what's good for the bureaucracy, you know what keeps the institution running smoothly, what makes the job easier for the staff and decisions are not going to be made on the basis of what's best for the inmate. So I would submit that, yes, you should completely eliminate forced drugging in

prison, but I do not think you should transfer people to state hospitals. That is not the solution. The solution is to humanize the criminal justice system. The solution is to make jails humane environments that are open to the community. I think that they should be small in scale, so that they do not become massive institiutions. You need to remove from the criminal justice system the majority of people who are there for non-victim crimes. They clog the system and make the system much more unworkable. People who are there because of their sexual orientation or behavior or for whatever drugs they put into their body, those activities should not be a crime. We should affirm the right of people to pursue their own path so long as they don't violate the rights of others. That's a very basic principle in this country that's been violated time and time again. The state should not have the power to incarcerate people who are not violating rights of other people, who are not commiting a crime as determined by a jury of peers. So I think that one of the problems of transferring people to a mental health system is that there are far fewer protections in a mental health system,and the risks there are much greater in terms of as long as you have the indeterminate sentence, people's discharge or parole can be delayed. The due process protections in the mental health system are far fewer than even in the criminal justice system. I could itemize how people who are transferred to the mental health system are in a much more vulnerable position and have far fewer protections. I'll go into that if you want. But to conclude, I think to

eliminate forced drugging in prison, you eliminate forced psychiatric treatments totally and affirm the right of people to be left alone if they want to be left alone and do their time. It would be a positive step, but in the long run transferring them to a mental health system is not a solution.

CHAIRMAN ALATORRE: Mr. Dixon.

ASSEMBLYMAN DIXON: Mr. Hudson can you give me just a thumbnail sketch of the nature and purpose of your organization? How many people it has, where it's located, what are its goals and purposes and how did it start?

MR. HUDSON: Its called Network Against Psychiatric Assault. We are composed primarily of former mental patients who are angry about the experiences we have been subjected to in psychiatric institutions. Other people and some professionals, work with us as well. We have chapters in San Francisco and Los Angeles and a group starting in St. Louis and Santa Cruz. Our basic commitment is to affirm the right of individuals to be left alone, as I stated earlier. We are opposed to all forms of forced psychiatric treatments and involuntary psychiatric commitment. We think that social control should be limited to the criminal justice system rather than having two different systems, that just confuses the situation; that we should have one system for social control and to focus all our reform activities on that system--make that system a humane system.

ASSEMBLYMAN DIXON: How are you doing that, I mean you are here today and I appreciate that, but what else are you doing as an organization?

MR. HUDSON: We publish a lot of literature. We published a book called, The Madness Network News Reader, The History of Shock Treatment and Forced Treatment Equals Torture, a newsletter called Madness Network News. We print a lot of articles, we speak to media, radio and T.V., community organizations, public seminars and public demonstrations. Right now we are sitting in on the Governor's office demanding that the Brown Administration take a position on these issues. We provide legal aid to people who want out and our experience is that most people do get out once they have a lawyer because they are not held in accordance with the law.

CHAIRMAN ALATORRE: Thank you very much.

CHAIRMAN ALATORRE: Would you just give us your name for the record?

ELEANOR GARDNER: Eleanor Gardner. I first became involved with the Department of Corrections in 1956 for forgery. I was just psychologically brain washed. The doctor previously stated and I need not report that your initial reports come from the social worker. At that time the institution did not have psychiatrists, but they had a consultant psychiatrist. He saw me for 15 minutes and the medications started.

CHAIRMAN ALATORRE: Let me ask you what institution were you in?

MS. GARDNER: California Institution for Women.

CHAIRMAN ALATORRE: Frontera?

MS. GARDNER: Frontera. This process went on the first time from April 9, 1956 until July of 1959. At that time I was paroled.

I was very hostile, disorganized and in a few months I was back in the institution. The entire process went on for a period of 17 years.

CHAIRMAN ALATORRE: Can I just stop you there.

MS. GARDNER: Un huh.

CHAIRMAN ALATORRE: Your first experience at the California Institution for Women, your testimony is that you were on medication. Do you know what kind of medication you were on?

MS. GARDNER: Thorazine, Stelazine.

CHAIRMAN ALATORRE: Now were you told why you were on those medications?

MS. GARDNER: No, I wasn't told why, but being con wise I raided the psychologist's office and read my files. There was no diagnosis, other than a sociopath. That's a catchall phrase like schizophrenia. So this continued and the late years around 1964 they built a psychiatric treatment unit within the institution at Frontera. At this time they placed a lay staff member as head of the institution. We had two consultant psychiatrists that came in. The woman that ran the treatment center had a B.A. in Education, no psychiatric experience whatsoever. She administered the drugs and gave hypnosis too. Fortunately, she was never able to hypnotize me.

CHAIRMAN ALATORRE: What kind of drugs were you on your second time?

MS. GARDNER: The second time? They upped the Thorazine. At one time I was on approximately 500 milligrams of Thorazine a day. I was able to function inasmuch as I could do my work.

It affected my memory, it's eaten my kidneys up, so I'm dying of congestive heart failure from the experience. I was kept in seclusion which is a hole, a hole on the floor, no clothing, no mattress and there's a hole in the middle of the cell for you to void and defecate in. I became an animal. A human being is vertebrate animal and when you take away all efforts for him to be able to use his intellect he resorts to the jungle. The experience is so horrible that after 8 years I still wake up with nightmares from it. Upon my release from the institution I went out to General Hospital and got a card and went to the outpatient department. I go every Friday for therapy. I have been on no medication: The doctor that first initiated me into the program was a Dr. Newman, that had worked at Vacaville. He said that there was nothing psychiatrically wrong with me, that I had a small amount of depression. I still go to the clinic, I receive no medication. I just go on Fridays for therapy and I was fortunate that I met someone who married me and I have a home now. In the meantime, speaking of the inmates legal rights, while this was happening to me I filed a writ of habeas corpus. I went through Superior Court, the Appeals Court. The State Supreme Court refused to hear the petition. What I wanted was a straight shot at the United States Court. They cut my mail privilege. See when everything was denied and it dawned on them what I was actually shooting for they cut my mail privileges. In other words, there was no way that I could get help. At this point in time, we had a psychiatrist, Dr. Ruth Anderson. She addressed the justice at Santa Barbara,

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the State of California College and told them that basically most Negroes were very hostile and that I was violent, my charge was forgery remember? That I was violent and that really I should be kept permanently in the Institution. Dr. Anderson's consultant is the doctor that is now head of the criminals that go to court here in Los Angeles, he's the head doctor at the department right now at General, and if the court send you for psychiatric evaluation now you go through his department. He put his name along with Dr. Anderson to keep me there and enough years went by that the members on the Adult Authority Board, which the women have a separate board changed and after 3 years and 9 months they finally called me to the Board. So I said if I was ill why wasn't I given treatment and had consultants? Why didn't I have a little therapy? I said these drugs do have a place, but their place in the therapeutic administration is so that the psychiatrists can get next to you to give you therapy. This was never done.

CHAIRMAN ALATORRE: So you received medication. Is it your testimony that during the time that you were incarcerated at Frontera that you never received any therapy?

MS. GARDNER: You heard me!

CHAIRMAN ALATORRE: Okay. Let me ask you another question. Did you voluntarily take the drugs or were you forced?

MS. GARDNER: No, I did not!

CHAIRMAN ALATORRE: The second time they prescribed Thorazine and upped the dose did they prescribe anything else?

MS. GARDNER: Oh yes! They experimented with their dear Prolixin.

CHAIRMAN ALATORRE: So in other words, they experimented with you, they tried Prolixin on you?

MS. GARDNER: Un huh!

CHAIRMAN ALATORRE: For what length of time?

MS. GARDNER: Oh, over two years.

CHAIRMAN ALATORRE: For over two years?

MS. GARDNER: That's right.

CHAIRMAN ALATORRE: Now, were you ever forced to take the medication?

MS. GARDNER: Well, what would you call guards holding you and you are naked?

CHAIRMAN ALATORRE: That's what I'm asking you.

MS. GARDNER: I told you that I regressed to an animal, and it was just through the help of God that somebody married me and the man is trying to lift me up. Because I still have the hostility and some days I have to stay in the house, and at this point in time and as old as I am and as aggressive and hostile as I feel about it, I know how my young brothers feel in those men's institutions. They throw you down and they inject it in your hips and bruises are from medication not given adequately and the wrong injections. Those bruises will stay until you die. They block your communications to the outside. You can't get through, you can't get a hearing in a court.

CHAIRMAN ALATORRE: When did you leave the institution?

MS. GARDNER: 1968.

CHAIRMAN ALATORRE: So you've been out since 1968?

MS. GARDNER: No, I went back for 3 months, but I was married

and my husband called the warden every day and I had visitors every week, my in-laws were there and the friends that I had made carried me. My husband was good in breaking my criminal behavior pattern you know.

CHAIRMAN ALATORRE: Okay, so the first time you went for forgery ... were you in on violation for forgery next time, or what were you in for the second time?

MS. GARDNER: Violation. Then this last incident I'm telling you about I had another forgery out in Plumas County, way up north. I had two forgery convictions, but this lasted a 17 year period. You know each time for forgery I did murder time.

CHAIRMAN ALATORRE: Let me ask you if you know whether other women were under forced medication during the period of time that you were there?

MS. GARDNER: Yes, not only that they killed one of them.

CHAIRMAN ALATORRE: How long ago was that?

MS. GARDNER: 1967 or 1966.

CHAIRMAN ALATORRE: Now the last time that you were there which was in 19 what?

MS. GARDNER: 1970.

CHAIRMAN ALATORRE: In 1970, was forced medication still going on at the institution?

MS. GARDNER: Yes. I wasn't in the psychiatric treatment unit ... see they are over-crowded, so you have to sleep there at night and then go to the receiving unit during the day.

CHAIRMAN ALATORRE: In other words what happens at the

reception center is that during the day you are there and at night you are housed in P.T.U.?

MS. GARDNER: Yes. I was housed in the east wing where I had been in seclusion for so long at night, so I requested that my lights stay on and the officer that brought me over, the one that worked at the other building, had to come and get me out. In other words, I wouldn't go out and I wouldn't let anyone in. I'd go in at night and take the steel bunk and try to gird up my door because I have had my privacy invaded at night, it's a nightmare. I do know of the women here in the city that have had the same experience, most of them are very embarrassed and they want to forget it. That's something you can't forget. I wrote the womens' clubs,like the American Federation of Womens' Clubs, I wrote them, but the joke of it comes with the day in 1966 in January, while I was in this filthy hole, the grand jury from Los Angeles County toured this area and saw us, and the foreman of the jury he saw us naked in this filth and you know what he said, "oh yes I hear this is what they are doing now", and put this hands over his nose and strolled on.

CHAIRMAN ALATORRE: Since the time that you have been out and you have been going to therapy have they discovered any medical side effects that have resulted from the over dosage ... of taking these medications for a long period of time?

MS. GARDNER: Not in the psychiatric unit. I go to the medical unit.

CHAIRMAN ALATORRE: No, that's what I'm talking about ... medically?

MS. GARDNER: The medical unit, like I can't explain to the doctor you know why my kidneys are like that.

CHAIRMAN ALATORRE: Did you ever have any kidney problems before?

MS. GARDNER: No. My kidneys have gone, the fluid balance of my body is upset, my lungs are going and I'm just dying of congestive heart failure. I have to take medication to try to keep fluid down and what not.

ASSEMBLYMAN DIXON: Ms. Gardner, I notice you indicated that you are at General Hospital on outpatient therapy, is that a condition of your probation, I mean of your parole?

MS. GARDNER: No. I got rid of that parole. I am off parole.

ASSEMBLYMAN DIXON: You are no longer on parole? Was it a condition of parole?

MS. GARDNER: No. It was not a condition of parole.

ASSEMBLYMAN DIXON: You just went voluntarily, you thought that there might be something there that would be of assistance to you?

MS. GARDNER: No, I went from the standpoint that I was fighting with everybody on the streets, you know I was just hostile and nasty.

ASSEMBLYMAN DIXON: My second question is, had you received any psychiatric care or care from a psychiatrist prior to your original convictions?

MS. GARDNER: No.

ASSEMBLYMAN DIXON: On the first conviction if you can recall was there any mention in the probation report about perhaps

you seeking some psychiatric treatment or recommendations?

MS. GARDNER: No.

ASSEMBLYMAN DIXON: Or recommendation that you go for an evaluation?

MS. GARDNER: No.

ASSEMBLYMAN DIXON: Did your attorney ever request a psychiatric evaluation?

MS. GARDNER: I didn't have an attorney, I had a P.D.

ASSEMBLYMAN DIXON: Thank you Ms. Gardner.

CHAIRMAN ALATORRE: Thank you very much.

DR. ISADORE ZIFERSTEIN: My name is Isadore Ziferstein. I'm a psychiatrist and psychoanalyst and my major research interest for many years has been the area of social psychiatry and this has made me very much concerned and involved in the question of the rights of patients both in mental institutions and in prisons. I assume that you saw this morning a video tape about forced drugging. I've been watching most of it on Channel 7 and from what I've seen I think this is done very dramatically and visually documents that there is the use of anti-psychotic medications in the specific California prison that was visited. I have read some reports by sociologists which demonstrate and report very wide-spread administration of anti-psychotic medications in state prisons in California, in Oregon, Missouri Illinois and also at the federal prison at Levenworth, Kansas. I have concluded on the basis of my work in this area, that the extensive use in prisons of anti-psychotic medications, that is medications which the Food and Drug Administration has approved

specifically for the treatment of psychoses like schizophrenia, that the use of these medications in prisons has certain very serious ethical, legal and social implications. The position I take is that there is a vast difference between a situation where a patient voluntarily comes to a physician requesting medical help and where the physician prescribes certain medications with the intention of relieving the patient of his specific symptoms and hopefully, ultimately enabling him to compensate and to function well. Although I must add the caution that there is always a possibility that either consciously or unconsciously even in a genuinely therapeutic setting in the outside world, outside the prison a doctor who prescribes such medications may be doing this in a way that is really an abuse of the medication. He may be doing it because he is unwilling to take the time that is required to do effective psycho-therapy or he may not be qualified to do psycho-therapy. I know that a great many general practioners for example, who are not trained in psychiatry, prescribe various medications, tranquilizers and even major tranquilizers, rather freely, I think, in a way that is abusive. But still at least there, the individual is not being forced to take this treatment, he is going voluntarily. Then, however, the physician prescribes anti-psychotic medications solely or primarily for purposes of control or management. Then I think it is important to underline that he is not acting as a physician whose primary concern is the well-being and the health of the patient. He is acting as an agent of the prison administration for purposes of control, for management, to deter and to punish behavior that is considered

undesirable.

I remember many years ago Gregory Zerborg the famed psychoanalyst said, "that anytime a psychiatrist wants to function in that capacity he should put on the uniform of a policeman and make it quite clear to the patient that he is not to function as a physician, that he is functioning as a law enforcement agent." Therefore, this is an abuse of the medical function, it is a manner of covering up disciplinary, administrative measures with the cloak of so-called medical care and treatment. Often the administration of such drugs against the prisoners will have a punitive function. It is perceived by the prisoner, and I think rightly so, as a punishment for past misdeeds and as a warning and deterent not to do it again.

I know of situations where this was actually verbalized. I remember when Arrectine was used in Vacaville, and when the person was ... felt like he was dying ... like he was suffocating, like he was drowning, he was told if you do that again you will get another shot. This was clear intimidation. A couple of years ago a new medical psychiatric diagnostic unit (MPDU) was opened at Vacaville. A statement was issued by the prison administration to the effect that the medication, and I quote "medication will be administered only to those inmates who are obviously hallucinating or functioning within the well established delusional system." However, there is considerable documentary evidence and also evidence from interviews with prisoners which indicate that major anti-psychotic medication, like Prolixin, for example, are used in ways that contradict this statement

of intent.

You've heard some statement of prisoners here, prisoners have said something like this, "if you speak out, if you say things they don't like, if you are a leader you know, then it's an unspoken threat they will put you on Prolixin." Another prisoner said, "they use Prolixin more for punitive action then for medical purposes. Someone expressing anger towards the system or anyone in it is viewed as expressing bad attitudes and labeled as incorrigible." Now as I already indicated, medications like Prolixin are approved by the Food & Drug Administration as treatment for psychosis. Therefore, since such misdeeds as speaking out, being a leader, or expressing anger or having so called bad attitudes are not diagnostic of insanity. Psychiatrists who signed prescription forms on the basis of such symptoms might be liable to legal action. Recently a young woman by the name of Elena Ackel of the Western Center on Law and Poverty at Los Angeles said that prison psychiatrists have surmounted this problem with a novel diagnostic classification that George Orwell, the inventor of Doublespeak, would have understood very well. She said and I quote:

> "The prison officials at the California Men's Colony, have created a new classification called "psychotic repression." This means that the inmate is psychotic but is repressing the symptoms of the psychosis so it is hard to tell that he is psychotic. It is apparent,

according to this person that Prolixin is being used in those cases for control purposes to undermine resistence and to quiet chronic complainers."

Now, this in effect, means that prison administrators can apply cruel and unusual punishment, and I use these words advisedly. They can provide cruel and unusual punishment under the guise of medical treatment and be immune from judicial review and from due process, and courts have been very hesitant to intervene in this kind of situation because somehow there is an aura about the word "medicine", "medical care" and "medical treatment" that even wise people fear to tread. So, a way in the use of the truncheon can by and large be abandoned and be replaced by the more sophisticated techniques of punishment and deterrence by medication. I might add, by the way, that forced drugging has an intimidating and a pacifying effect, not only on the prisoners who receive it but on many who do not, perhaps on most, or on the entire population because of the implicit threat of forced drugging so that you have an atmosphere of intimidation. All you have to do is pick out a certain percentage of the bad actors, give them Prolixin shots. The other people see what's happening and they learn the lesson very quickly. I notice, for example, that several of the ex-prisoners who testified said that they didn't even ask what the medication was for. I can well believe that because I know that very often patients of mine who are getting medical treatment some place, they come to me and say, the doctor prescribed this for me. What is it for, and I say, why do you ask the psychiatrist? Why don't

you ask an internist? She say, well, I'm afraid. He is a very busy man, so you see even people outside can be intimidated by the medical profession.

I would say there are some very serious ethical objections to forced treatment with drugs for purposes of control and management. But I think in addition, there are some very practical considerations of a social nature. I think we are being damaged, not only the prisoners, but we are being threatened and damaged. While forced drugging of prisoners may in the short run seem to have the beneficial effects of maintaining order in prison, and I put beneficial in quotation marks, the long-term effects may be seriously harmful, not only to the prisoners, and we have heard some of those, but also to society, because forced drugging produces bitterness and resentment in the prisoners and when they are discharged there can be resultant hostility, violent behavior, violent criminality after the prisoner is released. Unless, of course, we can find a way of keeping the released prisoners forever drugged. So it seems to me that in this way this forced drugging adds its contribution to the very large amount of recidivism that we have today. There is another practical objection and that is that anti-psychotic drugs are used in prisons, not to prepare the prisoners for a normal life in society, but to adjust them to prison life, to make them submissive and apathetic, to adjust them to a life that degrades and dehumanizes them and to punish them, to try to overcome their inability or their unwillingness to adjust to a basically inhumane system.

It seems to me that when they leave the prison after such a regime, they are even less equipped than they were before to cope with the problems of making a living in the outside world. They are not equipped to be self-supporting, to be self-reliant. This so-called treatment then increases the likelihood that the released prisoner will again resort to crime as a way of making a living because he doesn't know any other way and he is not equipped for any other way here again such treatment probably contributes its share to our high rate of recidivism.

A major point to keep in mind when we talk to prison officials as I have talked to some of them, is that the prison administration and perhaps sincerely so because of its particular standpoint and viewpoint, tends to see troublesome behavior or defiant attitudes in the prisoner as a manifestation of some kind of organic malfunction of the central nervous system or as the result of troublemakers from the outside, some kind of an outside conspiracy to overthrow the prison regime or to overthrow perhaps the government, something very subversive. It is very rare for a prison administrator to acknowledge the role of the prison system itself in producing troublesome behavior and producing violence in the prison.

In an effort to cope with these abuses, I would make a couple of very modest recommendations that really don't quite go to the root of the problem but might be a good start. First of all, treatment which is used primarily as a disciplinary, punitive, management control measure should be subject to exactly

the same prescription as any other kind of cruel and unusual punishment and that the courts must find this to be the case. Secondly, and this has been stated, I think, by some previous witnesses -- there has to be a watch-dog, oversight commission which is made up of legislators, representatives of the public, and I think should include behavioral scientists who are independent of the prisons system, to make frequent unscheduled inspections like the one that Assemblyman Alatorre made the other day, and to review the use of drugs in prison and also, to listen very carefully to the complaints of prisoners and to investigate the complaints of mistreatment by medication. Thank you.

ASSEMBLYMAN DIXON: Dr. Ziferstein, you touched on the subject of ethics within the profession.

DR. ZIFERSTEIN: Ethics?

ASSEMBLYMAN DIXON: Right. I am wondering if you can tell me, as I asked Dr. Coleman, is there any discussion about the administration of drugs within the prison environment in your profession.

DR. ZIFERSTEIN: The one paper that I recall was an excellent one that was presented by, not by a psychiatrist, but by a psychologist by the name of Dr. Ned Upton. That was presented at an annual meeting of the American Psychological Association. I do not recall very much discussion in the psychiatric profession.

ASSEMBLYMAN DIXON: Is that because the main trend is to accept the Biochemical theory?

DR. ZIPERSTEIN: Yes, you know I do not quite take the position that Dr. Coleman does, but there is no question in my mind that in recent years there has been a great deal of an upsurge of biological orientation among psychiatrists and a feeling that the ultimate solution to major psychoses like schizophrenia and manic depressive will be met through medication rather than psychotherapy. I do not subscribe to this. I am convinced that the human mind is an extremely complex structure and I also agree with one of the professionals who testified --- oh no, I think it was one of the ex-prisoners who very wisely pointed out that it is appropriate sometimes to use medication in the hope of helping the patient to become more amendable to psychotherapy, but I think that using medication without psychotherapy, whether it is done in prison or whether it is done in private practice is an abuse of medication.

ASSEMBLYMAN DIXON: Do you have a private practice?

DR. ZIFERSTEIN: Yes, I do.

ASSEMBLYMAN DIXON: Do you administer drugs in that practice?

DR. ZIFERSTEIN: You will probably ask me what percentage. I would say perhaps about one-fourth of my patients receive medications, nothing like the kind of dosages that I have heard are used in prisons, and I use it primarily as an adjunct to psychotherapy. I do find that when a patient is extremely anxious, is extremely depressed, that he is at a point where he is almost inaccessible to psychotherapy. It is difficult to get through and while there was a time -- I am a psychoanalyst -- there was a time when I never used medication, I now feel that

that was too rigid an attitude; that if used wisely and with good judgment it can be used in order to reduce the anxiety to a point where it is possible to carry on psychotherapy. There is a great danger, as I indicated before, that a physician, particularly one who is not even trained in psychiatry and who is desperate and doesn't know what to do, will resort to medication, sincerely looking for some kind of a magical cure which never occurs.

ASSEMBLYMAN DIXON: Do you have a thorough discussion with the patient prior to the administration of any drug?

DR. ZIFERSTEIN: I certainly do. You see here again, there are doctors who believe that it is best for the patient not to know what is going on. Their belief apparently is that this adds to the omnipotence of the doctor, that if the doctor really describes what is going on in his mind, he sort of goes down in the patient's estimation. I don't think that is such a bad idea because I am convinced that the patient comes in already feeling about knee-high to a grasshopper and the higher you are, the lower he feels and it is a good idea to reduce that gap. Yes, I am completely open with my patients. Any medication that is prescribed, he knows exactly what he is getting and I also forewarn him of some of the possible side effects to look out for and to let me know, to call me even if it is in the middle of the night if there is any problem at all and then we will work on it.

ASSEMBLYMAN DIXON: I want to thank you very much for coming and testifying this morning.

DR. ZIFERSTEIN: Thank you.

CHAIRMAN ALATORRE: Before we take a lunch break, we have one more individual that we will be taking testimony from and then we will be back by one o'clock.

ASSEMBLYMAN DIXON: Can you give us your name for the record.

MR. TAFOLLA: Yes. My name is Mr. Tafolla.

ASSEMBLYMAN DIXON: Are you presently on parole?

MR. TAFOLLA: No, I am not.

ASSEMBLYMAN DIXON: Have you ever been housed or institutionalized at C.M.C East?

MR. TAFOLLA: Yes, I have.

ASSEMBLYMAN DIXON: For what period of time were you housed at C.M.C. East?

MR. TAFOLLA: We'l, I was housed at C.M.C from May 1972 to July of 1973.

ASSEMBLYMAN DIXON: For approximately one year.

MR. TAFOLLA: Yes. About 13 months.

ASSEMBLYMAN DIXON: Okay. What were you institutionalized for?

MR. TAFOLLA: Probation violation.

ASSEMBLYMAN DIXON: What were you on probation for?

MR. TAFOLLA: Grand theft.

ASSEMBLYMAN DIXON: Okay. Can you relate to the Committee your experiences at C.M.C East with relationship to the topic at hand?

MR. TAFOLLA: Right. I entered C.M.C in May and I was

classified for D quad. As I entered D quad, I realized that in order for me to get out of there, I would have to do some heavy manipulation because if I was to wait for the guards or the doctors to justify my transfer to another quad or to another institution, I would never get it.

I entered C.M.C. They derouted the bus. It was going to Soledad, but due to some killings they had there they had to close the institution, so I ended up in C.M.C East. But I was originally scheduled for Soledad. I have no degrees but 17 years of experience in penal institutions. I have seen a lot of my friends who were raised in the same environment that I was raised and they were being treated with Prolixin and with so many other drugs. It was sad, and that is the purpose I am here today.

CHAIRMAN ALATORRE: Right. Were you ever, when you reported to D quad medicated?

MR. TAFOLLA: No. I was asked if I wanted medication but like I said before, I realized as soon as I entered there, by observing the other individuals that were running around there that it would take some heavy manipulation on my part in order to get out of there.

CHAIRMAN ALATORRE: How did you get out of D quad?

MR. TAFOLLA: I really don't know.

CHAIRMAN ALATORRE: You did some manipulation.

MR. TAFOLLA: Yes, I did.

CHAIRMAN ALATORRE: I guess it was successful.

MR. TAFOLLA: Yes, it was.

CHAIRMAN ALATORRE: You were in D quad for how long?

MR. TAFOLLA: Overnight.

CHAIRMAN ALATORRE: Overnight?

MR. TAFOLLA: Yes. I don't know if I got a sympathetic guard or a lieutenant but I did get out of D quad.

CHAIRMAN ALATORRE: Where were you put then?

MR. TAFOLLA: I was put in A quad.

CHAIRMAN ALATORRE: In A quad, were you able to observe any drugging going on there?

MR. TAFOLLA: Yes. There were a lot of individuals there -- like I said before; they were raised in the same environment that I was raised in and I knew that they did not need any medication in order for them to cope with the situation that they were in.

CHAIRMAN ALATORRE: What kinds of medication were the people given in A quad?

MR. TAFOLLA: Prolixin and -- I can't think of the other drug.

CHAIRMAN ALATORRE: Could you tell us about Prolixin Joe?

MR. TAFOLLA: Yes. Prolixin Joe is a Mexican person who they named Prolixin Joe because of this drug they would always give him. I don't feel that Joe's parents raised him to protect himself against the system because their only concern was to survive. I worked with Joe for about four months. I heard of all his tricks and I used to walk among the stars with him in order for him to get out and refuse the medication. The only reason that they stopped the medication was not because he refused it, but because a group of people got together and expressed their concern of taking the responsibility that Joe

would not be harmful to any other inmate or to himself or to the institution and like I said, for four months, he was putting up blocks bracing himself or let me say, to break down the psychological barriers that the individual puts up in order to accept friendship. When Proxlin Joe realized that I intended no harm, but that I understood his situation he came out.

CHAIRMAN ALATORRE: Do you know why he was given Prolixin?

MR. TAFOLLA: Well, whenever an individual is in a situation such as this he knows that it is wrong, he speaks up. Maybe the terminology he uses isn't quite what the institution likes to hear so they medicate him down and like the doctor said a few minutes ago, if you are a leader or show any signs of a leadership, they are going to break you or they are going to try and break you.

CHAIRMAN ALATORRE: How do they try and break you?

MR. TAFOLLA: By playing all kinds of psychological games, by drugs, by transfers from one institution to another. Many individuals spend the whole time in prison from say four months in one institution and then to another institution, no communication with the inmates to where the individual could be effective. The hardest thing I feel is to introduce an individual to his own mind, this is definitely what the system does not want because once the individual is introdcued to his own mind, he realizes the system is nothing but a crippling force.

CHAIRMAN ALATORRE: During the time that you spent in D quad or A quad or anywhere else, did you see anybody forced to take medication?

MR. TAFOLLA: I was in the hospital overnight and I had to go to court in order to get a physical.

CHAIRMAN ALATORRE: You had to go to court to get the physical?

MR TAFOLLA: Because they thought I was jiving, so I went to court and the doctors bawled me out and I went into the hospital overnight and I witnessed an individual being injected with Prolixin and saw another individual, whom I had never seen but you know the effects that it takes upon the individual at the moment of injection.

CHAIRMAN ALATORRE: What happened to the individual when he was injected with Prolixin?

MR. TAFOLLA: Well, when they brought him in, he was struggling, fighting and when he was going out, he was being helped out so his total resistence was broken down. The individual wasn't himself.

CHAIRMAN ALATORRE: Was he part of your quad?

MR. TAFOLLA: No. He was a man from another quad.

CHAIRMAN ALATORRE: Did you see any other examples of forced drugging?

MR. TAFOLLA: Forced drugging?

CHAIRMAN ALATORRE: Yes.

MR. TAFOLLA: Not in the sense of physical force. Let us say that I spoke to many individuals that the system, or let us say the psychiatrists, sociologists and all the other people that are there with degrees or whatever put the individual to a psychological wall to where the individual will take the drug and cannot say no.

ASSEMBLYMAN DIXON: Mr. Tafolla, I'm interested in primarily trying to distinguish you from other people in the prison community who receive drugs and I am wondering if you could articulate any reasons that you can think of why you weren't either intimidated or forced to take drugs. Was it that you didn't present a problem?

MR. TAFOLLA: Right. You know like I say, it took some heavy manipulation, not just in -- verbally, but let us say, trying to show the custodial staff that I wasn't presenting a threat to their institution. I realized that if I did this and it was successful, I would not be, let us say, forced to take drugs or asked to take drugs, so let us say, I became humble.

ASSEMBLYMAN DIXON: You gave them the response you thought they were looking for.

MR. TAFOLLA: Right.

ASSEMBLYMAN DIXON: You think that is primarily the reason?

MR. TAFOLLA: Right. If you understand it, then you get around it.

ASSEMBLYMAN DIXON: Then from the inside, you would agree with the testimony that the drugs are primarily used as a custodial or enforcement agent.

MR. TAFOLLA: A lot of individuals like I say, are just individuals that were raised in my same environment and I don't consider myself violent. I have no violence in my record. I was, let us say, brought into C.M.C. by misfortune, something that happened in another institution and as I went in there, was classified as material for D quad. I was asked if I wanted drugs.

CHAIRMAN ALATORRE: They asked you if you wanted drugs?

MR. TAFOLLA: Sure.

CHAIRMAN ALATORRE: If you had responded by saying, yes...

MR. TAFOLLA: If I didn't understand -- if I hadn't lived in the system for 17 years, then I would have taken the drugs.

CHAIRMAN ALATORRE: Okay. For a person who doesn't know the system, if that person was asked that question and responded yes to the drugs, they would just give them to the inmate?

MR. TAFOLLA: They will let us go up there and on kind of excuse -- if I say that I am nervous, I need some tranquilizers, I need this, I am going through this head change and I need some kind of -- to relieve me of it and they will give it to you. I am a drug addict. I have been for 20 years. When I went into...

CHAIRMAN ALATORRE: Excuse me for interrupting. You say that you were a drug addict?

MR. TAFOLLA: Yes. When I went into this institution and I realized what drugs can cause, not because let us say I liked the high, but to understand the reality of what's happening in prison and what is happening to good men, men let's say that have intelligence and are not able to express it. I read something the other day in a book that was written by one of the prisoners that said, it is said to be pregnant with ideas that he could not release and the institution will keep you in a state of pregnancy and will kill whatever idea you have.

CHAIRMAN ALATORRE: Okay. Thank you very much, Mr. Tafolla. We are going to be recessing until one o'clock.

The Assembly Select Committee on Corrections is now reconvened.

MR. MIKE QUINN: Assemblyman Alatorre, gentlemen.

REV. PETER GENCH: I will introduce you to Mike Quinn who heads up the Citizens Commission on Human Rights. I'm an advisor for that group. I am Reverend Peter Gench and we prepared this testimony, a short picture and if you feel like it is getting a little long, stop and we will give you our recommendations. Okay?

MR. MIKE QUINN: The Citizens' Commission on Human Rights was founded in 1969. This is just some brief background on the Commission for the records. Our purposes are achieving reform in the field of mental health and the preservation of individual rights on the universal declaration of human rights of the United Nations and the Bill of Rights of the Constitution of the United States. The Commission operates close to 20 chapters throughout the United States and has made, since 1969, submissions to several government agencies and commissions such as Sam Ervin's Committee on Constitutional Rights. The Citizens' Commission has helped expose many illegal activities including the exposure of illegal drug experimentation in St. Louis, at the Missouri Institute of Psychiatry, which brought about immediate governmental investigation and corrective state legislation. We have some excerpts from testimony, the first is from Lloyd McColey, who was an inmate at C.M.C.:

"The first person I ran into that was involved in forced drugging was Sterling Sutton at California Men's Colony. He was practicing martial arts which was slightly contra-regulations. They put him on Thorazine for the same reason as Townsend --

possible violence. Last I heard he was transferred to San Quentin by McCarthy, the former director at C.M.C. for practicing martial arts. He has since been shot by one of the guards at San Quentin but is still alive.

The bulls have quite a lot of juice. They could come and kick the (expletive deleted)out of you and take you to the hospital or detention cells and say that the guard has been attacked when in fact it wasn't true at all. I was there for 7 years, 28 days, 4 hours and 45 minutes and I personally saw stuff like that happen three times. One guy, Harry van Beaucheaut who is out now got heavy doses of Mellaril for about one and one-half years. The guards didn't like it when he'd come up and urinate on them. Harfy was sane and liked to have fun. Then they got him on the drugs for doing it to the guards and the last time I saw him about a month ago, he was totally withdrawn and bordering on psychotic.

There was an artist in Vacaville - a Mexican dude that did folk art. He was, or seemed to be, a little withdrawn because he was wrapped up in art work all the time. He was doing a mural on the wall of the dining room in the intensive treatment center in Vacaville. He was put on drugs to bring him out of supposed depression. The dude was so heavily medicated he couldn't do art work anymore.

Dr. Steeves, an old gal who was a psych at Vacaville was good at making threats at putting people on various drugs and getting them to do what she wanted them to do. She's been married five times.

Dr. Szot would use coercion allegedly to have homosexual relations with inmates. He would allegedly pay 5-10 bucks to have anal intercourse. He would use drugs if they didn't agree sometimes -- put them on drug programs.

Dr. Shawyer at Vacaville was doing experimental work on behavior modification. She was using stimulant drugs on the side. They would be prescribed phenobarbital for sleep and then she would slip them stimulants without their knowledge to find out how they'd react under the stimulants. Naturally they stayed awake. This was supposed to be classified information. The inmates never found out. I worked for her as a clerk.

Three to four months ago I testified in Sacramento for the State Criminal Justice Commitee on the experimental drug issue. After the hearing this guy who was a phycho that was connected with the Department of Corrections and also was a representative of a couple of drug companies approached me on the way out of the building and asked my name, B#, where I was living and what I was doing. He threatened to have me sent back to the joint if I didn't withdraw my testimony. There's more and I'll testify if I have to. This stuff must stop.

The worst case I saw, though, was Neil Townsend at C.M.C. I ran into Neil in 1970. He was a heavy Christian and most of his activities centered around religion. The Board had asked that he be put on the drug Prolixin because of his beef. If they believe there's any possibility of anyone showing violent tendencies, the Adult Authority can order it. Dr. Schultz was head of the psychiatry and medical department and his Prolixin dosage

was increased to a point where he could hardly walk or talk. That was going on up 'til I got out of there in 1974. They were getting ready to move him to Vacaville because they had classified him as a schizophrenic and something else. The drugs made him appear that way. We lived in the same building for 3 or 4 years. He was more sane than half the psychiatrists I've known up there. If the shrinks would leave him alone he'd be alright. The usual release point for his crime, assault with a deadly weapon, is 18 months to three years. He's been there for 6 years on a 1 to 10 rap. They're just hassling him. He's one of the softest spoken guys you'd ever hope to meet. The man has never been involved in any violence up there. He is not a violent man. It makes me mad just to find out he's still there because he's a pretty decent guy. They told him to either take the drug or go to the hole -- solitary confinement. That was Doctor Owre."

These are further excerpts from other testimony on Neil Townsend from his family.

Neil Townsend is about to be transferred to Vacaville Prison maximum mental security on the 31st of this month. He has been protesting forced drugging by Dr. Owre for some time now. Upon threat of issuance of a writ of Habeas Corpus to Dr. Owre and the officials, the forced drugging at CMC was stopped and transfer proceedings started so Neil could have further treatment at Vacaville as an "unruly" prisoner. Here is a report from Neil's brother-in-law who has visited Neil since his incarceration:

"After returning from visiting my brother-in-law in prison I recorded the following:

1. In 1970, he was given shock treatment at Atascadero prison. The officers there found a sharp object in his possession and wanted him to confess to them the names of 2 other guys.

2. In March of 1976, my brother-in-law was sent to the hospital for making threats to female employees. There he was given and is still on 2 drugs. One is Thorazine and the other is Prolixin. Those drugs were forced on him by a shrink named Owre. No witnesses were ever produced that claimed he made threats to them. He was about to appeal his case before the Parole Board. My father-in-law was taking the case to court to stop Dr. Owre from passing out the dope. His lawyer said Dr. Owre had pulled the same thing on other prisoners. This Dr. Owre promised my father-in-law he would take Neil off the drugs. So far, he hasn't. Neil has to go off the drugs very slowly as they will cause withdrawal symptoms. He is given Thorazine and Prolixin 4 times a day. I have known my brother-in-law for 2 years. He was not and is not capable of any kind of threat to anyone. I saw him in September of 1975 and he looked OK. Now he is a Zombie."

And here is a report from Neils mother, excerpted:

"Neil's difficulties began when he objected to having women stationed where the men strip down to be examined after being in the visiting area. He wrote to the Warden twice. He then talked

to one of the workers at CMC (a woman) who was stationed at this check point. Now this was against the rules and Neil was confined to his quad and asked to see the psychiatrist the next day (they asked him to see the psychiatrist). So, because of this incident Dr. Owre, the psychiatrist wanted to treat Neil for "his problem" saying that it was "way, way out and unreasonable to object to stripping down in the area where a woman was stationed." He also tried to tell Neil he was the only one who would feel that way or object. The psychiatrist seemed to want to make out that Neil was way out of bounds in objecting to something on Christian principles and that this was crazy. The psychiatrist in another quad had told Neil that fornication and casual sexual relationships will be necessary for him on the outside or he'll be dangerous and Dr. Owre's beliefs follow the same line.

Then during the first week of March, Dr. Owre called Neil to come in and see him, and Neil wrote a note saying he didn't want to see him, mistakenly thinking he had some rights in this matter. After being called four or five times, an officer was sent for Neil, and Dr. Owre put him in the hospital on heavy medication. One of the medical attendants saw how he was shuffling around with his head arched over and realized he had way too much medication and reduced it in half. When Neil went to see his lawyer, he was so heavily medicated that a correctional attendant went with him to see he didn't fall and injure himself. The letter Neil had written telling us he was in the hospital under heavy medication was written in March and cancelled March 18th, but for some reason we didn't get it until 20 days later, April 6."

And here's some more from Neils sister:

When Neil was convicted of ADW, the victim sustained 2 very slight bruises and didn't want to press charges. When I saw Neil in September of 1975, he was OK. Then when I visited him on April 10, 1976, Neil's hands were rough, abnormally parched, as in acute vitamin deficiency. His eys were slightly glazed looking. His skin was slightly sunburned and he is normally tanned. Neil said, "This medication has something in it which causes me to sunburn without going out. Funny, isn't it?" Neil walked with his head forward, his neck and shoulders extremely tense and tight. He could not sit still for more than a few moments although he had high affinity for us and wanted to visit with us. Neil told us he didn't feel the need of drugs at all and was getting a lot of them. His speech was sluggish. His neuromuscular control was not normal."

REVEREND GENCH: We went through the Physicians' Desk Reference last night to give layman terms on what Prolixin is and what it does, its contra indications. And just to give you a very basic idea, Mike, why don't you read that.

ADVERSE SIDE EFFECTS ATTENDING PROLIXIN AND THORAZINE

Quoted from attached advertisement from Squibb, manufacturers of Prolixin Decanoate.

"PRECAUTIONS: Caution must be exercised if another Phenothiazine compound caused cholestatic jaundice, dermatoses or other allergic reaction. Bear in mind that with prolonged therapy there is the possibility of liver damage, pigmentary retinopathy, lenticular and corneal deposits, and development of irreversible Dyskinesia.

ADVERSE REACTIONS: As with all antipsychotic agents, persistent and sometimes irreversible tardive dyskinesia may appear in some patients on longtermed therapy or may occur after discontinuation of drug. The syndrome is characterized by rhythmical involuntary movements of tongue, face, mouth, or jaw, and may be accompanied by involuntary movements of extremities. There is no known effective therapy for tardive dyskinesia (difficulty in performing voluntary movements.) Phenothiazine derivatives have been known to cause restlessness, excitement, or bizarre dreams and aggravation of psychotic processes have been encountered. Dosages far in excess of the recommended amounts may induce a catatonic-like state. Sudden deaths have been reported in hospitalized patients on phenothiazines. Previous brain damage or seizures may be predisposing factors. High doses should be avoided in known seizure patients. Shortly before death, several patients showed flare-ups of psychotic behavior patterns. Autopsy findings have usually revealed acute fulminating pneumonia or pneumonitis, aspiration of gastric contents, or intramyocardial lesions, etc.

Additional Data on Drug Program Sources

In quote from an article by Jessica Mitford appearing in Atlantic magazine January 1973:

"Over the past ten years a brisk traffic in human subjects for drug company experimentation has grown up in the California Medical Facility at Vacaville, a prison specifically designated for men deemed by the authorities to be in need of psychiatric treatment. Vacaville has a population of some 1500 of whom 300 to more than 1000 may be in the "volunteer" (quotes ours)

medical research program at any given time.

The medical experiments are organized under the aegis of an organization called the Solano Institute for Medical and Psychiatric Research (SIMPR) with headquarters in the prison. SIMPR is set up as a nonprofit corporation under California's charitable trust law. According to its financial statements filed with the Registry of Charitable Trusts SIMPR's income from "various researchers" (quotes theirs) rose from $47 thousand in 1963 to over a quarter of a million dollars, according to Mr. Ralph Urbino, SIMPR administrator, "as a nonprofit organization we are barred from receiving funds from private business concerns. Our income is derived from the physicians who have been given research grants for the purpose." Yet, the giant pharmaceutical firms give their money to University of California medical schools and physicians who conduct experiments at Vacaville. Dr. William C. Keating, Superintendent at Vacaville in 1962 was a founder of SIMPR and worked with Dr. Howard I. Maibach and Dr. William L. Epstein, and are mentioned in SIMPR's 1972 publication as the continuously active research team at Vacaville. They are both on the staff at the University of California.

SIMPR is not required under the California Public Records Act to disclose medical data, so deaths and serious complications could not be checked into. Other state laws, particularly Section 5328 of the Welfare and Institutions Code and Title 9 of the Institutions Title of the State Department of Health, prohibit inspection of medical records to protect patient confidentiality.

Dr. Alan Lisook of the Food and Drug Administrations Office

of Scientific Evaluation said: "We've no list of prisons where drug research is going on." He was unable to furnish the names of drug companies experimenting in these prisons or numbers of inmates involved.

"Criminals in our penitentiaries are fine experimental material and much cheaper than chimpanzees."

REVEREND GENCH: In other words, there are all that good old medical terminology, but basically he has problems with his muscular functioning and he has scars inside the heart created by the drug. We have a list of recommendations here that the Citizens Commission proposes.

Recommendations

A full inspection team not composed of Department of Corrections personnel and involving human rights and civic group members should be appointed by application to the Legislature. To determine to what extent forced drugging is continued in the prison system and what its results are, would be its purpose. Full protection should be granted to any prisoner who would give information to the inspection committee of abuses.

A strong deterrent factor for psychiatric and medical personnel involved in forced drugging making stiff criminal penalties for offenders, would be another purpose.

Presently, there is no punishment for these kinds of offenses. They should lose their jobs and licenses for these actions and, minimally, tried for criminal assault if there have been physical or phychic trauma or damage to the prisoners.

There should be a complete present evaluation by the Office of the Comptroller for the State of California into the facilities

to determine the following:

1. The amount of drugs purchased by each institution.
2. The amount dispensed and the cost factor.
3. How much was dispensed to prisoners and how much is on hand compared with how much was purchased that should be checked out and the directors held responsible for any discrepancies.
4. How much monies are being given for psychiatric programs of this nature, and how much is each doctor and psychiatrist receiving. How effective are these programs in terms of recidivism. If they are not producing any good results and the recidivism rate is continuing, then they should just be junked.

Only those programs that are viable should receive support. Statistics should be worked out determining program effectiveness along lines of rate of recidivism and ability of the individual to go out and work in the community.

There should be a yearly report from the Commission set up by the State of private individuals on the effectiveness of these programs and it should be published for the public to view via the Legislature.

It should also be determined how much material is being produced in prison workshops and how much the materials cost and how much is being received in receipts for prison manufactured goods. Who are the recipients of the goods. How does their purchase compare with the open market price? Are there any large profits being made in this direction?

Who are the suppliers and who are the recipients?

How much are the prisoners being paid for this kind of work? Perhaps a prisoner could work enough to pay for the amount of money he stole that was not recovered at a proper wage and then be allowed to return to society once he has more than made up for the debt and this could be determined by law, whether the debt was in terms of money or other obligations for crimes. This surely would be better than giving them a ticket to a psychiatric playground out of "Alice In Wonderland" or "Clockwork Orange" or more likely-1984.

CHAIRMAN ALATORRE: Thank you very much. Is Doctor Kupers here? Gordon Cook?

MR. GORDON COOK: Yes, sir, my name is Gordon Cook. I'm a board member of a small group of people called Project Involvement. This was an organization formed at one of the local prisons, California Rehabilitation Center and we have been visiting people in the work force at CRC for about 3 or 4 years.

What we've been listening to today is the example of what happens in a totally, I guess as close as you can say, totally negative institution. It is, in my mind, impossible to expect a negative institution to solve the problems that we've asked them to solve. Secondly, the prison is stuck with something that the entire system, the entire criminal justice system, has put to them. And in it the keeper and the kept can only learn how to adjust to a negative institution. And the example of what happened when we bring positive institutions in conjunction, mix them with the negative institutions, the prison, is best shown by what you did with Contact 7. You as a legislator, and in which I would call

a negative institution and have done more, in my opinion, than all of us who have been beating our brains out trying to bring out change.

You have started something. I put this concept to the rules and regulations hearings for the Department of Corrections in Ontario, and the concept I'd like to see promoted is bringing the entire community into the prison, working with the prison. Now, you have not destroyed them, although they may look at you as a danger. But, I don't think you've destroyed them. I think, instead, that you may possibly reverse the 200-year failure and may start something working because I defy you as a legislator to be told by anybody in the system that forced drugging is not occurring or going on in today's prisons in California. I don't see how you could possibly accept that; and, therefore, I can only see you doing something positively for it.

So the concept of asking the community to come in and work with the prisons is one that I would like to see proposed. And you have the model already set in the local prisons in the southern California area. At one time, we started what we call a conference of resources. We worked with Mr. Greggs, of the California Institute for Men, and this was bringing the community into the gymnasium and talking to people and telling them about their resources that they had available. That was also extended through Mr. Duran of the California Rehabilitation Center, to CRC, and there they call it a job fair. Now the community lost touch with this thing, but Mr. Duran has still kept that going. We have positive prison administrators, as well as possibly, you know, they pointed out, negative administrators. We have the model.

I think it's the Lanterman-Petris-Short Act; I think it has the model for the public, the entire public working with an institution to solve a given problem.

And then the final thing I'd like you to ask is the psychiatric problem that keeps coming up; asked in the terms, at least as far as the prison is concerned, of Thomas Juarez and his myth of mental illness, in which he feels that the mind cannot be ill, it is not a physical organ; therefore, it is a myth, mental illness. Since it is a myth that people believe, we establish the medical concept to treat, and we're getting nowhere. He would ask that we admit that psychiatry is a method of social control. But, in the prisons, this is certainly social control, because you know how bureaucracies protect themselves and they talked about 800 men out of 2,400 being medicated as being dangerous and psychotic type people. At the same time at Atascadero, we have another bureaucracy whose sole purpose is to deal with people who are psychotic and extremely dangerous. And if C.M.C.East had 800 men, you can bet your bottom dollar Atascadero would have them, because that's worth $3 or $4 million to them. So, this is the kind of thing we have to look at and judge and I'm asking your Committee to consider working with the community at large and make that blue ribbon commission that was suggested truly representative of people, because I think you, as a legislator, have done much, but could do more as a person. I think Jack Smith as a journalist did a great deal, but could do more and is capable of doing more as a person. So, if we all went in as people and dealt with people in prison, we might come up with some solutions instead of rehashing these horror stories going on and one. I'm sure you're sick of listening

to them, and I hope that now we can do something about it. That's basically what my statement is.

CHAIRMAN ALATORRE: Thank you very much, we appreciate it.

Yvonne Rice: Why don't you come up...alright, just so you can make it very short, okay?

MRS. YVONNE RICE: I have a brother at C.M.C. He isn't in D quad. He's not on any medication as far as we know now. We don't want to see him ever being forced to take any kind of drugs. I've seen a lot of the Thorazine shuffles by just visiting him. I've heard a lot of inmates' stories, just by talking to them. Once I was approached by a guard, there I was talking to the brothers of one of the guys that was on the news. He wanted to know why was his brother like this. He wanted me to ask my brother. My brother told him that he didn't know, and the only thing he could say was that he was on drugs and that he didn't want to get involved. I gave my phone number to the brothers that was there, but the guards took it away. They immediately took the inmates back to the cells and the brothers left. Like I say, I'm just here today because I'm interested. I have a brother there. I don't want to see him ever being forced to take any drugs.

One of the gentlemen that was here was an ex-inmate, I guess you could say. He said that he didn't take drugs because he used his head, more or less, doing what the system wanted him to do. This is basically what my brother is saying too, you know. But, I can see fear in him. He fears the guards, he fears everybody. They have harassed me. I've been there.

Oh, yes, by the way, I'd like to say this, too. When he was sent from Chino, he wasn't supposed to go to Soledad, but he did.

I wish I could think of the name of the prison, Tehachapi, they said they didn't have any beds for him. Last year we wrote Governors, we wrote to Sacramento for him to be transferred closer to home because my mother had cancer and we didn't think she would live. By the grace of God, she is living now. But they did transfer him, which they were suppose to transfer him to Tehachapi, again they sent him to C.M.C. this time. He's been there since January of this year. He's 24 years old, and in 6 months, in 6 and one-half months, I can see that he has aged 3 years since he has been at C.M.C. and maybe it's because of fear, I don't know. Thank you.

CHAIRMAN ALATORRE: Thank you. Yes. Mr. William Harris and Stan Hervey.

MR. STAN HERVEY: Mr. Alatorre what I'm going to say is that...

CHAIRMAN ALATORRE: Can you give us your name?

MR. HERVEY: My name is Stan Hervey.

CHAIRMAN ALATORRE: Okay.

MR. HERVEY: Basically I wanted William, here, to talk because he has just been released from C.M.C. in December. The point is...

CHAIRMAN ALATORRE: Let me just make it very clear that the record reflects that both of you are here at our request because I think it is important to note the hesitation that some of you have in bringing forth testimony, especially if you're still within the jurisdiction of the California Department of Corrections.

MR. HERVEY: I work for Central City Bricks and this is my

total function. What I'm saying is that I was in D quad, but that was in 1965-67. I was in D quad and C quad and although it was apparent then that there was a great deal of forced drugging, you know, at that time almost the whole quad was on medication. I was placed in D quad because of what I was sent to prison for.

CHAIRMAN ALATORRE: What were you sent to prison for?

MR. HERVEY: I had a homicide. But after being there a couple of weeks, I was transferred to C quad. Then C quad there was also, which was C and B quad. B quad was suppose to have been an honor quad and C quad was the quad for, as they say the incorrigibles. People with the heavy beefs, that was going to be there for a long time, the warehouse like. At the time I got there it was considered bold to be on medication and there was no discouragement by the administration at all. Take the administration, you know, the hospital story, and they would put you on drugs. I mean I got on drugs four times a day for 30 days on Libriums and I found out, hey man, this really was not my thing, and when I tried to get off, they would send the goon squad to see that I continued to take my medication.

CHAIRMAN ALATORRE: Is that all you were on, Librium?

MR. HERVEY: Yes, but I was glad to be off.

CHAIRMAN ALATORRE: Answer the question. When the goon squad picked you up and took you to P cell, or the hospital, or wherever, were you given an injection? Also, part of the testimony earlier was that they would give you an extra dosage as a penalty for not agreeing to take the medication orally.

CHAIRMAN ALATORRE: Did that ever happen to you?

MR. HERVEY: Well, no. What they would tell me is that if I didn't continue to take, you know, finish the 30 days off, that I would be extended 30 more days and it would be something else besides the Librium, you see. So I just finished taking it out and I just learned a way to hide the medication, and when I get outside I just spit it out and go on about my business. I found out that I didn't need this.

I want to talk about William because he was released in December, and he was released to the Half-Way House. In talking with William we find out that he was on 800 milligrams of Thorazine a day, okay. Then they just released him.

CHAIRMAN ALATORRE: First of all, when did you go into the institution and when did he come out?

MR. WILLIAM HARRIS: I went in at the beginning of '72. I got out December '75.

CHAIRMAN ALATORRE: So you went in '72 and got out late in '75?

MR. HARRIS: Yeh. December of '75.

CHAIRMAN ALATORRE: From the time you went in, were you given medication and who prescribed the medication?

MR. HARRIS: It began at the guidance center. They opened by asking do you need medication?

CHAIRMAN ALATORRE: What was your response?

MR. HARRIS: I refused the suggestion.

CHAIRMAN ALATORRE: What happened then?

MR. HARRIS? It continued to a transfer, and it was a psych referral place. There was negative conversations between receiving

at medication point, and then it became, "we're just going to give you this by force."

CHAIRMAN ALATORRE: Did they tell you why or what medication you were on?

MR. HARRIS: It began with Thorazine.

CHAIRMAN ALATORRE: What was the dosage initially?

MR. HARRIS: It was issued four times a day at 200 milligrams.

CHAIRMAN ALATORRE: Two hundred milligrams, four times a day, so that's 800 milligrams of Thorazine a day.

MR. HARRIS: Yes.

CHAIRMAN ALATORRE: Now how long did you take the 800 milligrams of Thorazine?

MR. HARRIS: They extended it for possibly seven to nine months.

CHAIRMAN ALATORRE: In that seven to nine months were you given any other medication beside Thorazine?

MR. HARRIS: There was more medication, but I can't remember the number of times.

CHAIRMAN ALATORRE: You don't know beside the Thorazine that you took what other medications they were giving you?

MR. HARRIS: In between.

CHAIRMAN ALATORRE: What happened after the nine months?

MR. HARRIS: I began working, programming and going to school, religious activities and it became a program decision that they observed you after someone requests, and then they let you get off.

CHAIRMAN ALATORRE: Is there any doctor that can state what a normal dosage of Thorazine might be? Is there anybody here,

any of the psychiatrists left? We'll get that information. You may continue, I'm sorry.

MR. HARRIS: It is when you go forward to ask to get off drugs and you begin working and going to school, they program within the institution. Then the argument comes when you go to see Pickett or Owry. Then that bring about the static and they refuse you there, and they increase the medication. After continuing to explain the point that less doses and a chance to exercise and go to school, would bring about a mentality that they could understand. Then they go off into the argument as to how they feel. Then it begins to come to psychiatric hassles. They ask you, so long as you said the drugs are a failure, and your mind goes back into your personal concept and what's happening to you. You're then placed on it again. With Thorazine and Stelazine something to take you down and to speed you up and that brings about a complete psychiatric disorder and so you become lazy.

CHAIRMAN ALATORRE: Let me follow the sequence exactly. After the nine months on Thorazine, did you ask to be taken off the medication or did they take you off the medication?

MR. HARRIS: No, first I refused and then they took me out to the hole.

CHAIRMAN ALATORRE: Then they forced the medication on you?

MR. HARRIS: Well, you know, yes.

CHAIRMAN ALATORRE: In other words, instead of taking it orally they then gave it to you with a hypodermic?

MR. HARRIS: They began challenging me and they took me to the hole and they placed me in a room. Then I positioned myself for defense and they would come forward with an outfit and say we're going to give you the Prolixin so which way do you want to do it. Do you want to drink it, or do you want it inserted in through the outfit? So I was given a liquid at the time. I didn't know what it was and I drank it. This was in a hospital of maximum security. I'm going to explain it to you that you get up out of your room and go get it, after being drugged by something that you have no knowledge of. From there, you're still trying to find yourself, you know, if you wish not to die.

CHAIRMAN ALATORRE: How long after the time they took you to the hole did you continue to take medication? Were you on medication the whole time that you were at the institution?

MR. HARRIS: No.

CHAIRMAN ALATORRE: How long were you on medication?

MR. HARRIS: Off and on, I'd say half the time; for approximately 16 months.

CHAIRMAN ALATORRE: Okay, were you at D quad?

MR. HARRIS: Yes.

CHAIRMAN ALATORRE: Aside from your experiences did you ever observe other people being forced to take medication?

MR. HARRIS: Well, this is the thing I explained to him. Everyone was within their procedure, you know. The only way I could survive was by doing excessive amounts of exercises and walking daily. Just to lay down and take that type of

medication, I would die, you know, and to a certain extent you lost more of yourself.

CHAIRMAN ALATORRE: Did they tell you why they gave you the medication?

MR. HARRIS: Refusing and different degrees of, using your hands on the yard, or you won't be still to the point of, you know, not exercising, sitting in groups, the regular procedure, of regulations of the expectations, even though there are at least 13 gun towers. So you can't do no more than hurt each other.

CHAIRMAN ALATORRE: Now when you left or toward the end of the time did you, were you still on drugs?

MR. HARRIS: Yeh, I was placed on drugs right after, I kind of had it, it wasn't a nervous breakdown, but my mind and body began to weaken. Then I was placed back, and they began cracking questions about, "do you see lights? What do you see in your mind?" You cannot produce a picture or a concept, you just apply it to medication, till you can say, whatever you see.

MR. HERVEY: Mr. Alatorre, what I'd like to say now is that when William came to the ex-offender house in December, he's, you know, he was just a shadow of what he is now. You see the Bricks program has been saying for years about, we've been talking about this, we know about this, we've seen time and time again, William as he sits now, he's a picture of health to what he was in December, since last year. He exercises like he says, regularly, everyday, you know, he exercises and he walks, things. We've had other guys that have come from the institution since then and they couldn't

get back, you know.

CHAIRMAN ALATORRE: Can I just ask you one more question? When he left the institution, did the doctors prescribe any drugs for him after his release?

MR. HERVEY: No, none.

MR. HARRIS: It ended there and still you know, that stuffs in your system for a long period of time, you know. The degrees of exercise 500 or 600 pushups a day, not just calisthenics, just not let it, you know, slow you down. You gain a lot of weight, then it's a mixture in normal blood, you can't pinpoint what's going to keep you awake and what's going to keep you asleep at night. As it was applied, even in periods when you were just asleep and relaxing, but to be sleeping all day off and on, up to eat, run to do this and run to do that and then locked up and continue to apply medication.

MR. HERVEY: I had one fellow here and he was in such bad shape we couldn't keep him there and the thing of it is that when they released these guys from the institution there was no medication, neither will the doctor prescribe anything to them and you can't get any assistance for them. There is no money other than what is given upon release. There is nothing that you are able to generate in the community, and this is just -- I wish I could have Raymond here so you could see him because he's a total wreck. Fourteen years off and on Prolixin. Well, like I said, he is the picture of health now.

CHAIRMAN ALATORRE: Where is Raymond now?

MR. HERVEY: I don't know, We don't know where he is. That's the whole thing. We don't know where he is. He's the man who was supposed to go to Atascadero ... There was nothing that we could do for him.

CHAIRMAN ALATORRE: Mr. Ramos. What is your name, for the record.

MANUEL RAMOS: Manuel Ramos. There are just a few things I would like to share with the Committee, Mr. Alatorre. First of all as a citizen concerned with this and second as a member of the Community Concern Corporation, Inc. Speaking as an ex-inmate of the institution and working directly with the medical staff there at the institution.

CHAIRMAN ALATORRE: What institution?

MR. RAMOS: California Rehabilitation Center at Corona. My duties involved working directly in the clinic with the men and under a doctor at one point and at another point under a psychiatrist.

CHAIRMAN ALATORRE: Okay.

MR. RAMOS: Usual policy and procedure was that when they had what they called management problems with inmates that they were right away referred to the Psychiatric Department for devaluation upon which time I would say 90 percent of the time they would come back prescribed with medication, Thorazine, Valium and all these other drugs. Now there were several alternatives a man had. You know he could refuse the medication and then custody would take over, or he could accept the medication and then just wander around the yard.

CHAIRMAN ALATORRE: When the person refused the medication, what would happen then?

MR. RAMOS: If a person refused the medication, usually he was reprimanded in what is called the CDC 128 which goes documented on his file so that when he goes to the Board it is documented that he refused medication and you cannot get out of the institution unless you comply with ... this one aspect of medical.

CHAIRMAN ALATORRE: What types of drugs are they giving? If a person was considered to be a management problem, then he would be given certain types of medication. Right?

MR. RAMOS: Right.

CHAIRMAN ALATORRE: How about for those that were not considered to be a management problem? What would happen to those people?

MR. RAMOS: The ones that were prescribed these particular medications?

CHAIRMAN ALATORRE: The person who was prescribed certain medications and didn't want to take them because he felt they were damaging and he had bad reactions from them.

MR. RAMOS: It was documented also on a 128 form.

CHAIRMAN ALATORRE: Did you see in your period of time at the institution people who were forced to take the medication?

MR. RAMOS: Well, forced but it was used in a subtle way. See that one I just ran down to you right now, is saying that if you refused it, okay, it is documented in your jacket, but on the other hand, if you refused and you were considered a

management problem, then you were transferred to C.M.C East. Then I guess, from what I have been hearing it was dealt with these other methods.

CHAIRMAN ALATORRE: Okay, continue.

MR. RAMOS: That's about all I have to share with this Committee at this point.

CHAIRMAN ALATORRE: Are you familiar with or were you ever at the California Men's Institution at San Luis Obispo?

MR. RAMOS: No.

CHAIRMAN ALATORRE: Thank you very much.

MR. PETER M. CALAGNA: Mr. Chairperson and Members of the Committee, the media and the public, my name is Peter M. Calagna and my purpose here today is to address you on behalf of the Los Angeles County Chapter of Napa, The Network Against Psychiatric Assault. We are an organization statewide which is led by and largely consists of ex-psychiatric inmates. We want to express our outrage over the forced drugging of inmates of California's penal institutions just as we opposed the forced drugging of psychiatric inmates at so-called mental hospitals. We would like to thank the Committee and especially Assemblyman Alatorre and his staff for conducting this long overdue investigation and we want to recall your attention to the basic similarity of these two types of confinement which no doubt has already emerged from your inquiry. The mental institution and the prison are becoming virtually indistinguishable in our society. At the same time, the psychiatric inmates are imprisoned because of the label of so-called mental illness rather than a legal

verdict. Persons confined in penal prisons after such a verdict are now subjected to the same dehumanizing and dangerous treatments so-called which for so long have been forced on the psychiatric inmates. Beginning with the daily experience of forced drugging with powerful tranquilizers which are really chemical straitjackets, both types of prisoners further are likely to be subjected to other Orwellian techniques such as aversive conditioning, electro-consulsive shock and psychosurgery. While the drugging and conditioning may be retained, especially the drugging, the drugs may be seen as chemical clubs used to beat the person into submission and the conditioning used to keep her or him there. The other so-called treatments form the repository of psychiatric final solutions. They have received a great deal of attention because of their traumatic aspect and because most people understandably have a gut revulsion to such obviously horrendous practices, but forced drugging, on the other hand, has yet to become a part of the public consciousness. When millions of Americans are on tranquilizers, this practice is not immediately recognized for what it is. However, as testimony may have already indicated, the over-the-counter tranquilizers and even those prescribed by non-psychiatric physicians in the community are geometrically less potent than those involuntarily imposed on penal and mental prisoners. The term tranquilizer, especially the latter type, of phenothiazines is really a misnomer because the drugs do not make you tranquil. What they do is subdue and suppress what may very well be justifiable anger but do not eliminate it. I know this because I was myself subjected daily

to forced drugging while a psychiatric inmate at California. When I attempted to assert what should be the inherent right to refuse such drugging, I was tied face-down to a bed in a solitary confinement room and forcibly injected in the hip. This happened to me many times because I was an agitator for change on the ward. On one occasion I was so over-drugged or "snowed" as it is called by professionals referring to PRN prescriptions, I did not awake for 26 hours. We believe that all of these practices, including the merging of the psychiatric and penal systems, reflect the growing power of the mental health establishment over all of our lives. This is occurring because increasingly we interpret behavior which is unethical or undesirable as "sick". We do not as a society or as individuals accept responsibility for that behavior and seek to explain and to change it. Instead, we simply reduce everything to individual "sickness". This tendency will result not only in a failure to solve human problems but it will also subject all of us to social control by technocratic elite bent on imposing its values in the name of science and our civil liberties and human dignity will be eliminated.

CHAIRMAN ALATORRE: Let me ask you, as your association been involved in any other institution besides C.M.C. East - - being that you are in the Los Angeles area, have you had any experiences in other penal institutions in the Southern California area?

MR. CALAGNA: Well, some of our members have also been inmates in penal institutions as well as psychiatric institutions. However, our organization is aimed primarily at the situation of the

psychiatric inmate but we are here to express our concern about what's going on obviously in the penal insitutions as well, and to show our support and our solidarity with prisoners that are trying to get that eliminated. I would like to point out -- I didn't include this in my statement but since the time that I was confined in a psychiatric institution, I have been working in the field of so-called Human Services and I did that so that I would try to regain the legitimacy that had been stripped from me by the label of psychotic and it has only been recently that I have been able to come out of the closet, if you will, around the fact that I have once been in a psychiatric institution because people are not prepared to accept that, particularly people who work in the field, although they claim to be interested in getting rid of stigma and all of that. But from what we've found that isn't really true and I have become involved in this in Napa because it is an organization of ex-psychiatric inmates banding together to try to fight for their own rights because we have a situation that is very similar to ex-prisoners of penal institutions as far as being discriminated against in employment, housing, you know, and in social relations generally and we could get into that but I just wanted to point that out.

CHAIRMAN ALATORRE: Thank you very much.

MR. CALAGNA: Thank you.

CHAIRMAN ALATORRE: Could we have a copy of your statement?

MR. CALAGNA: Yes, I have already submitted it.

CHAIRMAN ALATORRE: Thank you. This concludes the hearing for today. Let me state for the people that are here that this is the beginning of what I hope will be a thorough investigation of the

of the practices currently going on in some of the institutions. This is only one aspect of the Committee's charge by the California State Assembly because we also intend to look at other problem areas in the penal system. For those of you that have any information which you feel would be helpful to the Committee, during the period of time that we will be in existence, we would appreciate your forwarding that information to Mr. Castro, who is the Chief Consultant for the Committee. As I say, this is not the end, but the beginning. Thank you very much.

A P P E N D I X

MAJOR "TRANQUILIZERS/"ANTI-PSYCHOTIC" DRUGS

Drug Company Name	Relative Strength	Usual Dosage Milligrams Per Day Low	High
Thorazine	100	50	2000
Vesprin	25	25	150
Mellaril	100	25	800
Serentil	50	25	400
Quide	10	10	160
Tindal	20	40	120
Compazine	15	15	150
Trilafon	10	6	64
Repoise	10	10	100
Stelazine	2	4	30
Taractan	100	75	600
Navane	4	3	60 (oral) 30 (injection)
Haldol	2	2	15
Moban	5	15	225
Prolixin	2	2	20 (oral) 10 (injection)

For verification of these figures see: Physicians' Desk Reference, Medical Economics Company, Twenty-ninth Edition.

Par. 346.15

(d) Forced Medication

Forced medication is defined as the administration of medication by the use or threat of physical force or disciplinary action if an inmate does not consent to the administration of such medication.

Forced medication will not be used to control behavior that is not related to a diagnosable psychiatric or medical disorder, or when the inmate-patient is capable of giving informed consent and objects to such medication.

(e) Procedures When Forced Medication is Necessary

Emergency Situations - Inmate-patients incapable of informed consent because of an emergency psychiatric or neurological disorder which renders him or her (1) a danger to himself, or (2) a danger to others; or (3) gravely disabled as a result of the disorder may be furnished the required medication for a period not to exceed 10 working days provided that:

1. Within three working days an additional medical opinion be obtained and the chief of service be notified in writing.

2. The medical record clearly reflects

   a) The indication for the medication;

   b) The reason for the urgency;

   c) The mental status factors supporting incapacity for informed consent.

(f) Continuation of Forced Medication

When necessary to continue the forced administration of medication beyond a 10-day period a formal consultation will be obtained (with full report) addressed to the factors outlined under emergency situations. Consultants may be obtained from the special panel described later. Institutions having special treatment boards may utilize the same for such consultation. Copies of the

consultation report (CDC Form 243) or the minutes of the special treatment board will be forwarded to the chief of psychiatric service, the chief medical officer, if appropriate, warden/superintendent, and to the C.D.C. Medical Director. The consultation will not necessarily be binding upon the attending medical staff.

ADD

If forced medication continues, the patient will be seen personally and the file reviewed by the appropriate chief of service as recommended by the special treatment board or special panel. The review will be conducted at 30 day intervals or as recommended by the special treatment board.

ADD

Where the inmate has made a partial recovery from the psychiatric disorder, but the person's mental status still makes determination of capacity to give informed consent difficult, it is advisable to stop the medication pending consultation. However, if the recovery is so tenuous as to make such withholding detrimental to the patient, the attending physician may authorize administration of the medication pending consultation. If the patient recovers his capacity to give informed consent but still refuses, forced medication will be stopped.

(g) The Special Consultant Panel

The medical director, with the assistance of the Director of Health, will maintain a list of consultants who can be made available to the institution at no expense to the inmate for the purpose of evaluating capacity to give informed consent. The medical director may require that such noninstitutional consultants be utilized regardless of other case factors if such is warranted in his opinion, and has the prerogative of relieving the attending physician of responsibility for the case.

(h) Notification of Next-of-Kin

ADD

The inmate's family or next-of-kin will be notified by letter of the circumstances requiring forced medication.

(i) Requests for Independent Consultation

REV.

Inmates or their families may request, in accordance with the Department Administrative Manual, an

independent consultation at no expense to the state relevant to the patient's capacity to give informed consent. Normally such requests will be granted with the provision that the consultant is professionally qualified and that the normal practices of consultation be followed. The consultant's findings will not be binding upon the attending physician; however, the report will become a permanent part of the medical record

(j) Logs of Forced Medication

ADD

Each institution shall, through the appropriate section of its nursing service, maintain a log or logs of each and every occasion of the use of forced medication which shall record the date, time, inmate's name, number, name of ordering physician, and reason for administration. Such logs will be reviewed at least monthly by the appropriate chief of service and may be subject to such other reviews or inspections as required by the medical director. Such logs will be considered confidential under the Public Information Act by virtue of containing specific confidential information which could be harmful to the inmate if released to unauthorized persons.

(k) Inmate Appeals

ADD

Nothing in this policy is intended to interfere in any way with the inmate's utilization of the appeals procedure.

SIDE EFFECTS OF MAJOR TRANQUILIZERS/"ANTI-PSYCHOTIC" DRUGS

I. Temporary muscle side effects ("extra-pyramidal" in medicalese). These muscle reactions will gradually stop if the "anti-psychotic" drugs are stopped.

Ia. Dystonic Reactions: sudden, bizarre, uncontrollable, painful muscle cramps or spasms, especially of the mouth, face, neck, eyes, arms and breathing, although any muscle can be affected.

Ib. Dyskinesias: weird, involuntary, uncontrollable writhing, squirming, grimacing movements, especially of the legs, face, mouth and tongue. One form, called akathesia, consists of an inability to sit still, with constant agitation, pacing foot tapping, finger movements, and an unpleasant inner sensation of having a machine in your gut that won't stop.

Ic. Parkinsonism: a general increase in muscle tension which causes varying degrees of muscle stiffness, rigidity and slowness of muscle movements plus shaking (tremors) of hands and legs and at times a hunched-over robot-like state. The facial muscles become stiff so that a bland, unchanging facial expression is created chemically. This condition is is similar to Parkinson's disease, or paralysis agitans, which occurs naturally.

Id. Akinesia (zombie effect): At its worst, the victims of this side effect stop being spontaneous, have few body movements or gestures and little conversation or speech, feels apathetic and tired, and looks rigid and stiff. This happens to all people on these drugs to varying degrees, in part depending on the dose. The higher the dose the more likely the victim is to be made into a chemical Zombie. Often this drug-created situation is confused with depression or symptoms of "schizophrenia" and the person is given more drugs or different drugs, when what is needed is less drug or no drug at all.

II. Permanent brain damage, called Tardive Dyskinesia or Persistent Dyskinesia.

After taking any of the "anti-psychotic" drugs for an unknown length of time (weeks, months or years, depending on each person's sensitivity to these drugs) a person may develop permanent brain damage, manifested by strange, slow, uncontrolled muscle movements, usually around the mouth. Quite often it is only after the drug is stopped that the muscle movements start, indicating that possible permanent brain damage has already occurred. The movements last usually 5-8 seconds, are repetitive are reduced by voluntary muscle movement, and go away during sleep.

APPENDIX C

The movements look like sucking, puckering of the lips, chewing motions, and often occur with a rhythmic opening of the mouth with uncontrolled sticking out of the tongue. There may also be rhythmic jerks of head, neck, and/or entire body, foot tapping, or uncontrolled eye movements.

There is no known remedy for Tardive Dyskinesia, although with some people, if all "anti-psychotic" drugs are stopped completely and permanently, the movements gradually go away after many months, or at least reduce in intensity. For other people, once the muscle movements start, they never stop.

III. Non-muscular temporary side effects. These are usually most severe for the first weeks or months on these drugs, then may gradually diminish. They will gradually go away if the drugs are stopped.

IIIa. Common ones: sedation, dry mouth, lethargy, dry throat, uncontrolled salivation and drooling, blurred vision, constipation, difficulty in urinating, dizziness, fainting upon standing, low blood pressure, weight gain (often 10-15 lbs.), apathy, nausea, vomiting, loss of sexuality, lack of sex desire, impotence, menstrual irregularities.

IIIb. Less common, but some of these may be permanent:

IIIb (1). Skin rash, easy sunburn, permanent blue-gray discoloration of the skin (usually only after several years' use).

IIIb (2). Irregular periods; in some women, no periods. Secretion of milk (lactation) from breats may also occur.

IIIb (3). Increased chance of having an epileptic fit (convulsion, seizure), especially for those who have had prior fits.

IIIb (4). Allergic form of hepatitis (liver disease) with jaundice (yellow eyes and skin). This often appears 3-4 weeks after starting such drugs. Thorazine is the drug which most frequently causes this type of hepatitis.

IIIb (5). Eye problems: permanent pigment deposits in the retina caused by Mellaril, permanent pigment deposits in the lens and corena with Thorazine. Both these conditions reduce vision.

IIIb (6). Decrease in white blood cells, causing infections which can be fatal. This occurs because the drugs damage bone marrow where blood cells are made.

IIIb (7). Paralysis of the intestines; bowel movements stop completely.

IIIb (8). Heart problems, including low blood pressure, irregularities in heart beat, changes in electrocardiogram (EKG, or heart-beat tracing) of unknown significance but definitely abnormal.

IIIb (9). Rarely, people have suddenly died while taking "anti-psychotics." There seem to be two causes: suddenly, for no "apparent" reason, breathing or the heart stops. If the heart, it's called cardiac arrest. But to me there is an obvious explanation in the ability of these drugs to depress functions like blood pressure, heart electricity system, and the cough and gag reflexes.

> Others-Sudden deaths have been reported in hospitalized patients on phenothiazines. Previous brain damage or seizures may be predisposing factors. High doses should be avoided in known seizure patients. Shortly before death, several patients showed flare-ups of psychotic behavior patterns. Autopsy findings have usually revealed acute fulminating pneumonia or pneumonitis, aspiration of gastric contents, or intramyocardial lesions. Although not a general feature of fluphenazine, potentiation of central nervous system depressants such as opiates, analgesics, antihistamines, barbiturates, and alcohol may occur.

PSYCHIATRIC DRUG INFORMATION BOOKLET BY DR. CALIGARI

GLOSSARY

AKINESIA: Zombie effect.

ANTI-MANIC DEPRESSIVES: Known as lithium carleonates, and anti-depressants, are anti-psychotic agents which are prescribed in the manic phase of manic-depressive psychosis. These include: Eskalith, Lithane, Lithonate, Lithium Carbonate.

ANTI-PARKINSONIAN DRUGS: Drugs which are prescribed to counteract the muscle side-effects of the anti-psychotics. These include Artane, Akineton, Benadryl, Cogentin, Tremin.

ANTI-PSYCHOTIC DRUGS: (See Major Tranquilizers).

BOARD: Parole Board/Adult Authority.

BUTRYOPHENONES: Used to reduce symptoms of hyperactivity.

C.D.C.: California Department of Correction.

C.I.W.: California Institution For Women, Frontera.

C.M.C.: California Mens Colony, East.

CRONO: A cronological report on all the resident's activities.

"D" QUAD: A section of the California Mens Colony which houses those residents who are on high medication.

DRUG INDUCED PARKINSONISM: General increase in muscle tension which causes varying degrees of muscle stiffness, rigidity and slowness of muscle movements plus tremors of hands and legs and at times a hunched-over, robot-like state.

FORCED DRUGGING MEDICATION: Is defined as the administration of medication by the use of threat of physical force or disciplinary action if an inmate does not consent to the administration of such medication.

HOT DRUGS: Major Tranquilizer.

INFORMED CONSENT: Means that a person must knowingly and intelligently, without duress or coercion, clearly and explictly manifest his consent to the proposed therapy to the attending physician.

MAJOR TRANQUILIZERS: Drugs which modify psychotic symptoms; generally have a calming effect; the most important pharmacological characteristics of these substances are: 1) "anti-psychotic" activity (ability to decrease aggressive, overactive behavior and to ameliorate disorganized or withdrawn behavioral patterns); 2) failure of large doses to produce deep coma and anasthesia; 3) production of reversible, sometimes irreversible effects on the extrapyramidal system, leading to development of related signs and symptoms; and 4) lack of tendency to cause psychic or physical dependency. Major tranquilizers are also known as anti-psychotic agents, zines and super-downers. There are four major chemical categories of anti-psychotic drugs, there are:

PHENOTHIAZINES: Generally used in treatment of acute and chronic schizophrenics.

Thorazine	Trelcefon
Stelazine	Quide
Mellaril	Vesprin
Prolixin	Repoise
Tindal	Permitil

THIOXANTHENES: Most useful in stimulating withdrawn, apathetic schizophrenics.

Taractan
Navane

BUTYROPHENONES: Used to reduce symptoms of hyperactivity.

Haldol

RESPERINE DERIVATIVES:

NEUROLEPTIC DRUGS: Belongs to a variety of chemical classes such as Phenothiazines, Butyrophenones and Thioxanthenes, i.e. Thorazine, Stelazine, Prolixin, Navane, Haldol.

"P" CELL: (C.M.C., East) segregation unit.

PROLIXIN SHUFFLE: Involuntary movement of the legs and/or arms by a person on Prolixin.

PSYCHOTROPIC DRUGS: Refers to any drugs that changes or controls mental functioning or behavior through the direct pharmacological action of such drugs. Such drugs include, but are not limited to anti-psychotic (neuroleptic), anti-anxiety, sedative, anti-depressant and stimulant drugs.

P.T.U.: Psychiatric Treatment Unit at the California Institution For Women.

TARDIVE DYSKINESIA: Weird, involuntary, uncontrollable writhing, squirming, grimacing movement, especially of legs, face, mouth and tongue which are result of permanent brain damage caused by anti-psychotic drugs.

115's: Disciplinary report that is placed in the resident's file.

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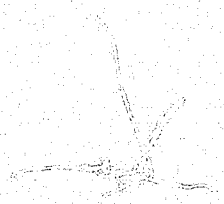

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