Law Project for Psychiatric Rights
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IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
THIRD JUDICIAL DISTRICT AT ANCHORAGE

ETTA BAVILLA,	)
	)
Plaintiff,	)
	)
	)
ALASKA DEPARTMENT OF CORRECTIONS,	)
	)
	)
Defendant.	)
	)

Case No. 3AN 04-5802 CI

MEMORANDUM IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT

Plaintiff Etta Bavilla, pursuant to Civil Rule 56, has moved for summary judgment that Defendant's Policy #807.16, Involuntary Psychotropic Medication (Policy #807.16) and AS 09.19.200 are unconstitutional. In Washington v. Harper, 494 U.S. 201, 110 S.Ct. 1028 (1990), the United States Supreme Court laid down minimum due process standards under the United States Constitution. Policy #807.16 does not comply with these standards and is therefore unconstitutional under the United States Constitution. In the more recent case Sell v. United States, Sell v. United States, 123 S.Ct. 2174 (2003), the United States Supreme Court evidenced an increased level of level judicial scrutiny regarding people facing forced psychiatric medication in the criminal justice context. It

is also asserted the Alaska Constitution affords more due process protection in the forced psychiatric drugging in prison context present here than the United States Constitition.

Among other things, AS 09.198.200 purports to limit the power of the courts to prevent and prohibit constitutional violations. It is respectfully suggested this the Legislature may not constitutionally do. Filed contemporaneously herewith is a motion for a preliminary injunction to prevent the Defendant, Alaska Department of Corrections (Corrections) from enforcing Policy #807.16 during the pendency of this action or further order of this Court. One of the things AS 09.19.200 purports to do, at section (b), is terminate any preliminary injunction after 90 days unless a final judgment has been issued. Even though it is believed this is unconstitutional, this motion for summary judgment with respect to the unconstitutionality of Policy #807.16 is being filed contemporaneously with the Motion for Preliminary Injunction to give this Court a procedural opportunity to comply with AS 09.19.200 if it so decides.

I. FACTS

On February 23, 2004, James B. Gottstein, esq., of the Law Project for Psychiatric Rights (Counsel) wrote Corrections advising he was going to assist Ms. Bavilla in resisting being subject to another forced drugging order upon the expiration of the existing one and stated he needed copies of any paperwork that might be associated with such an effort, including her chart.[1] Corrections never responded to this letter.

Instead, on Thursday, April, 1, 2004, Counsel was informed by Ms. Bavilla that

Corrections was going to obtain an involuntary medication order against her folowing a "Due Process Hearing,"[2] the following Monday, April 5, 2004, at 8:30 a.m. This resulted in a letter from Counsel to Corrections,[3] in which he indicated he believed the procedures being employed violated Ms. Bavilla's constitutional rights, suggested Corrections consult with its counsel to review compliance with constitutional requirements and moved for a one week continuance to allow for preparation of a defense.

The Alaska Department of Law, among other things, denied the requested continuance.[4] At this point, which was after the close of business on Thursday, April 1, 2004, Counsel still did not have any knowledge of the grounds for seeking the forced drugging order, including no notice of any witnesses or other evidence Corrections intended to rely upon.

Approximately 9:00 a.m., the following morning, Friday, April 2, 2004, a complaint and the temporary restraining order application was served upon counsel for Corrections and filed with this court, commencing this action. At approximately 4:00 p.m., Counsel was notified by the Superior Court Judge's clerk that the TRO Motion had been denied.[5]

In between, Plaintiff's Counsel faxed Mr. Bodick a letter which as most relevant

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[1] Exhibit 1 to the Memorandum in Support of Motion for Temporary Restraining Order (TRO Memorandum). Attached hereto are Exhibit lists for the TRO Memorandum as well as this one.
[2] Exhibit C, paragraph 6.
[3] See Exhibit 2 to TRO Memorandum.
[4] See, Exhibit 3 to TRO Memorandum.
[5] In spite of a certificate of service that Plaintiff's Counsel had been served, such was not the case.

here, (a) expressed concern about not being able to make formal submissions on behalf of his client directly to the Mental Health Review Committee, the decision making body, (b) noted he had still not received the documentation which Mr. Bodick had indicated would be available early in the day, (c) designated Grace E. Jackson, M.D., a board certified psychiatrist with penal experience as a witness on behalf of Ms. Bavilla, and (d) designated other witnesses designed to ensure Ms. Bavilla would be able to present an effective defense.[6]

Mr. Bodick responded by fax to this letter at the end of the day, stating (a) Dr. Jackson would not be allowed to testify, (b) refusing to allow Ms. Bavilla to call requested witnesses, and (c) Counsel would not be allowed to represent Ms. Bavilla:

> I am in receipt of your letter in which you request that psychiatrist Dr. Grace E. Jackson be permitted to appear and testify at Ms. Bavilla's hearing. Please be advised that this request is denied. Dr. Jackson has no personal knowledge regarding Ms. Bavilla and her medication needs. . . . The Department already has three psychiatrists scheduled to appear at the hearing; two as witnesses and one as a decision-maker on the committee. These licensed Alaska professionals should be able to provide sufficient expertise to evaluate the risks involved in the recommended medication and compare these risks to the benefits of the medication.
>
> In regard to your requests regarding the designation of witnesses or other statements, it appears that you have misunderstood the nature of these hearings. This is not an adversarial hearing where attorneys will appear and argue on behalf of their clients. As approved by the Supreme Court in Washington v. Harper, Ms. Bavilla will be assisted by an independent lay advisor. Consequently, your participation will be limited to the telephonic testimony you provide as to your personal observations of Ms. Bavilla's behavior.[7]
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> The TRO Opposition includes the affidavit of Laura Brooks, the Director of

[6] Exhibit E.

Mental Health Services for Corrections and who is also the chair of the Mental Health Review Committee which is the designated decision making body to conduct the "Due Process Hearing," under Corrections policy #807.16 and decide whether Ms. Bavilla should be forcibly medicated.[8] In this affidavit, Ms. Brooks, the chair of this hearing board, among other things, states:

> Ms. Bavilla has a fixed delusion that she has a sexually transmitted disease. . . . There was a noticeable decline in her mental functioning [after she stopped taking medications in 2003] and she was placed on involuntary medications August 18, 2003. . . . When not taking medications, Ms. Bavilla has exhibited increased delusional thinking and maintains she has been injected with a manipulated sexually transmitted disease designed to keep her sick. She has claimed she is vulnerable to spirits and those spirits are responsible for her having been diagnosed with a mental illness. She becomes increasingly hostile towards staff, making nonsensicial statements, gesturing and talking to "spirits" in her cell. . . .[9]

On Sunday, April 4, 2004, Dr. Jackson issued her report, which was given to Ms. Bavilla to present to the Mental Health Review Committee.[10] This report describes the serious harm faced by Ms. Bavilla if involuntary medication is allowed to proceed. Among them are medication caused (iatrogenic) psychosis,[11] cognitive losses, [12] extreme weight gain,[13] diabetes, even apart from the weight gain,[14] and a shortened life.[15] This report suggests Ms. Bavilla's psychiatric symptoms may be due to the medications -- both

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[7] Exhibit F.
[8] Exhibit C.
[9] Exhibit C, pages 2-3.
[10] Exhibit B.
[11] Exhibit B, page 14.
[12] Exhibit B, page 15.
[13] Exhibit B, page 12.
[14] Id.
[15] Exhibit B, page 16.

from taking them and from discontinuing them.[16]

On Monday, April 5, 2004, at the same time the "Due Process Hearing" was being held, a Petition for Review of the order denying the TRO Motion was served on Defendant and filed in the Alaska Supreme Court, along with an Emergency Motion for Interim Injunctive Relief. At the 8:30 a.m., "Due Process Hearing," Plaintiff provided the Mental Health Review Committee a copy of the exhibits to the TRO Memorandum and Dr. Jackson report. These documents run over 200 pages. By 11:18 a.m., according to the fax time stamp on the Mental Health Review Committee Hearing Summary, the Mental Health Review Committee, without having a chance to read Plaintiff's submissions, found that she suffers from a mental illness and that the proposed medications were in her best interest.[17] The Mental Health Review Committee also held it "fully supports forced medication" of Plaintiff, but deferred the forced drugging until such time as she becomes gravely disabled or presents a substantial danger.[18]

II. ANALYSIS

A. Summary

There is no doubt but that even convicted prisoners have a constitutional right to due process before psychotropic drugs can be involuntarily administered. Washington v. Harper, 494 U.S. 201, 110 S.Ct. 1028 (1990). Washington v. Harper holds "the forcible injection of medications into a nonconsenting person's body represents a substantial

[16] Exhibit B, pages 7, 10-13, 18.
[17] The timing makes clear that Ms. Bavilla's submissions were not read or considered by the Mental Health Review Committee. Exhibit I.
[18] Exhibit I.

interference with that person's liberty."[19] Any over-riding of this fundamental interest by "medical personnel"[20] in the penological setting,[21] must be under "fair procedural mechanisms"[22] and in her medical best interest.[23] Even though in the prison setting "constitutional rights are judged under a 'reasonableness' test less restrictive than that ordinarily applied,"[24] and "reasonably related to legitimate penological interests,"[25] the "Due Process Clause does require certain essential procedural protections."[26] These essential procedural requirements include (i) an unbiased, independent decision maker,[27] (ii) "notice, [28] (iii) the right to be present at an adversary hearing, and (iv) the right to present and cross-examine witnesses."[29] The procedures employed by Corrections here under Policy #807.16 fail to satisfy every one of these "essential procedural protections" required in Harper. In addition, for the reasons that follow, Plaintiff believes she is entitled to the provision of counsel as well as a judicial determination of medical best interest before she can be forcibly drugged.

B. Standard for Summary Judgment

Under Civil Rule 56(c), summary judgment should be granted,

if the pleadings, depositions, answers to interrogatories, and admissions on

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[19] 494 US at 229, 110 S. Ct. at 1041.
[20] 494 US at 231, 110 S. Ct. at 1042.
[21] 494 US at 223, 110 S. Ct. at 1037.
[22] 494 U.S. at 231, 110 S. Ct. at 1042.
[23] 494 U.S. at 227, 110 S. Ct. at 1040
[24] 494 US at 225, 110 S. Ct. at 1038.
[25] 494 US at 223, 110 S. Ct. at 1037.
[26] 494 US at 236, 110 S. Ct. at 1044.
[27] 494 US at 233, 110 S. Ct. at 1043.
[28] 494 US at 235, 110 S. Ct. at 1044
[29] 494 US at 225, 110 S. Ct. at 1044.

> file, together with the affidavits, show that there is no genuine issue as to any material fact and that any party is entitled to a judgment as a matter of law.

Here, the Defendant's admissions establish the unconstitutionality of Policy #807.16 as a matter of law. The question of the unconstitutionality of AS 09.19.200 solely involves questions of law therefore is similarly subject to disposition through summary judgment.

C. Policy #807.16 is Unconstitutional

Ms. Bavilla's complaint is that her United States and Alaska constitutional rights to due process are being violated by the procedures being employed by Corrections. The 1990 United States case of Washington v. Harper, speaks directly to this question with respect to the United States constitution and, it is respectfully submitted, the 2003 United States case of Sell v. United States, Sell v. United States, 123 S.Ct. 2174 (2003), can be looked to for more recent guidance on the level of deference to be given institutional psychiatrists in forced drugging proceedings, generally. There are no Alaska cases directly on point, but principles enunciated by the Alaska Supreme Court in considering other situations suggest there are a couple of areas where Alaska Constitutional protection are greater than under the United States Constitution.

As set forth above, in Washington v. Harper, in order to fulfill due process requirements, the United States Supreme court required (1) an impartial, independent decision maker,[30] (2) notice,[31] (3) the right to be present at an adversary hearing,[32] and (4)

[30] 494 US at 233, 110 S. Ct. at 1043.
[31] 494 US at 235, 110 S. Ct. at 1044
[32] 494 US at 235, 110 S. Ct. at 1044

the right to present and cross-examine witnesses."[33] Ms. Bavilla respectfully suggests the Alaska Constitution and the circumstances revealed here require (5) the assistance of counsel and (6) judicial approval of any forced drugging.

The procedures employed by Corrections here fail to satisfy every one of the "essential procedural protections" required in Harper and do not satisfy the additional protections Ms. Bavilla respectfully suggests are required under the Alaska constitution and under the circumstances revealed here.

(1) Impartial, Independent Decision Maker.

Washington v. Harper, at 494 US at 233-4, 110 S. Ct. at 1043, holds that minimum due process requires an impartial, independent decision maker:

> A State's attempt to set a high standard for determining when involuntary medication with antipsychotic drugs is permitted cannot withstand challenge if there are no procedural safeguards to ensure the prisoner's interests are taken into account. . . . [I]ndependence of the decisionmaker is addressed to our satisfaction by these procedures. None of the hearing committee members may be involved in the inmate's current treatment or diagnosis. . . . In the absence of record evidence to the contrary, we are not willing to presume that members of the staff lack the necessary independence to provide an inmate with a full and fair hearing in accordance with the Policy.

Here, unlike the situation in Harper, the chair of the decision maker has clearly pre-judged the case and even filed testimony against Ms. Bavilla in resisting the temporary restraining order.[34]

> 5. . . . When not taking medications, Ms. Bavilla has exhibited increased delusional thinking and maintains she has been injected with a manipulated sexually transmitted disease designed to keep her sick. She

[33] 494 US at 225, 110 S. Ct. at 1044.
[34] See, Exhibit C.

> has claimed she is vulnerable to spirits and those spirits are responsible for her having been diagnosed with a mental illness. She becomes increasingly hostile toward staff, making nonsensical statements, gesturing and talking to "spirits" in her cell. Ms. Bavilla adamantly denies she has a mental illness and blames mental health staff for "covering up and lying about perverse practices of forcing people to live diseased and then labeling them mentally ill." Ms. Bavilla has also expressed suicidal ideation in journal entries and has stated that she cannot think of her son or she will "give in to the destroyer" and die.

This testimony by the chair of the hearing body shows she has clearly pre-judged both the issue of mental illness and the need for medication. This is not an unbiased, independent decision maker and is unconstitutional under Washington v. Harper.

(2) Notice.

The United States Supreme Court in Washington v. Harper, at 494 US at 216, 110 S. Ct. at 1033 also held that adequate notice is a constitutional due process requirement:

> Third, the inmate has certain procedural rights before, during, and after the hearing. He must be given at least 24 hours' notice of the Center's intent to convene an involuntary medication hearing, during which time he may not be medicated. In addition, he must receive notice of the tentative diagnosis, the factual basis for the diagnosis, and why the staff believes medication is necessary.

The Washington v. Harper court also noted the procedure used there was adequate because, "The Policy provides for notice, the right to be present at an adversary hearing, and the right to present and cross-examine witnesses," noting the "requirement that the opportunity to be heard 'must be granted at a meaningful time and in a meaningful manner.'"[35]

Here, while notice of the hearing was given verbally, Corrections failed to provide

[35] Id.

Ms. Bavilla or her counsel anything in writing, nor any notice of the grounds for the forced drugging. Notice was thus totally deficient.[36]

(3) The Right To Be Present At An Adversary Hearing.

Under Washington v. Harper, 494 US at 235, 110 S. Ct. at 1044, the United States Supreme Court ruled an adversary hearing was an essential due process element before forced psychiatric medication could occur in the prison context. Here, the Department of Corrections has admitted its procedures do not include an adversarial hearing.[37] Correction's response that Ms. Bavilla would not be allowed to call an independent psychiatrist as a witness because Department employed psychiatrists had sufficient expertise also shows its procedures are not adversarial in nature.

(4) The Right To Present And Cross-Examine Witnesses."

Washington v. Harper, 494 US at 235, 110 S. Ct. at 1044, also requires that a prisoner faced with forced drugging be allowed to present and cross examine witnesses. Here, Ms. Bavilla designated Grace E. Jackson, M.D., a board certified psychiatrist with penal experience to be a witness on her behalf.[38] However, Dr. Jackson was not allowed to testify:

> I am in receipt of your letter in which you request that psychiatrist Dr. Grace E. Jackson be permitted to appear and testify at Ms. Bavilla's hearing. Please be advised that this request is denied. Dr. Jackson has no

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[36] Counsel wrote Corrections as long ago as February 23, 2004, requesting notice (Exhibit 1 to TRO Memorandum). There was never any response to this letter and it wasn't until after the temporary restraining order had been denied without Counsel having received a copy of Corrections' opposition that he was informed by Corrections that he would not be allowed to participate in the "Due Process Hearing."

[37] Exhibit F.

[38] Exhibit E.

> personal knowledge regarding Ms. Bavilla and her medication needs. She is also not licensed to practice in Alaska. The Department already had three psychiatrists scheduled to appear at the hearing; two as witnesses and one as decision-maker on the committee. These licensed Alaska professionals should be able to provide sufficient expertise to evaluate the risks involved in the recommended medication and compare these risks to the benefits of the medication. Thus, there is no need for Dr. Jackson's testimony.[39]

The Alaska Supreme Court has also held the right of a prisoner to call witnesses in an internal Corrections proceeding is a fundamental due process right and the failure to allow it is constitutionally fatal. Brandon v. Dep't. of Corrections, 865 P.2d 87, 90 (Alaska 1993).

That the Department of Corrections' Policy #807.16 does not allow Ms. Bavilla to call witnesses of her choosing renders it unconstitutional under Washington v. Harper as well as Brandon v. Dept. of Corrections.[40]

(5) Staff Assistant

Policy #807.16 §G.1. provides that a staff assistant will be assigned to assist the inmate-patient. However, the staff assistant's role is to "act in the prisoner's best interest," rather than be an advocate. This is consistent with Corrections' "Due Process Hearing" not being adversarial, but is inconsistent with actual due process.

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[39] Exhibit F.

[40] It can also be noted that while Policy #807.16 §H.3., purports to allow cross-examination of witnesses, the form adopted to implement this only allows the inmate-patient to designate a witness to be "interviewed by the Mental Health Review Committee" and have the Mental Health Review Committee ask a single question. See Exhibit A, page 12.

(6) Assistance of Counsel

Corrections' position, citing Washington v. Harper, is Ms. Bavilla is not allowed to have counsel assist her in defending against forced drugging under Policy #807.16.[41] First, it is not entirely clear that Washington v. Harper allows the denial of counsel as opposed to not requiring the appointment of counsel. Second the Alaska Supreme Court has specifically held Corrections must provide the assistance of counsel under the Alaska Constitution when the United States Supreme Court would not require access to counsel at all under the United States Constitution. In McGinnis v. Stevens, 543 P.2d 1221, 1232, 1236 (Alaska 1975), the Alaska Supreme Court held under the Alaska Constitution, "a departure from the general no-counsel standard ordained by Wolffwas in order:"[42]

> In light of the possibility of prolonged specialized housing pending disposition of the conduct referred to the district attorney's office, the possible loss of other privileges, the close nexus with possible criminal prosecution, and the inherently coercive circumstances flowing from the interim imposition of specialized housing and suspension of other prison privileges, we believe that Miranda rights can be best assured through provision of counsel to the inmate.

The question presented here then is whether the forcible administration of psychotropic drugs into an inmate rises to the level of protection which requires the provision (or allowance) of counsel under the Alaska Constitution. Ms. Bavilla respectfully suggests it does.

Even though Washington v. Harper, itself did not require the provision of counsel, it did recognize that the right to be free from unwanted psychotropic medication was a

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[41] Exhibit F.

fundamental right under the due process clause of the United States Constitution (prisoners possess a " significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment") Washington v. Harper, 494 U.S. at 221-222, 110 S.Ct. at 1036; see also id., at 229, 110 S.Ct., at 1041 ("The forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty").[43]

In the relatively recent case of Steele v. Hamilton County Community Mental Health Board, , 736 N.E.2d 10, 16 (Ohio 2000), the Ohio Supreme Court confirmed "persons suffering from a mental illness have a 'significant liberty interest' in avoiding the unwanted administration of antipsychotic drugs" protected by the due process clauses of both the Fourteenth Amendment of the U.S. Constitution and the Ohio Constitution.

> The liberty interests infringed upon when a person is medicated against his or her wishes are significant. "The forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty." This type of intrusion clearly compromises one's liberty interests in personal security, bodily integrity, and autonomy.
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> The intrusion is "particularly severe" when the medications administered by force are antipsychotic drugs because of the effect of the drugs on the human body. Antipsychotic drugs alter the chemical balance in a patient's brain producing changes in his or her cognitive processes. . . .

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[42] The full citation to Wolffis Wolff v. McDonnell, 418 U.S. 539, 94 S.Ct. 2963, 41 L.Ed.2d 935 (1974).

[43] On at least three other occasions, the United States Supreme Court has found the right to be free of unwanted psychiatric medications to be fundamental: Mills v. Rogers, 457 U.S. 291, 303, 102 S.Ct. 2442, 2450 (1982) ("assumed" in n. 6); Riggins v. Nevada, 504 U.S. 127, 112 S.Ct. 1810, 118 L.Ed.2d 479 (1992); and Sell v. U.S., __ U.S. __, 123 S.Ct. 2174, 156 L.Ed.2d 197 (2003).

> The interference with one's liberty interest is further magnified by the negative side effects that often accompany antipsychotic drugs, some of which can be severe and/or permanent.

Id, at 16-17, citations omitted.

The Massachusetts Supreme Court, in Guardianship of Roe, 421 N.E.2d 40, 52-3 (Mass 1981), held:

> We can identify few legitimate medical procedures which are more intrusive than the forcible injection of antipsychotic medication. "In general, the drugs influence chemical transmissions to the brain, affecting both activatory and inhibitory functions. Because the drugs' purpose is to reduce the level of psychotic thinking, it is virtually undisputed that they are mind-altering. . . . The drugs are powerful enough to immobilize mind and body. Because of both the profound effect that these drugs have on the thought processes of an individual and the well-established likelihood of severe and irreversible adverse side effects, see Part II A(2) infra, we treat these drugs in the same manner we would treat psychosurgery or electroconvulsive therapy.

(footnote and citations omitted).

The question then, is whether under the Alaska Constitution, the constitutional right involved rises to a level requiring the provision of counsel as under McGinnis. Ms. Bavilla, respectfully suggests the right to be free from the forcible injection of psychiatric drugs rises to at least the same level as the right against self-incrimination and other factors involved there.

(7) Judicial Determination

In Washington v. Harper, the United States Supreme Court did hold, <u>in the facts of that case</u>, that judicial determination of the forced drugging was not constitutionally required. The facts relied upon are the ones set forth above, to wit: (a) an impartial, independent decision maker, (b) proper notice, (c) the right to be present at an adversary

hearing, and (d) the right to present and cross-examine witnesses." As has been shown Corrections violates all of these constitutional requirements under Policy #807.16. This removes the very foundation upon which the lack of judicial involvement was approved in Washington v. Harper and, it is respectfully suggested the authorization to force drug anyone without judicial approval is therefore removed as well.

In a stinging dissent, Justice Stevens expresses disagreement with the majority's acceptance in Washington v. Harper that all will go as set forth on paper and therefore the courts must be involved to protect people's rights.[44] The circumstances here completely vindicate Justice Stevens' dissent in that while Policy #807.16 was clearly written to follow the strictures of Washington v. Harper, the practice under Policy #807.16 makes a mockery of people's due process rights. Thus, even under the majority opinion in Washington v. Harper, judicial review is required because the required due process elements are not, in fact, provided under Policy #807.16. In other words, it is clear that procedural safeguards promulgated in Corrections' policies can not be relied upon to be carried out in practice. In such circumstances judicial determination is required. Washington v. Harper at n. 13, essentially held as much ("That such a practice may take place in some institutions in some places affords no basis for a finding as to [Washington's] program,") because Corrections has made admissions that show it is not

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[44] 110 S. Ct. at 1045:

> The Court has undervalued respondent's liberty interest; has misread the Washington involuntary medication Policy and misapplied our decision in Turner v. Safley, 482 U.S. 78, 107 S.Ct. 2254, 96 L.Ed.2d 64 (1987); and has concluded that a mock trial before an institutionally biased tribunal constitutes "due process of law."

complying with the Washington v. Harper due process standards notwithstanding the provisions of Policy #807.16 purporting to do so.

There is, however, an additional reason why judicial approval of forced drugging is constitutionally required. Washington v. Harper, does make clear that such forced drugging may occur only where medically appropriate.[45] It is respectfully suggested that the facts here show only through a judicial approval process may there be any assurances this will be the case.

Justice Stevens discusses this in his dissent and other courts have considered the propensity of institutional psychiatrists to subjugate patients' interests to institutional ones. For example, the Massachusetts Supreme Court, in Rogers, 458 N.E. 2d 308, 317 (Mass 1983), held because of the inherent conflicts of interest, the doctors should not be allowed to make the forced drugging decision.

> The doctors who are attempting to treat as well as to maintain order in the hospital have interests in conflict with those of their patients who may wish to avoid medication.

Rogers at 382-3, citation omitted. The court also found additional sources of conflicts of interest between the patient and doctors:

> Economic considerations may also create conflicts between doctors and patients. Because medication with antipsychotic drugs "saves time, money, and people," Zander, Prolixin Decanoate: Big Brother by Injection? 5 J. Psychiatry & Law 55, 56 (1977)
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> * * *
>
> [T]he temptation to engage in blanket prescription of such drugs to maintain order and compensate for personnel shortages may be irresistible. See

[45] 110 S. Ct. 1039.

> Guardianship of Roe, supra, 383 Mass. at ---, Mass.Adv.Sh. (1981) at 1004 n. 11, 421 N.E.2d 40 (citation to literature documenting "abuses of antipsychotic medication by those claiming to act in an incompetent's best interests").

Id., n. 19.

Thus, the assumption Corrections employed psychiatrists and the other Corrections employees on the Mental Health Committee will make decisions based solely upon the patient's best medical interests turns out to be factually dubious at best.

Moreover, without a patient having the right to judicial determination of medical best interests, there is no real opportunity to challenge the medical basis of the decision. In Washington v. Harper, the United States Supreme Court accepted the conventional wisdom of the time that "the therapeutic benefits of antipsychotic drugs are well documented."[46] Currently, though, a debate rages over whether there are in fact any significant therapeutic benefits of "antipsychotic" drugs and even if there are, whether the proposed class of medications are in the patients' best interests. This controversy is demonstrated by Exhibits 4-20 of the TRO Memorandum, which are hereby incorporated by reference as though fully set forth herein.

These exhibits demonstrate the lack of scientific support for the safety and efficacy of the proposed forced drugging.

> Although the standard of care in developed countries is to maintain schizophrenia patients on neuroleptics, this practice is not supported by the 50-year research record for the drugs. A critical review reveals that this paradigm of care worsens long-term outcomes . . . . Evidence-based care would require the selective use of antipsychotics, based on two principles: (a) no immediate neuroleptisation of first-episode patients; (b) every patient

[46] 110 S.Ct. 1041.

> stabilized on neuroleptics should be given an opportunity to gradually withdraw from them. This model would dramatically increase recovery rates and decrease the percentage of patients who become chronically ill.

"The case against antipsychotic drugs: a 50-year record of doing more harm than good," by Robert Whitaker, Medical Hypotheses, Volume 62, Issue 1 , 2004, Pages 5-13[47]

Another review notes the ability of neuroleptics (NLPs)[48] to reduce "relapse" in schizophrenia affects only one in three medicated patients; the overall usefulness of NLPs in the treatment of schizophrenia is far from established; and that an analysis of 1,300 published studies which found neuroleptics were no more effective than sedatives. "A Critique of the Use of Neuroleptic Drugs" by David Cohen, Ph.D., in From Placebo to Panacea, Putting Psychiatric Drugs to the Test, edited by Seymour Fisher and Roger Greenburg, John Wiley and Sons, 1997, a comprehensive review of the scientific evidence regarding the safety and efficacy of neuroleptics (Cohen Critique).[49]

The side effects of these drugs are also addressed:

> [T]he negative parts [the side effects] are perceived as quite often worse than the illness itself. . . . even the most deluded person is often extraordinarily articulate and lucid on the subject of their medication. . . . their senses are numbed, their willpower drained and their lives meaningless.

Concluding, Dr. Cohen states:

> Forty-five years of NLP use and evaluation have not produced a treatment scene suggesting the steady march of scientific or clinical progress. . . . Unquestionably, NLPs frequently exert a tranquillizing and subduing action on persons episodically manifesting agitated, aggressive, or disturbed

[47] Exhibit 4, to TRO Memorandum
[48] This class of drugs is commonly known by a number of names, including "neuroleptics" and "anti-psychotics."
[49] Exhibit 5 to TRO Memorandum.

> behavior. This unique capacity to swiftly dampen patients' emotional reactivity should once and for all be recognized to account for NLPs' impact on acute psychosis. Yet only a modestly critical look at the evidence on short-term response to NLPs will suggest that this often does not produce an abatement of psychosis. And in the long-run, this outstanding NLP effect probably does little to help people diagnosed with schizophrenia remain stable enough to be rated as "improved" -- whereas it is amply sufficient to produce disabling toxicity.
>
> A probable response to this line of argument is that despite the obvious drawbacks, NLPs remain the most effective of all available alternatives in preventing relapse in schizophrenia. However, existing data on the effectiveness of psychotherapy or intensive interpersonal treatment in structured residential settings contradicts this. Systematic disregard for patients' own accounts of the benefits and disadvantages of NLP treatment also denigrates much scientific justification for continued drug-treatment, given patients' near-unanimous dislike for NLPs. Finally, when social and interpersonal functioning are included as important outcome variables, the limitations of NLPs become even more evident . . .
>
> The positive consensus about NLPs cannot resist a critical, scientific appraisal.

Id.

In an even more recent analysis, Dr. Cohen concludes the systematic flaws and biases pervading the published research on neuroleptics, including the "atypicals," "raise serious doubts about the scientific justifications for the widespread use of neuroleptics." "Research on the Drug Treatment of Schizophrenia: A Critical Appraisal and Implications for Social Work Education," by David Cohen, Ph.D., Social Work Education, volume 38, issue 2 (Spring 2002).[50]

These observations have been confirmed by Dr. Emmanual Stip as follows:

> "At this point in time, responsibility and honesty suggest we accept that a large number of our therapeutic tools have yet to be proven effective in

[50] Exhibit 6 to TRO Memorandum.

> treating patients with schizophrenia." . . . "One thing is certain: if we wish to base psychiatry on EBM [Evidence Based Medicine], we run the genuine risk of taking a closer look at what has long been considered fact."

"Happy birthday neuroleptics! 50 year later: la folie du doute," by Emmanuel Stip, European Psychiatry 2002 ; 17 : 1-5.[51]

People given medications for schizophrenia have reduced functioning in attention and declarative memory, including auditory and visual memory and complex attention. Doses of psychiatric medication within the range of routine pharmacotherapy practice may have clinically significant effects on memory and complex attention in patients with schizophrenia and these effects may contribute as much as one-third to two-thirds of the memory deficit typically seen in patients with schizophrenia. "Association of Anticholinergic Load With Impairment of Complex Attention and Memory in Schizophrenia," by Michael J. Minzenberg, M.D., John H. Poole, Ph.D., Cynthia Benton, M.D., Sophia Vinogradov, M.D. in the American Journal of Psychiatry 2004; 161:116–124).[52]

New-generation medications do not provide symptomatic improvement in the broader spectrum of clinical outcomes which include social competence and problem solving and do not produce substantial changes in social role functioning or social problem-solving capacity. "Do Clozapine and Risperidone Affect Social Competence and Problem Solving?" by Alan S. Bellack, Ph.D., Nina R. Schooler, Ph.D., Stephen R.

[51] Exhibit 7 To TRO Memorandum.
[52] Exhibit 8, to TRO Memorandum.

Marder, M.D., John M. Kane, M.D., Clayton H. Brown, Ph.D., Ye Yang, M.S. in American Journal of Psychiatry, 2004, 161:364–367).[53]

"Drug treated patients tend to have longer periods of hospitalization." "An Approach to the Effect of Ataraxic Drugs on Hospital Release Rates," American Journal of Psychiatry, 119 (1962), 36-47[54].

Relapse rates rise in direct relation to neuroleptic dosage--the higher the dosage patients are on before the drugs are withdrawn, the greater the relapse rates. "Relapse in Chronic Schizophrenics Following Abrupt Withdrawal of Tranquillizing Medication," British Journal of Psychiatry, 115 (1968), 679-86.[55]

Psychotropic drugs are not indispensable and the data suggests neuroleptics prolong social dependency. "Comparison of Two Five-Year Follow-Up Studies: 1947 to 1952 and 1967 to 1972," American Journal of Psychiatry, 132 (1975), 796-801.[56]

Prolonged use all of the neuroleptics studied, except clozapine, cause an increase in dopamine receptors in the brain) which results in a supersensitivity. "Dopaminergic Supersensitivity after Neuroleptics: Time-Course and Specificity, Psychopharmacology 60 (1978), 1-11.[57] The "tendency toward psychotic relapse" is caused by the medication itself and that this and other deleterious effects can be permanent. "Neuroleptic-induced supersensitivity psychosis," American Journal of Psychiatry, 135 (1978), 1409-1410;[58]

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[53] Exhibit 9, to TRO Memorandum.
[54] Exhibit 10 to TRO Memorandum.
[55] Exhibit 11 to TRO Memorandum.
[56] Exhibit 12, to TRO Memorandum.
[57] Exhibit 13 to TRO Memorandum.
[58] Exhibit 14 to TRO Memorandum.

"Neuroleptic-induced supersensitivity psychosis: clinical and pharmacologic characteristics," American Journal of Psychiatry, 137 (1980), 16-20.[59]

The relapse risk is relatively high within six months of discontinuation; most patients who remain stable for 6 months continued to do so for long periods without medication; and the risk of relapse is lower when the medication is gradually discontinued as compared to abrupt discontinuation. "Clinical Risk Following Abrupt and Gradual Withdrawal," by Adele C. Viguera, MD, Ross J. Baldessarini, MD, James D. Hegarty, MD, MPH, Daniel P. van Kammen, MD, PhD, Maricio Tohen, MD, DrPH, Archives of General Psychiatry, 1997, 54: 49-55.[60]

Patients with schizophrenia in poor countries (where neuroleptic use was uncommon) "had a considerably better course and outcome than [patients] in . . . developed countries (where neuroleptic use is common). This is true whether clinical outcomes, social outcomes, or a combination of the two are considered." "The International Pilot Study of Schizophrenia: five-year follow-up findings," Psychological Medicine, 22 (1992), 131-145 conducted by the World Health Organization.[61]

"Being in a developed country is a strong predictor of not attaining a complete remission." "Schizophrenia: manifestations, incidence and course in different cultures, A World Health Organization ten-country study," Psychological Medicine, suppl. 20

[59] Exhibit 15, to TRO Memorandum.
[60] Exhibit 16 to TRO Memorandum.
[61] Exhibit 17 to TRO Memorandum.

(1992), 1-95, conducted by the World Health Organization because the previous study's finding was so unexpected, confirmed the earlier study.[62]

Dr. Courtenay Harding addressed what she called myths surrounding the treatment of schizophrenia as follows:

> This paper presents empirical evidence accumulated across the last two decades to challenge seven long-held myths in psychiatry about schizophrenia which impinge upon the perception and thus the treatment of patients. Such myths have been perpetuated across generations of trainees in each of the mental health disciplines. These myths limit the scope and effectiveness of treatment offered. These myths maintain the pessimism about outcome for these patients thus significantly reducing their opportunities for improvement and/or recovery. Counter evidence is provided with implications for new treatment strategies.

"Empirical Correction of Seven Myths About Schizophrenia with Implications for Treatment," ACTA Psyciatrica Scandinava, 1994: 90 (suppl 384): 140-146 (Schizophrenia Myths).[63]

Myth Number One in Schizophrenia Myths is "Once a schizophrenic always a schizophrenic:"

> Evidence: Recent worldwide studies have . . . consistently found that half to two thirds of patients significantly improved or recovered, including some cohorts of very chronic cases. The universal criteria for recovery have been defined as no current signs and symptoms of any mental illness, no current medications, working, relating well to family and friends, integrated into the community, and behaving in such a way as to not being able to detect having ever been hospitalized for any kind of psychiatric problems.

[62] Exhibit 18 to TRO Memorandum.
[63] Exhibit 19, to TRO Memorandum.

Myth Number 5 in Schizophrenia Myths is "Patients must be on medication all their lives. Reality: It may be a small percentage who need medication indefinitely . . . Evidence: There are no data existing which support this myth. "

After a systematic and rigorous statistical analysis it was found that "There is no clear evidence that atypical antipsychotics are more effective or are better tolerated than conventional antipsychotics." "Atypical antipsychotics in the treatment of schizophrenia: systematic overview and meta-regression analysis," by Geddes J, Freemantle N, Harrison P, Bebbington P., BMJ (British Medical Journal) 2000 Dec 2;321(7273):1371-6.[64]

Other articles attached to the TRO Memorandum demonstrate that many "relapses" are actually caused by what is known as "Neuroleptic Discontinuation Syndrome" where it is the withdrawal from the drugs that is causing the psychosis, not any underlying mental illness.[65]

Most of the articles attached to the TRO Memorandum were presented to the Alaska Superior Court, Third Judicial District a little over a year ago in the case of In the Matter of the Hospitalization of Faith J. Myers, 3AN 03-277 PR.[66] There, after a review of these materials and the testimony of two expert witnesses for Ms. Myers and two expert witnesses for the hospital, the Superior Court found:

> The relevant conclusion that I draw from them is that there is a real and viable debate among qualified experts in the psychiatric community regarding whether the standard of care for treating schizophrenic patients should be the administration of anti-psychotic medication.

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[64] Exhibit 20, to TRO Memorandum.
[65] See, e.g., Exhibits 10, 11, 12, 13, 14, 15 and 16 to the TRO Memorandum.
[66] On appeal to the Alaska Supreme Court in Case No. S-11021.

* * *

> [T]here is a viable debate in the psychiatric community regarding whether administration of this type of medication might actually cause damage to her or ultimately worsen her condition.[67]

Unless inmate-patients have the right to judicially contest the medical appropriateness of the proposed forced drugging there can be no assurances their constitutional rights to have such medically appropriate treatment is being honored.

The relatively recent case of United States v. Sell is potentially instructive. There, in the context of force drugging someone to make him competent to stand trial, the United States Supreme Court rejected the notion that the institutional psychiatrist's determination of medical appropriateness was sufficient, holding instead:

> the court must conclude that administration of the drugs is medically appropriate, i.e., in the patient's best medical interest in light of his medical condition. The specific kinds of drugs at issue may matter here as elsewhere. Different kinds of antipsychotic drugs may produce different side effects and enjoy different levels of success.

(United States v. Sell, supra., 123 S.Ct. at 2185. Italics in original, underlining added).

While the court in Sell did not explicitly overrule Washington v. Harper it also did not explicitly examine whether institutional psychiatrists' determination of medical best interest in the prison context can still be immune from judicial scrutiny. However, in rejecting the concept in the competence to stand trial context it did reaffirm that in the context here, i.e., the prison context, Washington v. Harper stands for the proposition that

> "the Due Process Clause permits the State to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if the

[67] Exhibit H, pages 8, 13

> inmate is dangerous to himself or others and the treatment is in the inmate's medical interest."[68]

There is no indication in Sell that the same reasoning as to why the courts can no longer defer to institutional psychiatrists' determination of medical best interests in the competence to stand trial context should not apply in the context here. The Alaska Court of Appeals in the unpublished decision[69] of State v. Baker, No. A-8435, 2003 WL 21663992 (Alaska App. 2003) recognized that the reasoning of Sell extended beyond the competence to stand trial situation, holding it was also applicable to parole conditions.

Moreover, even if "penological interests" can still theoretically justify a non-judicial approval of forced psychiatric drugging, in addition to the structural defects in the procedures under Policy #807.16 vitiating such theoretical permissibility, there can be little question the Corrections process will not provide for an unbiased evaluation of the medical appropriateness issue. This is demonstrated in this case and is a critical difference from the facts in Washington v. Harper. Ms. Bavilla presented the Mental Health Review Committee at the "Due Process Hearing" with all of the Exhibits from the TRO Memorandum, as well as Dr. Grace E. Jackson's report.[70] These documents run over 200 pages and, at a minimum, raise grave doubts as to the medical appropriateness of the proposed forced drugging, if not prove outright it is not in her medical best interest,

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[68] 123 S. Ct. at 2183, emphasis added.

[69] While unpublished decisions may not be cited as "precedent" that control or restrict future judicial decisionmaking under Appellate Rule 214(d), they may be cited for whatever persuasive power they may have. McCoy v. State, 59 P.3d 747 (Alaska App. 2002).

[70] Exhibit B.

as well as question the diagnosis of any underlying mental illness.[71] Yet the Mental Health Review Committee found the medication in Ms. Bavilla's best interest for medical reasons and that she was suffering from a mental disorder without even reading Ms. Bavilla's submissions.

In this case, Justice Stevens' concerns in his dissent in Washington v. Harper regarding the likelihood of non-judicial proceedings being "a mock trial before an institutionally biased tribunal"[72] has been proven true for the Alaska Department of Corrections. Even under the majority opinion in Harper this is not permitted. It is thus clear the only way to afford inmate-patients their due process right to be free from forced psychiatric drugging is through requiring a court order.

(8) Summary re: Policy #807.16.

It is clear beyond cavil that proceedings under Department of Corrections' Policy #807.16 are unconstitutional under Washington v. Harper. In addition, the facts in this case demonstrate that both the provision of counsel and requiring a court order before drugging someone against their will by the Alaska Department of Corrections is required in order to protect inmate-patients' constitutional due process rights.

D. AS 09.19.200

AS 09.19.200 purports to impose certain restrictions on the court's ability to remedy constitutional violations by Corrections:

> (a) Except as provided in (b) and (e) of this section, a court may not order prospective relief in a civil action with respect to correctional facility

[71] See, Exhibit B, pages 7, 10-13, 18 for the latter.
[72] 110 S. Ct. at 1045.

conditions unless the court finds that (1) the plaintiff has proven a violation of a state or federal right, (2) the prospective relief is narrowly drawn and extends no further than is necessary to correct the violation of the right, (3) the prospective relief is the least intrusive means necessary to correct the violation of the right, and (4) the prisoner exhausted all administrative remedies available to the prisoner before filing the civil action. When a court finds multiple violations of a state or federal right, when multiple remedies are ordered by the prospective relief, or when prospective relief applies to multiple correctional facilities, the findings required by this subsection shall be made as to each violation, each remedy, and each facility, as appropriate. In a civil action with respect to correctional facility conditions that has been certified as a class action, prospective relief applicable to the class may only be ordered after the court makes the findings required by this subsection and finds that the violation of a state or federal right is applicable to the entire class. In making the findings required under this subsection, the court shall give substantial weight to any adverse effect on public safety or the operation of a criminal justice system caused by the prospective relief.

(b) In a civil action with respect to correctional facility conditions, to the extent otherwise authorized by law, the court may enter a temporary restraining order or an order for preliminary injunctive relief only if the court finds that the relief is (1) narrowly drawn and extends no further than is necessary to correct the harm that requires preliminary relief, and (2) the least intrusive means necessary to correct that harm. In making the findings required under this subsection, the court shall give substantial weight to any adverse effect on public safety or the operation of a criminal justice system caused by the preliminary relief. Preliminary injunctive relief shall automatically expire 90 days after the entry of the order unless the court orders final relief in the civil action before the expiration of the 90-day period.

(c) Prospective relief ordered in a civil action with respect to correctional facility conditions, including prospective relief ordered under a consent decree, regardless of whether that civil action was filed or the relief ordered before or after August 30, 1999, shall be terminated upon the motion of the defendant unless the court finds that there exists a current violation of a state or federal right and makes the findings required by (a) of this section as to each current violation and as to each remedy and facility, as appropriate. A civil action that has been certified as a class action shall be terminated upon the motion of the defendant unless the court makes the findings required by this subsection and finds that the current violation of a state or federal right is applicable to the entire class. Prospective relief must

be modified upon the motion of a party whenever, and to the extent, the findings required by this section no longer apply to one or more provisions of the prospective relief then in effect. This subsection and the time limits provided in (d) of this section do not prevent a party from seeking modification or termination before the relief is otherwise terminable under this section to the extent that modification or termination would otherwise be legally permissible.

(d) A defendant may not file a motion to modify or terminate under (c) of this section until

(1) two years after the date the court ordered the prospective relief if the order occurred after August 30, 1999;

(2) one year after the date the court entered an order denying modification or termination of prospective relief made under (1) or (3) of this subsection; or

(3) in the case of an order issued on or before August 30, 1999, one year after August 30, 1999.

(e) Notwithstanding (a) of this section, in a civil action with respect to correctional facility conditions, a court may order prospective relief as provided in a consent decree without complying with (a) of this section, provided the prospective relief does not continue for a period of more than two years unless the court finds and orders that the continuation of the relief is appropriate under the standards in (c) of this section. In addition, parties may enter into private settlement agreements that do not comply with the limitations of relief set out in (a) of this section if the terms of the agreements are not subject to court enforcement other than the reinstatement of the civil proceedings that the agreements settled.

(f) The court shall promptly rule on a motion to modify or terminate prospective relief in a civil action with respect to correctional facility conditions. A motion to modify or terminate prospective relief made under this section stays the order for prospective relief beginning on the 90th day after the motion is filed, and the stay ends on the date the court enters a final order ruling on the motion. An automatic stay under this subsection may be postponed by the court for not more than 30 days for good cause.

(g) In this section,

(1) "civil action with respect to correctional facility conditions"

means a civil proceeding arising under state or federal law with respect to the conditions of confinement or the effects of actions by government officials on the lives of persons confined in correctional facilities;

(2) "consent decree" means a court order that is based on the agreement of the parties; the term "consent decree" does not include a private settlement agreement;

(3) "prisoner"

(A) means a person held in a state correctional facility or under authority of state or municipal law in official detention as defined in AS 11.81.900(b);

(B) includes a minor committed to the custody of the commissioner when,

(i) under AS 47.12.030, 47.12.065, or 47.12.100, the minor has been charged, prosecuted, or convicted as an adult; or

(ii) under AS 47.12.160(e), the minor has been ordered transferred to the custody of the commissioner of corrections or a municipality;

(4) "private settlement agreement" means an agreement entered into among the parties that is not subject to judicial enforcement other than the reinstatement of the civil proceeding that the agreement settled;

(5) "prospective relief" means all relief other than compensatory monetary damages;

(6) "relief" means any legal or equitable remedy in any form that may be ordered by the court, and includes a consent decree but does not include a private settlement agreement;

(7) "state or federal right" means a right arising from the United States Constitution, the Constitution of the State of Alaska, or a federal or state statute.

There are tremendous constitutional and other problems with AS 09.19.200. First, and most importantly, the legislature is simply without power to prevent constitutional challenges. CSEA v. Beans, 965 P.2d 725, 728 (Alaska 1998).

> We note that AS 25.27.246(i) purports to limit the grounds on which judicial relief may be requested, and does not explicitly include inability to pay. This is, of course, ineffective to prevent a litigant from challenging an unconstitutional application of the statute.

AS 09.19.200 purports to limit the court's ability to enforce prisoner's constitutional rights and, as set forth in Beans, must fall.

More specifically, since constitutional rights do not expire upon the passage of time, any judicial determination of constitutional rights can not be legislatively terminated automatically as provided in AS 09.19.200 by the passage of time. The Legislature simply doesn't have the power to pass a law that overturns a judicial decision determining constitutional rights.

III. CONCLUSION

For the foregoing reasons, Plaintiff respectfully requests the court to grant summary judgment that

(A) Defendant's Policy #807.16, Involuntary Psychotropic Medication and

(B) AS 09.19.200

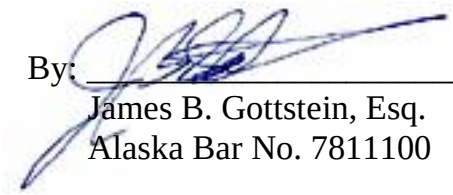
are unconstitutional, and that before the Defendant may involuntarily medicate an inmate with psychotropic medications,

(C) the inmate must be provided with counsel, and

(D) the court must approve the medication as medically appropriate.

Dated this 5th day of May, 2004, at Anchorage, Alaska.

LAW PROJECT FOR PSYCHIATRIC RIGHTS



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