Law Project for Psychiatric Rights
James B. Gottstein, Esq.
406 G Street, Suite 206
Anchorage, Alaska 99501
(907) 274-7686

Attorney for Plaintiff

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
THIRD JUDICIAL DISTRICT AT ANCHORAGE

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

Case No. _____

MEMORANDUM IN SUPPORT OF
MOTION FOR TEMPORARY RESTRAINING ORDER

Etta Bavilla, Plaintiff in the above captioned matter, pursuant to Civil Rule 65, has moved for a temporary restraining order:

1. Prohibiting Defendant from proceeding with a involuntary psychiatric medication proceeding against Plaintiff until seven days after the requirements of the Temporary Restraining Order have been satisfied.
2. Ordering Defendant to allow Plaintiff's counsel unhindered access between counsel and Plaintiff, subject only to necessary restrictions such as curfew and meal times in order to allow Plaintiff to assist in the preparation of her defense.

3. Allowing Plaintiff to take the deposition of witnesses the Department intends to rely upon in support of subjecting Plaintiff to involuntary psychotropic medication.
4. Requiring the Defendant to provide Plaintiff with the specific facts to be relied upon by Defendant in support of subjecting Plaintiff to involuntary psychotropic medication.
5. Disclosing to Plaintiff the specific drug(s) and dosage(s) proposed to be involuntarily administered to Plaintiff.
6. Allowing Plaintiff's counsel to assist her in defense of the Defendant's involuntary psychotropic medication proceeding.
7. Staying any involuntary psychotropic medication order that might be issued for 2 full court days to allow Plaintiff to seek a further stay in this court and if such further stay is requested, the stay to remain in effect until such time as this court rules on such further stay request.

A Facts

The Plaintiff is incarcerated at the Hiland Mountain Correctional Center (Hiland). On February 23, 2004, Defendant was notified that James B. Gottstein Esq., (Counsel) was representing Plaintiff with respect to a prospective forced psychiatric medication order and that he needed notice and copies of relevant documents in the event such an order was sought by the Defendant. See, Exhibit 1.

Instead, without any notice to Counsel, on Thursday, April 1, 2004, Plaintiff was informed the Defendant was going to seek such a forced psychiatric medication order at a

hearing set for the following Monday, April 5, 2004, at 8:30 a.m. at Hiland. On April 1, 2004, Counsel faxed a letter to the Defendant informing Defendant that it was violating Plaintiff's constitutional rights and demanded copies of relevant documents, as well as moving for:

(a) unhindered access between counsel and Plaintiff, subject only to necessary restrictions such as curfew and meal times in order to allow Plaintiff to assist in the preparation of her defense;

(b) a one week continuance of the hearing to allow for preparation of Plaintiff's defense; and

an order allowing counsel to take the deposition of witnesses the Department intends to rely upon. See, Exhibit 2.

The Defendant responded at the end of the day on April 1, 2004, through its counsel, with a letter attached as Exhibit 3. In it, the Defendant indicates the Plaintiff's mental health records will be provided Friday, April 2, 2004, but it is unclear whether the forced medication proceeding documents will be included. The one week continuance was denied. The institutional records will not be made available until after the forced medication proceeding is over, which, of course, makes it meaningless.

The letter indicates the Plaintiff is free to call her counsel throughout most of the day, but this is inconsistent with counsel's understanding. However, it is possible that counsel misunderstands that. The letter does state that Plaintiff's counsel may not call his client; that Plaintiff's counsel can fax a request for his client to call which request will be delivered some time during the day.

Plaintiff indicates she has not been told what medication(s) the Defendant intends to force her to take, nor what evidence or facts are to be relied upon in support of the Defendant's intention to involuntarily subject her to psychotropic medication. It also does not appear she has been informed of what witnesses are to be called against her.

Plaintiff has been told that her attorney will not be allowed to represent her, but this seems inconsistent with the letter from the Department. It seems likely that both are true, i.e., the Plaintiff was told that her attorney will not be allowed to represent her at the forced medication proceeding, and Defendant's counsel is unaware of that.

It is somewhat difficult to discuss some of the specific facts relating to the irreparable harm to be faced Plaintiff if the Temporary Restraining Order is not granted because the Defendant has failed to disclose the specific medication(s) to which it is seeking to subject Plaintiff. However, there are general facts that can be recited.

> 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 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, attached hereto as Exhibit 4.

The ability of neuroleptics (NLPs)[1] 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. 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, attached hereto as Exhibit 5 (Cohen Critique). 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 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.

---

[1] This class of drugs is commonly known by a number of names, including "neuroleptics" and "anti-psychotics."

> 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.

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), attached hereto as Exhibit 6.

> "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 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, attached hereto as Exhibit 7.

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), attached hereto as Exhibit 8.

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. 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), attached hereto as Exhibit 9.

"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, attached hereto as Exhibit 10.

Relapse rates rose in direct relation to neuroleptic dosage--the higher the dosage patients were on before the drugs were withdrawn, the greater the relapse rates. "Relapse in Chronic Schizophrenics Following Abrupt Withdrawal of Tranquillizing Medication," British Journal of Psychiatry, 115 (1968), 679-86, attached hereto as Exhibit 11.

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, attached hereto as Exhibit 12.

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, attached hereto as Exhibit 13. 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, attached hereto as Exhibit 14; "Neuroleptic-induced supersensitivity psychosis: clinical and pharmacologic characteristics," American Journal of Psychiatry, 137 (1980), 16-20, attached hereto as Exhibit 15.

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, attached hereto as Exhibit 16.

Patients with schizophrenia 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 , attached hereto as Exhibit 17.

"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 (1992), 1-95, conducted by the World Health Organization because the previous study's finding was so unexpected, confirmed the earlier study , attached hereto as Exhibit 18.

> 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) , attached hereto as Exhibit 19.

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.

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, attached hereto as Exhibit 20.

B Analysis

1. Due Process

While a prisoner may have fewer United States constitutional protections than a person facing a civil forced medication order, there are certain minimum substantive and procedural due process rights. Washington v. Harper, 494 U.S. 201, 110 S.Ct. 1028 (1990). Under Washington v. Harper, a prisoner has the substantive due process right to be free of forced medication unless the prison can prove the inmate has a serious mental illness, the inmate is a serious danger to himself or others and the treatment is in the inmate's medical best interests. Id, 494 U.S. at 227, 110 S. Ct. at 1039-40. With respect to procedural due process, the decision must be made "under fair procedural mechanisms." Id, 494 U.S. at 231, 110 S. Ct. at 1042. This includes a full, fair hearing

by an independent, unbiased, impartial decisionmaker. Id, 494 U.S. at 233, 110 S.Ct. at 1043. It also includes notice sufficient to satisfy due process. Id, 494 U.S. at 235, 110 S.Ct. at 1044.[2]

Here, the procedure is clearly defective in that it does not provide Plaintiff with adequate notice, nor a full, fair hearing. Plaintiff has not even been told what drug the Defendant wants to force her to take.[3] Plaintiff has not been informed of the specifics facts the Defendant intends to rely upon to justify forced medication. Plaintiff has not been given an adequate time to prepare a defense. Plaintiff is being hampered in communicating with her counsel, particularly in light of the compressed time frame. These do not comport with minimum due process standards under either the United States or Alaska constitutions.

2. Temporary Restraining Order Requirements.

(a) Plaintiff Meets the Standard for Issuing Temporary Restraining Order.

In Alaska Public Utilities Commission v. Greater Anchorage Area Borough, 534 P.2d 549, 554, (Alaska 1975), the Alaska Supreme Court held that where injury to the movant is certain and irreparable and harm to the non-movant inconsiderable, injunctive relief should normally be granted.

---

[2] Washington v. Harper did find it unnecessary under the facts in that case for the determination to be made by a court. It is unclear how much that remains true in light of Sell v. United States, 123 S.Ct. 2174 (2003), but this is not at issue for this particular motion. It may very well become an issue later in the proceeding.

[3] Sell is almost certainly applicable on this issue. "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." Sell, 123 S.Ct. at 2185.

> Where the questions presented by an application for an interlocutory injunction are grave, and the injury to the moving party will be certain and irreparable if the application be denied and the final decree be in his favor, while if the injunction be granted the injury to the opposing party, even if the final decree be in his favor, will be inconsiderable, or may be adequately indemnified by a bond, the injunction usually will be granted.

In Alaska v. United Cook Inlet Drift Association, 815 P.2d 378 (Alaska 1991), the court made clear this applied to temporary restraining orders if the movant showed "serious and substantial questions going to the merits of case" where it is relatively slight in comparison to the injury which the person seeking the injunction will suffer if the injunction is not granted.

Here, as set forth in the facts section, the Plaintiff faces potentially irreparable brain damage and a probability that the medications will cause her to become more susceptible to psychotic relapses or even cause psychosis, potentially leading to chronic mental illness, if psychotropic medications are forced upon her. Since it the Defendant has failed to disclose what medication(s) it is proposing Plaintiff should be forced to take, it is not possible at this juncture to specify with particularity the side effects. However, there is no doubt that all of the psychotropic medications normally used in these types of circumstances have serious, life threatening and life shortening side effects. See, e.g., Steele v. Hamilton County Community Mental Health Board, 736 N.E.2d 10, 16-17 (Ohio 2000). In contrast, it does not appear the Defendant faces anything other than minor administrative inconvenience if the temporary restraining order is issued.

The harm to Plaintiff is even more certain with respect to the denial of procedural due process rights if the restraining order is not granted. Once her constitutional right to

due process has been violated by the conduct of a hearing in violation thereof, the court is without power to remedy it. The harm will have occurred and can't be cured.

With respect to the merits, Plaintiff has shown far more than serious and substantial questions going to the merits of the case. Plaintiff respectfully suggests that her claims to procedural due process rights of meaning notice and a meaningful opportunity to be heard; of the right to a full, fair and impartial hearing are very likely to prevail. In these circumstances the temporary restraining order should be issued.

(b) No Bond Should Be Required.

Since there is an insubstantial injury to Defendant if the restraining order is improperly granted, no bond should be required. Both Alaska Public Utilities Commission and United Cook Inlet Drift Ass'n, by putting the bond requirement in the alternative to no substantial injury to the non-movant in the alternative implicitly so hold.

(c) Length of Restraining Order.

Full notice has been given to the Defendant so the provisions of Civil Rule 65 pertaining to the length of temporary restraining orders without such notice are inapplicable. In this case, the Restraining Order need remain in place only so long as Defendant fails to provide Plaintiff with her constitutional rights. In any event, Plaintiff can move promptly for a Preliminary Injunction if the court so desires so that the court can delve more fully into the merits.

3. Timing/Potential Hearing

Civil Rule 65(b) provides that the court can grant a temporary restraining order without a hearing. Plaintiff respectfully suggests that if no meaningful hearing can be

scheduled for Friday, April 2, 2004, the restraining order should be issued until such time as a meaningful hearing can be held. This can be done on an expedited a basis.

The Defendant was notified on February 23, 2004, which was more than a month before the forced medication proceeding was commenced that Plaintiff was represented by counsel and should provide such counsel with notice. Instead, in blatant violation of Plaintiff's rights, the Defendant failed to provide such notice. Moreover, the hearing was scheduled on an unreasonably short time frame that seems designed to prevent Plaintiff from exercising her rights to contest the proceeding. Plaintiff respectfully suggests she is entitled to a hearing into these matters as it bears directly on the question of the fairness of the procedures.

C Conclusion

For the foregoing reasons, Plaintiff respectfully requests the court grant a temporary restraining order

1. Prohibiting Defendant from proceeding with a involuntary psychiatric medication proceeding against Plaintiff until seven days after the requirements of the Temporary Restraining Order have been satisfied.
2. Ordering Defendant to allow Plaintiff's counsel unhindered access between counsel and Plaintiff, subject only to necessary restrictions such as curfew and meal times in order to allow Plaintiff to assist in the preparation of her defense.

3. Allowing Plaintiff to take the deposition of witnesses the Department intends to rely upon in support of subjecting Plaintiff to involuntary psychotropic medication.
4. Requiring the Defendant to provide Plaintiff with the specific facts to be relied upon by Defendant in support of subjecting Plaintiff to involuntary psychotropic medication.
5. Disclosing to Plaintiff the specific drug(s) and dosage(s) proposed to be involuntarily administered to Plaintiff.
6. Allowing Plaintiff's counsel to assist her in defense of the Defendant's involuntary psychotropic medication proceeding.
7. Staying any involuntary psychotropic medication order that might be issued for 2 full court days to allow Plaintiff to seek a further stay in this court and if such further stay is requested, the stay to remain in effect until such time as this court rules on such further stay request

Dated this 2nd day of April, 2004 at Anchorage, Alaska.

LAW PROJECT FOR PSYCHIATRIC RIGHTS

By: _____
James B. Gottstein, Esq.
Alaska Bar No. 7811100