IN THE SUPREME COURT FOR THE STATE OF ALASKA

WILLIAM S. BIGLEY, Appellant, vs. ALASKA PSYCHIATRIC INSTITUTE Appellee.	)	Supreme Court No. S-13116

Trial Court Case No. 3AN 08-493 PR

APPEAL FROM THE SUPERIOR COURT
THIRD JUDICIAL DISTRICT AT ANCHORAGE
THE HONORABLE SHARON L. GLEASON, PRESIDING

APPELLANT'S EXCERPT OF RECORD
VOLUME 1 OF 1

James B. Gottstein (7811100)
Law Project for Psychiatric Rights, Inc.
406 G Street, Suite 206
Anchorage, Alaska
(907) 274-7686

Attorney for Appellant
William S. Bigley

Filed in the Supreme Court of
the State of Alaska, this _____
day of _____, 2008

Marilyn May, Clerk

By: _____
Deputy Clerk

Table of Contents

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

In the Matter of the Necessity for the Hospitalization of:	)
WILLIAM BIGLEY,	)
Respondent.	)
	) Case No. 3AN-07-1064 PR

NOTICE TO THE COURT

The Department of Health and Social Services, Division of Behavioral Health, Alaska Psychiatric Institute, by and through the Office of the Attorney General, wishes to notify the court and the parties that Mr. Bigley was not released on Thursday as previously expected. The basis for the early discharge was the presence of a less restrictive alternative placement, however that alternative was not available on Thursday, due to Mr. Bigley's refusal. Mr. Bigley was discharged against medical advice on Friday, September 14. The traditional paperwork will follow.

DATED: Sept. 18, 2007

TALIS J. COLBERG
ATTORNEY GENERAL

By: Elizabeth Russo
Elizabeth Russo
Assistant Attorney General
Alaska Bar No. 0311064

DEPARTMENT OF LAW
OFFICE OF THE ATTORNEY GENERAL
ANCHORAGE BRANCH
1031 W. FOURTH AVENUE, SUITE 200
ANCHORAGE, ALASKA 99501
PHONE: (907) 269-5100

DEFENDANT
EXHIBIT NO. C
ADMITTED ☑
3AN 08-493 PS
(CASE NUMBER)

PEACE OFFICER/MENTAL HEALTH PROFESSIONAL APPLICATION FOR EXAMINATION
(AS 47.30.705)

Name of Potential Patient: Bill Bigley

Date and Time: 4-25-08 1755

Age: _____ Sex: M Race: N Marital Status: _____

I hereby certify that probable cause exists under AS 47.30.705 to believe that the above-named individual is mentally ill and is:

- [X] gravely disabled
- [ ] likely to cause serious harm to [X] self [ ] others

of such immediate nature that considerations of safety do not allow initiation of involuntary commitment procedures under AS 47.30.700.

Pertinent Information: Bill was trespassed from 1st Val Bank for causing a disturbance. Bill spit on staff at OPA.

I am a:

- [X] peace officer
- [ ] psychiatrist/physician currently licensed to practice in the State of Alaska or employed by the federal government.
- [ ] clinical psychologist licensed by the State Board of Psychologists and Psychological Examiners.

R M
Signature of Peace Officer or Mental Health Professional

B. Ce
Print Name

786 8905
Daytime Telephone Number

Mailing Address City State Zip

NOTE: Pursuant to AS 47.30.705, any police officer or mental health professional requesting an emergency evaluation must complete an application for examination of the person in custody and be interviewed by a mental health professional at the evaluating facility.

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
AT Anchorage

In the Matter of the Necessity for the Hospitalization of:

William Bigley,
Respondent.

Case No. _____

PETITION FOR INITIATION OF INVOLUNTARY COMMITMENT

Leona Gillespie ANP, petitioner alleges that the respondent is mentally ill and as a result of that condition is gravely disabled or presents a likelihood of causing serious harm to himself/herself or others.

☐ Petitioner respectfully requests the court to conduct or to arrange for a screening investigation of the respondent as provided in AS 47.30.700.

If this investigation results in a determination that the respondent is mentally ill and as a result of that condition is gravely disabled or presents a likelihood of causing serious harm to himself/herself or others, the petitioner requests that the court issue an ex parte order for temporary custody and detention for emergency examination or treatment.

☑ Respondent was taken into emergency custody by API under AS 47.30.705. The Peace Officer/Mental Health Professional Application for Examination is attached. Petitioner respectfully requests that the court issue an ex parte order authorizing hospitalization for an evaluation as provided for in AS 47.30.710.

Facts in support of this request are as follows:

1. The respondent named above is 55 years of age and resides at Anchorage, Alaska.

2. The facts which make the respondent a person in need of (a screening investigation) (hospitalization for evaluation) are:

Mr Bigley has been threatening towards others in the community. He is increasingly agitated and verbally assaultive. Reported to have trespassed at 1st National Bank. Spit on workers at OPA. Recently evicted from his housing. Currently delusional stating "the bombs of 911 is all a conspiracy" Believes he is being persicuted.

Bigley

Case No. _____

3. Persons having personal knowledge of these facts are: (include addresses)

4/26/08
Date

Leora Gillespie AWP
Petitioner's Signature

Leora Gillespie
Type or Print Name

2800 Providence Dr Anch. AK 99508
Petitioner's Address

269-7100
Petitioner's Phone

Verification

Petitioner says on oath or affirms that petitioner has read this petition and believes all statements made in the petition are true.

Subscribed and sworn to or affirmed before me at Anchorage, Alaska on 4/28/08 (date).

MARY C. MARTINEZ NOTARY PUBLIC (SEAL) STATE OF ALASKA My Commission Expires With Office

Mary Martinez
Clerk of Court, Notary Public or other person authorized to administer oaths.
My commission expires: with office

A person acting in good faith upon either actual knowledge or reliable information who makes application for evaluation or treatment of another person under AS 47.30.700-47.30.915 is not subject to civil or criminal liability. [AS 47.30.815(a)]

A person who willfully initiates an involuntary commitment procedure under AS 47.30.700 without having good cause to believe that the other person is suffering from a mental illness and as a result is gravely disabled or likely to cause serious harm to self or others, is guilty of a felony. [AS 47.30.815(c)]

I certify that on _____
a copy of this petition was sent to:

Clerk: _____

File

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
AT ANCHORAGE

In the Matter of the Necessity for the Hospitalization of:
WILLIAM BIGLEY
Respondent.

Case No. 3AN-3AN-08-493 PR

EX PARTE ORDER
(TEMPORARY CUSTODY FOR EMERGENCY EXAMINATION/ TREATMENT)

FINDING AND CONCLUSIONS

Having considered the allegations of the petition for initiation of involuntary commitment and the evidence presented, the court finds that there is probable cause to believe that the respondent is mentally ill and as a result of that condition is gravely disabled or presents a likelihood of causing serious harm to him/herself or others.

ORDER

Therefore, it is ordered that:

1. Alaska Psychiatric Institute take the respondent into custody and deliver him/her to Alaska Psychiatric Institute, in Anchorage, Alaska, the nearest appropriate evaluation facility for examination.
2. The respondent be examined at the evaluation facility and be evaluated as to mental and physical condition by a mental health professional and by a physician within 24 hours after arrival at the facility.
3. The evaluation facility personnel promptly report to the court the date and time of the respondent's arrival.
4. The examination and evaluation be completed within 72 hours of the respondent's arrival at the evaluation facility.
5. A petition for commitment be filed or the respondent be released by the evaluation facility before the end of the 72 hour evaluation period (unless respondent requests voluntary admission for treatment).
6. Public Defender Agency is appointed counsel for respondent in this proceeding and is authorized access to medical, psychiatric or psychological records maintained on the respondent at the evaluation facility.

4/26/08
Date 6:20 P.M.

Superior Court Judge

Recommended for approval on

I certify that on _____ a copy of this order was sent to: AG, PD, API, RESP

Clerk:

Magistrate

MC-305 (12/87)(st.5)
AS 47.30.700, .710 & .715

Subject: Mr. B.
From: Jim Gottstein <jim.gottstein@psychrights.org>
Date: Sat, 26 Apr 2008 11:38:47 -0800
To: "Russo, Elizabeth M H (DOA)" <elizabeth.russo@alaska.gov>, "Twomey, Timothy M (LAW)" <tim.twomey@alaska.gov>, "Gillilan-Gibson, Kelly (DOA)" <kelly.gillilan-gibson@alaska.gov>, "Beecher, Linda R (DOA)" <linda.beecher@alaska.gov>, "Brennan, Elizabeth (DOA)" <elizabeth.brennan@alaska.gov>
CC: jim.gottstein@psychrights.org

Hi Tim, Elizabeth, Linda, Beth and Kelly,

Mr. Bigley is back in API. Unless and until otherwise notified, I am representing him with respect to forced drugging, including prospective proceedings.

With respect to his current admission, in thinking about things, it seems to me there is a pretty high likelihood that because:

(a) he had lost his housing and wasn't willing to accept the housing offered by OPA,
(b) he wasn't allowed at the shelter,
(c) there was a $#@)*&% blizzard late Friday afternoon, and
(d) API was preferable to a snowbank or jail,

he acted the way he had to act at OPA in order to get sent to API. I don't think he should have to act that way to access API. Therefore, I propose the following:

1. He be allowed to come and go from API as he wishes, including being given food, good sleeping conditions, laundry, washing facilities, toiletry items, etc.

2. If brought to API on a PoA or *Ex Parte*, absent compelling concern about the safety of doing so, he be allowed out on pass each day for at least four hours, with or without escort. Actually, it seems to me that most of the time he ought to be let out each morning with him not being required to return. If he gets brought back for his behavior in the community then the process can be repeated. That way he has a place to sleep, get his food, wash, etc.

This, of course, doesn't apply if he gets charged criminally, but since he is considered incompetent to stand trial with no prospects for becoming competent, they aren't hanging on to him, which tends to land him back at API.

Of course, the Guardian will continue to work with him to provide a more suitable arrangement for all concerned.

Tim, I understand Dr. Gomez is his treating physician. This is a formal proposal and I will appreciate your conveying it to him and/or whoever else might be necessary to approve it. I will, of course, be pleased to meet to discuss why I think this approach should be adopted and have the Guardian and Public Defender Agency involved if they so desire.

--

James B. (Jim) Gottstein, Esq.
President/CEO

S-13116 Exc. 6

Law Project for Psychiatric Rights
406 G Street, Suite 206
Anchorage, Alaska 99501
USA
Phone: (907) 274-7686) Fax: (907) 274-9493
jim.gottstein[[at]]psychrights.org
http://psychrights.org/

PsychRights®
Law Project for
Psychiatric Rights

The Law Project for Psychiatric Rights is a public interest law firm devoted to the defense of people facing the horrors of forced psychiatric drugging. We are further dedicated to exposing the truth about these drugs and the courts being misled into ordering people to be drugged and subjected to other brain and body damaging interventions against their will. Extensive information about this is available on our web site, http://psychrights.org/. Please donate generously. Our work is fueled with your IRS 501(c) tax deductible donations. Thank you for your ongoing help and support.

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
AT ANCHORAGE

file

In the Matter of the Necessity for the Hospitalization of:	)	
WILLIAM BIGLEY, Respondent.	)	Case No. 3AN-08-493 PR
	)	EX PARTE ORDER (TEMPORARY CUSTODY FOR EMERGENCY EXAMINATION/ TREATMENT)

FINDING AND CONCLUSIONS

Having considered the allegations of the petition for initiation of involuntary commitment and the evidence presented, the court finds that there is probable cause to believe that the respondent is mentally ill and as a result of that condition is gravely disabled or presents a likelihood of causing serious harm to him/herself or others.

ORDER

Therefore, it is ordered that:

1. Alaska Psychiatric Institute take the respondent into custody and deliver him/her to Alaska Psychiatric Institute, in Anchorage, Alaska, the nearest appropriate evaluation facility for examination.
2. The respondent be examined at the evaluation facility and be evaluated as to mental and physical condition by a mental health professional and by a physician within 24 hours after arrival at the facility.
3. The evaluation facility personnel promptly report to the court the date and time of the respondent's arrival.
4. The examination and evaluation be completed within 72 hours of the respondent's arrival at the evaluation facility.
5. A petition for commitment be filed or the respondent be released by the evaluation facility before the end of the 72 hour evaluation period (unless respondent requests voluntary admission for treatment).
6. Public Defender Agency is appointed counsel for respondent in this proceeding and is authorized access to medical, psychiatric or psychological records maintained on the respondent at the evaluation facility.

4/28/08
Date

Peter A. Michalski
Superior Court Judge

I certify that on 4/29/08 a copy of this order was sent to: AG, PD, API, RESP

Clerk: M. Hrentchen

Recommended for approval on

Master
AS 47.30.700, .710 & .715

MC-305 (12/87)(st.5)
EX PARTE ORDER
S-13116

File

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
AT Anchorage

In the Matter of the Necessity for the Hospitalization of: William Bigley, Respondent.	Case No. 3AN08 493PR

PETITION FOR 30-DAY COMMITMENT

As mental health professionals who have examined the respondent, the petitioners allege that:

1. The respondent is mentally ill and as a result is
   - ☒ likely to cause harm to himself/herself or others.
   - ☒ gravely disabled and there is reason to believe that the respondent's mental condition could be improved by the course of treatment sought.
2. The evaluation staff has considered, but has not found, any less restrictive alternatives available that would adequately protect the respondent or others.
3. API is an appropriate treatment facility for the respondent's condition and has agreed to accept the respondent.
4. The respondent has been advised of the need for, but has not accepted, voluntary treatment.

The petitioners respectfully request the court to commit the respondent to the above-named treatment facility for not more than 30 days.

The facts and specific behavior of the respondent supporting the above allegations are:

Mr. Bigley has deteriorated psychiatrically through not taking medication, by refusing food and fluid. He makes frequent threats including assault. He has attempted to threaten peers inviting retaliation. Mr. Bigley must be isolated from other patients such that they are not injured or harmed by his behavior. Mr. Bigley is likely to continue to deteriorate physically through further refusal of sustenance, absence of sleep, injuring himself by striking walls, windows.

Case No. 3AN 08 493 PR

The following persons are prospective witnesses, some or all of whom will be asked to testify in favor of the commitment of the respondent at the hearing:

Ronald McAdoo Ed. M.
R. Duane Hopson, M.D.
Carolyn Seegana, AWP
Kamaree Altafer

4/28/08
Date

Signature

L.J. MAILE Ph.D.
Printed Name

Licensed Psychologist
Title

4/28/08
Date

Signature

R Duane Hopson, MD
Printed Name

Medical Director
Title

Note: This petition must be signed by two mental health professionals who have examined the respondent, one of whom is a physician. AS 47.30.730(a).

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
AT Anchorage

In the Matter of the Necessity) for the Hospitalization of:)

William Bigley

Respondent.

) Case No. 3AN 08 493 P/R

)PETITION FOR COURT APPROVAL OF ADMINISTRATION OF PSYCHOTROPIC MEDICATION [AS 47.30.839]

Lawrence J. MATTLE Ph.D. petitioner, requests a hearing on the respondent's capacity to give or withhold informed consent to the use of psychotropic medication, and alleges that:

☒ There have been, or it appears that there will be, repeated crisis situations requiring the immediate use of medication to preserve the life of, or prevent significant physical harm to, the patient or another person. The facility wishes to use psychotropic medication in future crisis situations.

☒ Petitioner has reason to believe the patient is incapable of giving or withholding informed consent. The facility wishes to use psychotropic medication in a noncrisis situation.

☐ Court approval has been granted during a previous commitment period, and the facility wishes to continue medication during the subsequent commitment period. A 90/180 day petition is being filed. The patient continues to be incapable of giving or withholding informed consent.

The patient ☒ has refused ☐ has not refused the medication.

4/28/08
Date

L. J. Mattle Ph.D.
Signature
(Representative of evaluation or designated treatment facility)

L. J. Mattle Ph.D.
Printed Name

Licensed Psychologist
Title

Verification

Petitioner says on oath or affirms that petitioner has read this petition and believes all statements made in the petition are true.

Subscribed and sworn or affirmed before me at Anchorage Alaska on 4/29/08 (date).

Mary C. Martinez
Notary Public
State of Alaska
My Commission Expires With Office

Clerk of Court, Notary Public, or other person authorized to administer oaths.
My commission expires: with office

Subject: RE: [Fwd: Mr. B.]
From: "Twomey, Timothy M (LAW)" <tim.twomey@alaska.gov>
Date: Tue, 29 Apr 2008 08:31:58 -0800
To: Jim Gottstein <jim.gottstein@psychrights.org>, "Adler, Ronald M (HSS)" <ronald.adler@alaska.gov>, "Kraly, Stacie L (LAW)" <stacie.kraly@alaska.gov>
CC: "Beecher, Linda R (DOA)" <linda.beecher@alaska.gov>, "Brennan, Elizabeth (DOA)" <elizabeth.brennan@alaska.gov>, "Gillilan-Gibson, Kelly (DOA)" <kelly.gillilan-gibson@alaska.gov>

Jim – I have received your emails and will communicate to you as appropriate.
Thank you. Tim

Tim Twomey (907) 269-5168 direct

From: Jim Gottstein [mailto:jim.gottstein@psychrights.org]
Sent: Tuesday, April 29, 2008 8:24 AM
To: Adler, Ronald M (HSS); Kraly, Stacie L (LAW)
Cc:
Twomey, Timothy M (LAW); Beecher, Linda R (DOA); Brennan, Elizabeth (DOA); Gillilan-Gibson, Kelly (DOA); jim.gottstein@psychrights.org
Subject: [Fwd: Mr. B.]
Importance: High

Hi Ron,

In the absence of any response to the below from Mr. Twomey and therefore not knowing who might be representing the hospital, I am forwarding the below e-mail to you and advising you that I am representing Mr. Bigley with respect to forced drugging (presumably under AS 47.30.838 and/or AS 47.30.839) unless and until otherwise notified. Thus, any forced drugging petition must be served on me. My fax number is 274-9493. Please forward this to whoever is representing the hospital with respect to Mr. Bigley regarding any proceedings that have arisen or might arise out of Mr. Bigley's current admission. I will also need a copy of Mr. Bigley's chart, updated daily.

Please also note that I made a formal proposal to Mr. Twomey, which was required to be presented to the appropriate decision maker(s) at API, unless prior discussions with your attorney left it clear the proposal will be unacceptable. Even if so, I think it is imperative that all parties get together to try and work out an approach for Mr. Bigley that comports with his rights.

-------- Original Message --------
Subject: Mr. B.
Date: Sat, 26 Apr 2008 11:38:47 -0800
From: Jim Gottstein <jim.gottstein@psychrights.org>
Organization: Law Project for Psychiatric Rights
To: Russo, Elizabeth M H (DOA) <elizabeth.russo@alaska.gov>, Twomey, Timothy M (LAW) <tim.twomey@alaska.gov>, Gillilan-Gibson, Kelly (DOA) <kelly.gillilan-gibson@alaska.gov>, Beecher, Linda R (DOA) <linda.beecher@alaska.gov>, Brennan, Elizabeth (DOA) <elizabeth.brennan@alaska.gov>
CC:jim.gottstein@psychrights.org

Hi Tim, Elizabeth, Linda, Beth and Kelly,

Law Project for Psychiatric Rights
406 G Street, Suite 206
Anchorage, AK 99501
907-274-7686 phone
907-274-9493 fax

Attorney for Respondent

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

In The Matter of the Necessity for the)
Hospitalization of William S. Bigley,)
Respondent.)
Case No. 3AN 08-00247 P/S

MOTION FOR LESS INTRUSIVE ALTERNATIVE

COMES NOW, Respondent William S. Bigley (Mr. Bigley), pursuant to *Myers v. Alaska Psychiatric Institute*,[1] and moves for an order requiring API to provide the following less intrusive alternative:[2]

1. Mr. Bigley be allowed to come and go from API as he wishes, including being given food, good sleeping conditions, laundry and toiletry items as reasonably requested by Mr. Bigley.

2. If involuntarily in a treatment facility in the future, Mr. Bigley be allowed out on passes at least once each day for four hours with escort by staff members who like him, or some other party willing and able to do so.

3. API shall procure and pay for a reasonably nice apartment that is available to Mr. Bigley should he choose it.[3] API shall first attempt to negotiate an acceptable abode, and failing that procure it and make it available to Mr. Bigley.

---

[1] 138 P.3d 238 (Alaska 2006).

[2] In his Submission for Representation Hearing, Mr. Bigley pointed out that the AS 47.30.839 forced drugging petition is premature under *Myers*, 138 P.3d at 242-3, and *Wetherhorn v. Alaska Psychiatric Institute*, 156 P.3d 371, 382 (Alaska 2007). Thus, this motion is technically premature as well. However, this motion is being made in the event the Court disagrees the forced drugging petition is premature.

LAW PROJECT FOR PSYCHIATRIC RIGHTS, INC.
406 G Street, Suite 206
Anchorage, Alaska 99501
(907) 274-7686 Phone ~ (907) 274-9493 Fax

Mr. Bigley is back in API. Unless and until otherwise notified, I am representing him with respect to forced drugging, including prospective proceedings.

With respect to his current admission, in thinking about things, it seems to me there is a pretty high likelihood that because:

(a) he had lost his housing and wasn't willing to accept the housing offered by OPA,
(b) he wasn't allowed at the shelter,
(c) there was a $#@)*&% blizzard late Friday afternoon, and
(d) API was preferable to a snowbank or jail,

he acted the way he had to act at OPA in order to get sent to API. I don't think he should have to act that way to access API. Therefore, I propose the following:

1. He be allowed to come and go from API as he wishes, including being given food, good sleeping conditions, laundry, washing facilities, toiletry items, etc.

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This, of course, doesn't apply if he gets charged criminally, but since he is considered incompetent to stand trial with no prospects for becoming competent, they aren't hanging on to him, which tends to land him back at API.

Of course, the Guardian will continue to work with him to provide a more suitable arrangement for all concerned.

Tim, I understand Dr. Gomez is his treating physician. This is a formal proposal and I will appreciate your conveying it to him and/or whoever else might be necessary to approve it. I will, of course, be pleased to meet to discuss why I think this approach should be adopted and have the Guardian and Public Defender Agency involved if they so desire.

--

James B. (Jim) Gottstein, Esq.
President/CEO

Law Project for Psychiatric Rights
406 G Street, Suite 206
Anchorage, Alaska 99501
USA
Phone: (907) 274-7686) Fax: (907) 274-9493
jim.gottstein[[at]]psychrights.org
http://psychrights.org/

File

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

In the Matter of the Necessity for the Hospitalization of:	
William Bigley	Case No. 3AN-08-00493PR
Respondent.	NOTICE OF 30-DAY COMMITMENT HEARING

To: Respondent

Respondent's Attorney:

State's Attorney: Attorney General's Office

Petitioner/Facility: API

The court has received a petition requesting examination and evaluation of the respondent to determine if the respondent is mentally ill and as a result of that condition is gravely disabled or presents a likelihood of causing serious harm to himself/herself or others. The court has also received a petition for commitment of the respondent for up to 30 days pursuant to AS 47.30.730 (copy attached).

A hearing to decide whether commitment of respondent is necessary will take place in the Superior Court at **Anchorage, Alaska, in Courtroom 29, Boney Courthouse** on **April 30, 2008** at **8:30 am** before the Honorable Lucinda J McBurney.

The court has appointed as counsel for the respondent in this matter.

At the hearing, the respondent has the following rights:

1. Representation by counsel
2. To be present at the hearing
3. To view and copy all petitions and reports in the court file on respondent's case.
4. To have the hearing open or closed to the public as the respondent elects.
5. To have the rules of evidence and civil procedure applied so as to provide for the informal but efficient presentation of evidence.
6. To have an interpreter if the respondent does not understand English.

7. To present evidence on his/her own behalf.

8. To cross-examine witnesses who testify against him/her.

9. To remain silent.

10. To call experts and other witnesses to testify on the respondent's behalf.

11. To appeal any involuntary commitment.

If commitment or other involuntary treatment beyond the 30 days is sought, the respondent shall have the right to a full hearing or jury trial.

Before the court can order the respondent committed, the court must find by clear and convincing evidence that respondent is mentally ill and as a result of that condition is gravely disabled or presents a likelihood that he/she will cause harm to himself/herself or others.

4/29/2008	SRichmond
Date	Judge/Clerk

I certify that on 4/29/2008
A copy of this notice and the Petition for
30-Day Commitment were sent to the persons
listed on page one.

Clerk: SRichmond

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT

In the Matter of the Necessity for the Hospitalization of:	)	
William Bigley	)	
Respondent.	)	
	)	Case No. 3AN-08-493 PR

NOTICE OF HEARING AND ORDER FOR APPOINTMENT OF COURT VISITOR

A hearing on the Petition for Court Approval of Administration of Psychotropic Medication will take place in the Superior Court at Anchorage, Alaska Boney Courthouse Courtroom 29 April 30, 2008 at 8:30 AM before the Master McBurney.

The Court has appointed Public Defender Agency as counsel for the respondent in this matter.

OPA is appointed as visitor and is authorized to receive all medical/psychiatric, financial, educational and vocational records including those from secondary sources, and any pertinent information necessary information necessary to formulate recommendations to the court.

DATED at Anchorage, Alaska on April 29, 2008.

JOHN E. DUGGAN
PROBATE MASTER

I certified that on 04/29/08
copies of this form were sent
To: AG/PD/OPA/API/RESP

Clerk: ser

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

In The Matter of the Necessity for the Hospitalization of William Bigley, Respondent	)
Case No. 3AN 08-00493PR	

LIMITED ENTRY OF APPEARANCE

Pursuant to Civil Rule 81(d), the Law Project for Psychiatric Rights (PsychRights) hereby enters its appearance on behalf of William Bigley, the Respondent in this matter, limited only to any forced drugging under AS 47.30.838 or AS 47.30.839. All papers filed in this proceeding should be served on the undersigned at 406 G Street, Suite 206, Anchorage, Alaska 99501. Attached hereto are the Submission for Representation Hearing[1] and the affidavits of Robert Whitaker, Ronald Bassman and Paul Cornils, and Motion for a Less Restrictive Alternative, filed in 3AN 08-247PR, pertaining to the Respondent, of which this Court may take Judicial Notice, and a copy of the April 26-29, 2007, e-mail thread advising the petitioner of PsychRights' representation of Respondent.

DATED: April 29, 2008.

Law Project for Psychiatric Rights

By: _____
James B. Gottstein
ABA # 7811100

[1] Counsel was notified at 4:37 pm April 29, 2008, of the hearing to be held in this matter at 8:30 a.m., the next morning, necessitating the attachment of prior pleadings rather than drafting new ones. If counsel had had a chance to draft new pleadings he would have substantially changed his characterization of the Public Defender Agency's performance based on more recent information.

LAW PROJECT FOR PSYCHIATRIC RIGHTS, INC.
406 G Street, Suite 206
Anchorage, Alaska 99501
(907) 274-7686 Phone ~ (907) 274-9493 Fax

4. At API's expense, make sufficient staff available to be with Mr. Bigley to enable him to be successful in the community.

5. The foregoing may be contracted for from an outpatient provider.

This motion is supported by Submission For Representation Hearing, Affidavit of Paul Comils, Affidavit of Ronald Bassman, PhD., and Affidavit of Robert Whitaker, all filed March 6, 2008.

DATED: March 10, 2008.

Law Project for Psychiatric Rights

By: _____
James B. Gottstein
ABA # 7811100

The foregoing and proposed form or order, was hand delivered to Timothy Twomley of the Attorney General's Office and Elizabeth Brennan/Kelly Gibson of the Alaska Public Defender Agency and faxed to the Court Visitor on March 10, 2008.

_____
James B. Gottstein

LAW PROJECT FOR PSYCHIATRIC RIGHTS, INC.
406 G Street, Suite 206
Anchorage, Alaska 99501
(907) 274-7686 Phone ~ (907) 274-9493 Fax

[3] API may seek to obtain a housing subsidy from another source, but such source may not be his Social Security Disability income.

Subject: RE: [Fwd: Mr. B.]
From: "Twomey, Timothy M (LAW)" <tim.twomey@alaska.gov>
Date: Tue, 29 Apr 2008 08:31:58 -0800
To: Jim Gottstein <jim.gottstein@psychrights.org>, "Adler, Ronald M (HSS)" <ronald.adler@alaska.gov>, "Kraly, Stacie L (LAW)" <stacie.kraly@alaska.gov>
CC: "Beecher, Linda R (DOA)" <linda.beecher@alaska.gov>, "Brennan, Elizabeth (DOA)" <elizabeth.brennan@alaska.gov>, "Gillilan-Gibson, Kelly (DOA)" <kelly.gillilan-gibson@alaska.gov>

Jim – I have received your emails and will communicate to you as appropriate.
Thank you. Tim

Tim Twomey (907) 269-5168 direct

From: Jim Gottstein [mailto:jim.gottstein@psychrights.org]
Sent: Tuesday, April 29, 2008 8:24 AM
To: Adler, Ronald M (HSS); Kraly, Stacie L (LAW)
Cc:
Twomey, Timothy M (LAW); Beecher, Linda R (DOA); Brennan, Elizabeth (DOA); Gillilan-Gibson, Kelly (DOA); jim.gottstein@psychrights.org
Subject: [Fwd: Mr. B.]
Importance: High

Hi Ron,

In the absence of any response to the below from Mr. Twomey and therefore not knowing who might be representing the hospital, I am forwarding the below e-mail to you and advising you that I am representing Mr. Bigley with respect to forced drugging (presumably under AS 47.30.838 and/or AS 47.30.839) unless and until otherwise notified. Thus, any forced drugging petition must be served on me. My fax number is 274-9493. Please forward this to whoever is representing the hospital with respect to Mr. Bigley regarding any proceedings that have arisen or might arise out of Mr. Bigley's current admission. I will also need a copy of Mr. Bigley's chart, updated daily.

Please also note that I made a formal proposal to Mr. Twomey, which was required to be presented to the appropriate decision maker(s) at API, unless prior discussions with your attorney left it clear the proposal will be unacceptable. Even if so, I think it is imperative that all parties get together to try and work out an approach for Mr. Bigley that comports with his rights.

-------- Original Message --------
Subject: Mr. B.
Date: Sat, 26 Apr 2008 11:38:47 -0800
From: Jim Gottstein <jim.gottstein@psychrights.org>
Organization: Law Project for Psychiatric Rights
To: Russo, Elizabeth M H (DOA) <elizabeth.russo@alaska.gov>, Twomey, Timothy M (LAW) <tim.twomey@alaska.gov>, Gillilan-Gibson, Kelly (DOA) <kelly.gillilan-gibson@alaska.gov>, Beecher, Linda R (DOA) <linda.beecher@alaska.gov>, Brennan, Elizabeth (DOA) <elizabeth.brennan@alaska.gov>
CC:jim.gottstein@psychrights.org

Hi Tim, Elizabeth, Linda, Beth and Kelly,

Mr. Bigley is back in API. Unless and until otherwise notified, I am representing him with respect to forced drugging, including prospective proceedings.

With respect to his current admission, in thinking about things, it seems to me there is a pretty high likelihood that because:

(a) he had lost his housing and wasn't willing to accept the housing offered by OPA,
(b) he wasn't allowed at the shelter,
(c) there was a $#@)*&% blizzard late Friday afternoon, and
(d) API was preferable to a snowbank or jail,

he acted the way he had to act at OPA in order to get sent to API. I don't think he should have to act that way to access API. Therefore, I propose the following:

1. He be allowed to come and go from API as he wishes, including being given food, good sleeping conditions, laundry, washing facilities, toiletry items, etc.

2. If brought to API on a PoA or *Ex Parte*, absent compelling concern about the safety of doing so, he be allowed out on pass each day for at least four hours, with or without escort. Actually, it seems to me that most of the time he ought to be let out each morning with him not being required to return. If he gets brought back for his behavior in the community then the process can be repeated. That way he has a place to sleep, get his food, wash, etc.

This, of course, doesn't apply if he gets charged criminally, but since he is considered incompetent to stand trial with no prospects for becoming competent, they aren't hanging on to him, which tends to land him back at API.

Of course, the Guardian will continue to work with him to provide a more suitable arrangement for all concerned.

Tim, I understand Dr. Gomez is his treating physician. This is a formal proposal and I will appreciate your conveying it to him and/or whoever else might be necessary to approve it. I will, of course, be pleased to meet to discuss why I think this approach should be adopted and have the Guardian and Public Defender Agency involved if they so desire.

--

James B. (Jim) Gottstein, Esq.
President/CEO

Law Project for Psychiatric Rights
406 G Street, Suite 206
Anchorage, Alaska 99501
USA
Phone: (907) 274-7686) Fax: (907) 274-9493
jim.gottstein[[at]]psychrights.org
http://psychrights.org/

Law Project for Psychiatric Rights
406 G Street, Suite 206
Anchorage, AK 99501
907-274-7686 phone
907-274-9493 fax

Attorney for Respondent

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

In The Matter of the Necessity for the Hospitalization of William S. Bigley,

Respondent

Case No. 3AN 08-00247 PR

SUBMISSION FOR REPRESENTATION HEARING

In the afternoon of March 5, 2008, I received a call from the Court advising me that Mr. Bigley informed the Court earlier that afternoon that he desired me to represent him in the above captioned matter and that a representation hearing was set for 3:00 pm today.

I. Background

The Law Project for Psychiatric Rights (PsychRights®) with whom I work, is a public interest law firm whose mission is to mount a strategic litigation campaign against unwarranted forced psychiatric drugging and electroshock around the country.[1] A key component of this strategic campaign is to rectify that judges ordering people to take these

[1] Forced electroshock is not administered in Alaska to my knowledge.

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drugs are being misled about them.[2] Psychiatric respondents are particularly vulnerable because what they say is characterized as symptoms of mental illness, *ie.*, that they are delusional. In other words, judges (usually Probate Masters in Anchorage) and even the lawyers assigned to represent them, exhibit an attitude of "if he wasn't crazy, he would know this is good for him," and therefore don't engage in the required adversary process that make judicial proceedings legitimate. If a proper adversarial process were to occur, the courts would be presented with the truth about these drugs, or at least closer to the truth about them,[3] which reveals they are far less effective and far more harmful than the courts are being told and that the ubiquitous use of these drugs is at least halving the number of people who would fully recover after experiencing a psychotic episode(s) and finding themselves subject to involuntary commitment and forced drugging proceedings.[4]

The failure of the Alaska Public Defender Agency to do any investigation of this,[5] nor present any evidence on their clients behalf with respect thereto has led to the current

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[2] Because judges tend to reflect the larger society's views, and because the public should also be told the truth about these drugs, another key component of PsychRights strategic campaign is public education.

[3] Drug manufacturers hide negative data regarding their drugs, claiming they are "trade secrets" and not even the Food and Drug Administration (FDA) is provided with this important data. In my most recent representation of Mr. Bigley, I subpoenaed this secret material from the drug manufacturers involved on the grounds that the court can not possibly properly find Mr. Bigley should be drugged against his will for it being in his best interests under *Myers v. Alaska Psychiatric Institute*, 138 P.3d 238 (Alaska 2006) when critical efficacy and safety data is being hidden. These subpoenas became moot when API abandoned its forced drugging petition.

[4] This will be discussed below.

[5] In fact, they fail to present this evidence even though I have given it to them.

situation where the courts are unknowingly ordering massive amounts of harm on society's most vulnerable people.

As mentioned above, PsychRights seeks to mount strategic litigation and selects which cases it will take based on an evaluation of its potential for achieving PsychRights' strategic objectives.[6] It will also only take cases in which it believes it can provide zealous representation through adequate preparation, and presentation to the court, including appropriate motions. This is the context in which this representation hearing is taking place.

In the instant case, when Mr. Bigley implored me to represent him, I decided I was simply not in a position at that time to zealously represent him because of impending deadlines. However, I am prepared to represent Mr. Bigley with respect to the forced drugging petition only upon the considerations and motions which follow.[7]

II. Mr. Bigley's History and Previous Proceedings

(A) Respondent's History

Prior to 1980, Respondent was successful in the community, he had long-term employment in a good job, was married with two daughters.[8]

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[6] Of course, once a case is taken, the client is entitled to zealous representation with respect to all of the client's issues in the case and PsychRights' strategic objectives are subordinated to the client's interests.

[7] Mr. Bigley, of course, is entitled to the lawyer of his choice, if he can obtain such representation.

[8] Appendix 1-8.

In 1980, Respondent's wife divorced him, took his two daughters and saddled him with high child support and house (trailer) payments, resulting in his first hospitalization at the Alaska Psychiatric Institute (API).[9]

When asked at the time what the problem was Respondent said "he had just gotten divorced and consequently had a nervous breakdown."[10] He was cooperative with staff throughout that first admission.[11]

At discharge, his treating psychiatrist indicated that his prognosis was "somewhat guarded depending upon the type of follow- up treatment patient will receive in dealing with his recent divorce."[12]

Instead of giving him help in dealing with his recent divorce and other problems, API's approach was to lock him up and force him to take drugs that, for him at least, do not work, are intolerable, and have harmful mental and physical effects.[13]

This pattern was set by his third admission to API as described in the Discharge Summery for that admission:" The medication seemed not to have noticeable favorable effects throughout the first several hospital weeks, despite the fact that there were a

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[9] Appendix 1.
[10] Appendix 1.
[11] Appendix 5.
[12] Appendix 8.
[13] The Affidavit of Robert Whitaker, the substance of which is set forth below, describes what the scientific research reveals regarding the lack of effectiveness of these drugs for many, if not most, the way they dramatically increase the likelihood of relapses and prevent recovery, and the extreme physical harm caused by these drugs.

variety of unpleasant Extra Pyramidal Symptoms (EPS)."[14] The Discharge Summary of this admission also states:

> On 3/26/81, a judicial hearing determined that there would be granted a 30 day extension during which time treatment efforts would continue, following which there would be a further hearing concerning the possibility of judicial commitment. Mr. Bigley was furiously angry that he was deprived of his right to freedom outside the hospital, but despite his persistent anger and occasional verbal threats, he never became physically assaultive, nor did he abuse limited privileges away from the locked unit.
>
> After the first six hospital weeks he continued to believe that he had some special mission involving Easter Island - drug addicts and alien visitors to the Earth. When these views were gently challenged he became extremely angry, usually walking away from whoever questioned his obviously disordered thoughts.[15]

Twenty-Three years and over Fifty admissions later, the Visitor's Report of May 25, 2004 in his guardianship case, reports, "when hospitalized and on medications, [Respondent's] behaviors don't appear to change much . . . . Hospitalization and psychotropic medication have not helped stabilize him."[16]

On March 23, 2007, at discharge from his 68th admission to API, Dr. Worrall, summarized his condition after having "potentially reached the maximum benefits from hospital care," by which, he has consistently testified solely means forcing Respondent to take psychiatric drugs against his will, that Respondent was "delusional" had "no insight

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[14] Appendix 11. Extra Pyramidal Symptoms, are involuntary movements resulting from the brain damage caused by these drugs. In the early 1980's, the standard of care was that the "therapeutic dose" had been achieved when Extra Pyramidal Symptoms appeared.
[15] Appendix 11.
[16] 3AN-99-1108. The Court may take judicial notice of this and other filings in this and other proceedings. *Drake v. Wickwire*, 795 P.2d 195, n1 (Alaska 1990).

and poor judgment, . . . paranoid and guarded." [17] In other words, even after he had been given the drugs against his will and achieved "maximum benefit" therefrom, he was still "delusional" had "no insight and poor judgment, . . . paranoid and guarded."

Prior to the Alaska Supreme Court's ruling in *Wetherhorn*, API's plan was to have Mr. Bigley continuously on an involuntary commitment under the unconstitutional "gravely disabled" standard definition contained in AS 47.30.915(7)(B), pump him full of long-acting Risperdal Consta, administer other psychotropic drugs, such as Seroquel and Depakote, give him an "Early Release" under AS 47.30.795(a), knowing he would quit them once discharged and then order him returned pursuant to AS 47.30.795(c) when he wasn't drugged to their liking.[18]

The Office of Public Advocacy (OPA) was appointed Mr. Bigley's conservator in 1996 or so in Case No. 3AN-99-1108.

On April 14, 2004, API filed a petition for temporary and permanent guardianship. On June 30, 2004, OPA was appointed Mr. Bigley's temporary full guardian and on December 26, 2004, permanent full guardian.

After being appointed, the Guardian unilaterally, without consultation with Mr. Bigley, decided he should become Medicaid eligible even though Mr. Bigley did not want Medicaid Services.[19]

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[17] Appendix 15.
[18] Tr. 4/3/07:275 (3AN 07-247 PR). This is an illegal use of AS 47.30.795(c) because it only allows an order to return if the outpatient provider "determines" the person is a harm to self or others or gravely disabled.
[19] Tr. 4/3/07:216 *et. seq.* (3AN 07-247 PR).

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Because Mr. Bigley's income was above the Medicaid limit, the Guardian established an irrevocable trust, known as a "Miller Trust," with the Guardian as trustee without discussing this with Mr. Bigley or certainly obtaining his consent.[20]

This removed a substantial percentage of Mr. Bigley's income as available for general financial support.[21] Mr. Bigley is eligible for free medical care as an Alaska Native and doesn't need Medicaid to be eligible for such services.[22]

The Guardian has filed a number of *ex parte* petitions to have Mr. Bigley committed in order to have him forcibly drugged against his will.[23]

This includes "insisting" Respondent is gravely disabled under the "unable to survive safely in freedom" standard recently enunciated in *Wetherhorn v. API*, 156 P.3d 371, 379 (Alaska 2007), when his treating psychiatrist did not believe his survival was in jeopardy as required by *Wetherhorn*.[24]

(B)2007 Involuntary Commitment and Forced Drugging Proceedings

30-Day petitions for commitment and forced drugging were filed on February 23, 2007 under Case No. 3AN-07-274 P/S, a hearing held before the Probate Master on February 27, 2007, and approved by the Superior Court on March 2, 2007.

Mr. Bigley was given an "early release" under AS 47.30.795(a), and then illegally "ordered to return," under AS 47.30.795(c), prior to the expiration of the 30-day

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[20] *Id.*
[21] *Id.*
[22] Tr. 4/3/07:208. (3AN 07-247 PR).
[23] *See*, e.g., Tr. 4/3/07:202 (3AN 07-247 PR).
[24] Appendix 19.

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commitment for not taking Depakote as prescribed.[25] This put Respondent back in API before the expiration of the 30-Day commitment order and on March 21, 2007, a 90-day continuation petition was filed.

On March 22, 2007, PsychRights, which had not represented Respondent at the 30-Day Petition hearing, filed an entry of appearance on behalf of Respondent, electing, among other things, a jury trial.

Respondent won the jury trial when the jury found API had not met its burden of proving Respondent's mental condition would be improved by the course of treatment, and he was released on April 4, 2007.

Yet another 30-day commitment petition was filed on May 14, 2007, and a forced drugging petition on May 15th, both of which were granted. PsychRights did not represent Respondent. In due course, API filed 90-day petitions for commitment and forced drugging petition. PsychRights did not represent Respondent with respect to those petitions, but I testified as a fact witness on his behalf in the public jury trial elected by Respondent. On June 26, 2007, the jury found API had not met its burden of proving Respondent was gravely disabled and he was released.[26]

On August 29, 2007, Mr. Bigley was brought in on an *Ex Parte* Order,[27] and I subsequently filed an entry of appearance on his behalf for the forced drugging petition

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[25] Appendix 20-24. The order to return was illegal because it was based solely on Respondent failing to take Depakote and AS 47.30.795(c) only allows someone to be ordered to return if it is determined, the person is a danger to self or others or gravely disabled.
[26] Appendix 25-26.
[27] 3AN 07-1064PR.

only. I mounted a serious defense and filed for a specific less intrusive alternative which was available, essentially what is presented here, and before the court could consider the less intrusive alternative, API abandoned the forced drugging petition, discharging him to the street knowing full well that he was likely to be arrested because he was bothering Senator Murkowski's staff. This exactly what happened.

Then when I was on an extended trip outside of the State, API filed a new set of involuntary commitment and forced drugging petitions. I came back before the hearing, but did not represent Mr. Bigley and he was involuntarily committed for 30 days and subjected to a forced drugging order, which was subsequently extended for 90 days. Mr. Bigley was then placed in an assisted living home outside of Houston, Alaska, called the "Country Club," which required him to take his prescribed medications. After living there for over a month, he quit taking his medications and left, whereupon he was picked up and delivered to API, which resulted in these proceedings.

(C) CHOICES, Inc.'s Involvement with Respondent.

Paul Cornils of CHOICES, Inc., an independent case management agency, first began working with Respondent Bill Bigley in January of 2007, under contract with PsychRights, but when the cost of services exceeded $5,000 PsychRights said it could not afford to continue paying and Mr. Bigley informed Mr. Cornils he did not want to work with him any more so services were discontinued.[28]

[28] ¶B of Paul Cornils Affidavit.

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CHOICES began working with Mr. Bigley again in July of that year at the request of the Office of Public Advocacy (OPA), Mr. Bigley's Guardian, and has continued to do so.[29]

According to Mr. Cornils, Respondent is so angry at being put under a guardianship that he takes extreme measures to try to get rid of his guardianship, and as a result, he is mostly refusing to cooperate in virtually any way with the Guardian.[30]

Mr. Cornils cites as an example that Respondent rips up checks from the Guardian made out to Vendors on his behalf, trying to force the Guardian to give him his money directly and as part of his effort to eliminate the guardianship.[31]

According to Mr. Cornils, Respondent has also refused various offers of "help" from the Guardian, such as grocery shopping in a similar attempt to get out from under the guardianship.[32]

Mr. Cornils further testified that Respondent exhibits the same types of behavior to him, but CHOICES/Mr. Cornils have a different approach, which involves negotiation and discussion, does not involve coercion and where the natural consequences of Respondent's actions are allowed to occur.[33]

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[29] ¶C of Paul Cornils Affidavit.
[30] ¶D of Paul Cornils Affidavit.
[31] ¶E of Paul Cornils Affidavit.
[32] ¶F of Paul Cornils Affidavit.
[33] ¶G of Paul Cornils Affidavit.

(D) 2006/2007 Guardianship Proceedings

In late November, 2006, I was invited to subpoena documents pursuant to a protective order in the *Zyprexa Products Liability Litigation*,[34] that had been culled from some 15 million pages of documents produced by Eli Lilly, the manufacturer, by an expert retained in that case. Getting such information legally out to the public would advance PsychRights strategic goals so I looked for an appropriate case from which to subpoena the documents. On December 5, 2006, I met with Mr. Bigley at API and determined his was a suitable case.[35]

On December 6, 2006, I filed a petition in the guardianship proceeding, Case No. 3AN 04-545 PG, to:

(1) Terminate the Guardianship.

(2) Remove the Guardian and appoint a successor of Respondent's choice.

(3) Amend the powers of the Guardian under the Guardianship Plan to the least restrictive necessary to meet Respondent's essential requirements for physical health and safety.

(4) Review and reverse the decision of the guardian to consent to the administration of psychotropic medication against the wishes of Respondent.

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[34] MDL 1596, United States District Court for the Eastern District of New York.

[35] Great consternation has ensued over my subpoenaing and releasing these documents to the New York Times and other persons, but I am not otherwise addressing it here. However, all of the court documents and related material are available on the Internet at http://psychrights.org/States/Alaska/CaseXX.htm. Because of how much Zyprexa is prescribed, I was pretty sure when I subpoenaed the documents that Mr. Bigley had been prescribed it pursuant to a forced drugging order. He had. Appendix 28. He was also later "taken down" with a Zypexa injection, in what is known as an "IM Backup." Appendix 29. To me the opportunity to subpoena an expert who had already combed the documents and could testify to them was "low hanging fruit." In contrast, I think it is fair to characterize Eli Lilly's view of how the events ended up transpiring as a "drive by shooting."

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(5) Amend the powers of the Guardian to eliminate the authority to consent to mental health treatment.

After numerous proceedings, this resulted in a settlement agreement on July 20, 2007, which (a) established some parameters for the administration of the guardianship and (b) provided Respondent with a clear path towards terminating his guardianship (Guardianship Settlement Agreement). As relevant here, the Guardianship Settlement Agreement provides:

> 4.2. Increase of Discretionary Funds. It is recognized the amounts available for food and spending money (Discretionary Funds) are low and efforts will be made to find housing acceptable to Respondent which will increase the amount of Discretionary Funds. To that end, the Guardian shall make its best efforts to obtain subsidized housing for Respondent that will allow an increase in Respondent's Discretionary Funds. ...
>
> 6. Mental Health Services. Respondent has largely been unwilling to accept mental health services. Some services that Respondent may hereafter, from time to time, desire are identified in the subsections that follow. Others may be identified later. To the extent Respondent, from time to time, desires such services, the Guardian and API will support the provision of such services, including taking such steps as may be required of them to facilitate the acquisition thereof to the best of their ability.[36]
>
> 6.2. Extended Services. Extended services, such as Case Management, Rehabilitation, Socialization, Chores, etc., beyond the standard limits for such services.
>
> 6.3. Other Services. Additional "wrap-around" or other types of services Respondent, from time to time, desires.
>
> 7. Involuntary Commitment Proceedings. The Guardian will make a good faith effort to (a) avoid filing any initiation of involuntary commitment petitions against Respondent under AS 47.30.700. In making such efforts,

[36] A footnote here, states: "By agreeing to this stipulation API is not making any judgment regarding eligibility standards under Medicaid regulations."

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the Guardian will explore all available alternatives, including notifying and requesting the assistance of Respondent's counsel herein, James B. Gottstein.

7.2. Unless the Guardian determines it is highly probable that serious illness, injury or death is imminent, in the event the Guardian believes a petition to initiate involuntary commitment might be warranted, rather than the Guardian filing such a petition, the Guardian shall relay its concerns to another appropriate party for evaluation. Without in any way limiting the generality of the foregoing, appropriate parties, might be Respondent's outpatient provider, if any; other people working with him; or other people who know him.

8. Psychotropic Medications. API shall not accept a consent by the Guardian to the administration of psychotropic medication, while Respondent is committed to API to which Respondent objects.

III. Substantive and Procedural Matters

The core holding of the Alaska Supreme Court in *Myers* is:

> [A] court may not permit a treatment facility to administer psychotropic drugs unless the court makes findings that comply with all applicable statutory requirements and, in addition, expressly finds by clear and convincing evidence that the proposed treatment is in the patient's *best interests* and that *no less intrusive alternative is available*.[37]

(A) Best Interests

In addressing the required *Myers* requirements, API must rebut the following, which is taken from the Affidavit of Robert Whitaker filed in the forced drugging proceeding API abandoned last September, a certified copy of which is filed herewith.[38]

> **II. Overview of Research Literature on Schizophrenia and Standard Antipsychotic Medication**
>
> 5. Although the public has often been told that people with schizophrenia suffer from too much "dopamine" in the brain, researchers who investigated this hypothesis during the 1970s and 1980s were unable to find evidence

[37] 38 P.3d at 254, emphasis added.
[38] 3AN 08-1064PR

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that people so diagnosed have, in fact, overactive dopamine systems. Within the psychiatric research community, this was widely acknowledged in the late 1980s and early 1990s. As Pierre Deniker, who was one of the founding fathers of psychopharmacology, confessed in 1990: "The dopaminergic theory of schizophrenia retains little credibility for psychiatrists."[39]

6. Since people with schizophrenia have no known "chemical imbalance" in the brain, antipsychotic drugs cannot be said to work by "balancing" brain chemistry. These drugs are not like "insulin for diabetes." They do not serve as a corrective to a known biological abnormality. Instead, Thorazine and other standard antipsychotics (also known as neuroleptics) work by powerfully blocking dopamine transmission in the brain. Specifically, these drugs block 70% to 90% of a particular group of dopamine receptors known as D2 receptors. This thwarting of normal dopamine transmission is what causes the drugs to be so problematic in terms of their side effects.

8. Psychiatry's belief in the necessity of using the drugs on a continual basis stems from two types of studies.

a) First, research by the NIMH has shown that the drugs are more effective than placebo in curbing psychotic symptoms over the short term (six weeks).[40]

b) Second, researchers have found that if patients abruptly quit taking antipsychotic medications, they are at high risk of relapsing. [41]

9. Although the studies cited above provide a rationale for continual drug use, there is a long line of evidence in the research literature, one that is not generally known by the public or even by most psychiatrists, that shows that these drugs, over time, produce these results:

a) They increase the likelihood that a person will become chronically ill.
b) They cause a host of debilitating side effects.
c) They lead to early death.

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[39] Deniker, P. "The neuroleptics: a historical survey." *Acta Psychiatrica Scandinavica* 82, supplement 358 (1990):83-87.
[40] Cole, J, et al. "Phenothiazine treatment in acute schizophrenia." *Archives of General Psychiatry* 10 (1964):246-61.
[41] Gilbert, P, et al. "Neuroleptic withdrawal in schizophrenic patients." *Archives of General Psychiatry* 52 (1995):173-188.

III. Evidence Revealing Increased Chronicity of Psychotic Symptoms

10. In the early 1960s, the NIMH conducted a six-week study of 344 patients at nine hospitals that documented the efficacy of antipsychotics in knocking down psychosis over a short term. (See footnote five, above). The drug-treated patients fared better than the placebo patients over the short term. However, when the NIMH investigators followed up on the patients one year later, they found, much to their surprise, that it was the drug-treated patients who were more likely to have relapsed/ This was the first evidence of a paradox: Drugs that were effective in curbing psychosis over the short term were making patients more likely to become psychotic over the long term.[42]

11. In the 1970s, the NIMH conducted three studies that compared antipsychotic treatment with "environmental" care that minimized use of the drugs. In each instance, patients treated without drugs did better over the long term than those treated in a conventional manner.[43, 44, 45] Those findings led NIMH scientist William Carpenter to conclude that "antipsychotic medication may make some schizophrenic patients more vulnerable to future relapse than would be the case in the natural course of the illness."

12. In the 1970s, two physicians at McGill University, Guy Chouinard and Barry Jones, offered a biological explanation for why this is so. The brain responds to neuroleptics and their blocking of dopamine receptors as though they are a pathological insult. To compensate, dopaminergic brain cells increase the density of their D2 receptors by 40% or more. The brain is now "supersensitive" to dopamine, and as a result, the person has become more *biologically* vulnerable to psychosis than he or she would be naturally. The two Canadian researchers wrote: "Neuroleptics can produce a dopamine supersensitivity that leads to both dyskinetic and psychotic symptoms. An implication is that the tendency toward psychotic relapse in

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[42] Schooler, N, et al. "One year after discharge: community adjustment of schizophrenic patients." *American Journal of Psychiatry* 123 (1967):986-95.

[43] Rappaport, M, et al. "Are there schizophrenics for whom drugs may be unnecessary or contraindicated?" *Int Pharmacopsychiatry* 13 (1978):100-11.

[44] Carpenter, W, et al. "The treatment of acute schizophrenia without drugs." *American Journal of Psychiatry* 134 (1977):14-20.

[45] Bola J, et al. "Treatment of acute psychosis without neuroleptics: two-year outcomes from the Soteria project." *Journal of Nervous Mental Disease* 191 (2003):219-29.

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a patient who had developed such a supersensitivity is determined by more than just the normal course of the illness. [46]

13. MRI-imaging studies have powerfully confirmed this hypothesis. During the 1990s, several research teams reported that antipsychotic drugs cause atrophy of the cerebral cortex and an enlargement of the basal ganglia.[47, 48, 49] In 1998, investigators at the University of Pennsylvania reported that the drug-induced enlargement of the basal ganglia is "associated with greater severity of both negative and positive symptoms." In other words, they found that the drugs cause morphological changes in the brain that are associated with a worsening of the very symptoms the drugs are supposed to alleviate.[50]

IV. Research Showing that Recovery Rates are Higher for Non-Medicated Patients than for Medicated Patients.

14. The studies cited above show that the drugs increase the chronicity of psychotic symptoms over the long term. There are also now a number of studies documenting that long-term recovery rates are much higher for patients off antipsychotic medications. Specifically:

a) In 1994, Courtenay Harding at Boston University reported on the long-term outcomes of 82 chronic schizophrenics discharged from Vermont State Hospital in the late 1950s. She found that one-third of this cohort had recovered completely, and that all who did shared one characteristic: They had all stopped taking antipsychotic medication.

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[46] Chouinard, G, et al. "Neuroleptic-induced supersensitivity psychosis." *American Journal of Psychiatry* 135 (1978):1409-10. Also see Chouinard, G, et al. "Neuroleptic-induced supersensitivity psychosis: clinical and pharmacologic characteristics." *American Journal of Psychiatry* 137(1980):16-20.

[47] Gur, R, et al. "A follow-up magnetic resonance imaging study of schizophrenia." *Archives of General Psychiatry* 55 (1998):142-152.

[48] Chakos M, et al. "Increase in caudate nuclei volumes of first-episode schizophrenic patients taking antipsychotic drugs." *American Journal of Psychiatry* 151 (1994):1430-6.

[49] Madsen A, et al. "Neuroleptics in progressive structural brain abnormalities in psychiatric illness." *The Lancet* 352 (1998): 784-5.

[50] Gur, R, et al. "Subcortical MRI volumes in neuroleptic-naive and treated patients with schizophrenia." *American Journal of Psychiatry* 155 (1998):1711-17.

The notion that schizophrenics needed to stay on antipsychotics all their lives was a "myth," Harding said.[51, 52, 53]

b) In the World Health Organization studies, 63% of patients in the poor countries had good outcomes, and only one-third became chronically ill. In the U.S. countries and other developed countries, only 37% of patients had good outcomes, and the remaining patients did not fare so well. In the undeveloped countries, only 16% of patients were regularly maintained on antipsychotics, versus 61% of patients in the developed countries.

c) In response to this body of literature, physicians in Switzerland, Sweden and Finland have developed programs that involve minimizing use of antipsychotic drugs, and they are reporting much better results than what we see in the United States.[54, 55, 56, 57] In particular, Jaako Seikkula recently reported that five years after initial diagnosis, 82% of his psychotic patients are symptom-free, 86% have returned to their jobs or to school, and only 14% of his patients are on antipsychotic medications.[58]

d) This spring, researchers at the University of Illinois Medical School reported on the long-term outcomes of schizophrenia patients in the Chicago area since 1990. They found that 40% of those who refused to take their antipsychotic medications were recovered at five-year and

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[51] Harding, C. "The Vermont longitudinal study of persons with severe mental illness," *American Journal of Psychiatry* 144 (1987):727-34.
[52] Harding, C. "Empirical correction of seven myths about schizophrenia with implications for treatment." *Acta Psychiatrica Scandinavica* 90, suppl. 384 (1994):140-6.
[53] McGuire, P. "New hope for people with schizophrenia," *APA Monitor* 31 (February 2000).
[54] Ciompi, L, et al. "The pilot project Soteria Berne." *British Journal of Psychiatry* 161, supplement 18 (1992):145-53.
[55] Cullberg J. "Integrating psychosocial therapy and low dose medical treatment in a total material of first-episode psychotic patients compared to treatment as usual." *Medical Archives* 53 (199):167-70.
[56] Cullberg J. "One-year outcome in first episode psychosis patients in the Swedish Parachute Project. *Acta Psychiatrica Scandinavica* 106 (2002):276-85.
[57] Lehtinen V, et al. "Two-year outcome in first-episode psychosis according to an integrated model. *European Psychiatry* 15 (2000):312-320.
[58] Seikkula J, et al. Five-year experience of first-episode nonaffective psychosis in open-dialogue approach. *Psychotherapy Research* 16/2 (2006): 214-228.

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15-year followup exams, versus five percent of the medicated patients.[59]

V. Harmful Side Effects from Antipsychotic Medications

15. In addition to making patients chronically ill, standard antipsychotics cause a wide range of debilitating side effects. Specifically:

a) Tardive dyskinesia. The most visible sign of tardive dyskinesia is a rhythmic movement of the tongue, which is the result of permanent damage to the basal ganglia, which controls motor movement. People suffering from tardive dyskinesia may have trouble walking, sitting still, eating, and speaking. In addition, people with tardive dyskinesia show accelerated cognitive decline. NIMH researcher George Crane said that tardive dyskinesia resembles "in every respect known neurological diseases, such as Huntington's disease, dystonia musculorum deformans, and postencephalitic brain damage."[60] Tardive dyskinesia appears in five percent of patients treated with standard neuroleptics in one year, with the percentage so afflicted increasing an additional five percent with each additional year of exposure.

b) Akathisia. This is an inner restlessness and anxiety that many patients describe as the worst sort of torment. This side effect has been linked to assaultive, murderous behavior.[61, 62, 63, 64, 65]

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[59] Harrow M, et al. "Factors involved in outcome and recovery in schizophrenia patients not on antipsychotic medications." *Journal of Nervous and Mental Disease* 195 (2007): 406-414.

[60] Crane, G. "Clinical psychopharmacology in its 20th year," *Science* 181 (1973):124-128. Also see American Psychiatric Association, *Tardive Dyskinesia: A Task Force Report* (1992).

[61] Shear, K et al. "Suicide associated with akathisia and deport fluphenazine treatment," *Journal of Clinical Psychopharmacology* 3 (1982):235-6.

[62] Van Putten, T. "Behavioral toxicity of antipsychotic drugs." *Journal of Clinical Psychiatry* 48 (1987):13-19.

[63] Van Putten, T. "The many faces of akathisia," *Comprehensive Psychiatry* 16 91975):43-46.

[64] Herrera, J. "High-potency neuroleptics and violence in schizophrenia," *Journal of Nervous and Mental Disease* 176 (1988):558-561.

[65] Galynker, I. "Akathisia as violence." *Journal of Clinical Psychiatry* 58 (1997):16-24.

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c) Emotional impairment. Many patients describe feeling like "zombies" on the drugs. In 1979, UCLA psychiatrist Theodore van Putten reported that most patients on antipsychotics were spending their lives in "virtual solitude, either staring vacantly at television, or wandering aimlessly around the neighborhood, sometimes stopping for a nap on a lawn or a park bench . . . they are bland, passive, lack initiative, have blunted affect, make short, laconic replies to direct questions, and do not volunteer symptoms . . . there is a lack not only of interaction and initiative, but of any activity whatsoever.[66] The quality of life on conventional neuroleptics, researchers agreed, is "very poor." [67]

d) Cognitive impairment. Various studies have found that neuroleptics reduce one's capacity to learn and retain information. As Duke University scientist Richard Keefe said in 1999, these drugs may "actually prevent adequate learning effects and worsen motor skills, memory function, and executive abilities, such as problem solving and performance assessment."[68]

d) Other side effects of standard neuroleptics include an increased incidence of blindness, fatal blood clots, arrhythmia, heat stroke, swollen breasts, leaking breasts, obesity, sexual dysfunction, skin rashes and seizures, and early death.[69, 70, 71] Schizophrenia patients now commit suicide at 20 times the rate they did prior to the use of neuroleptics.[72]

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[66] Van Putten, T. "The board and care home." *Hospital and Community Psychiatry* 30 (1979):461-464.

[67] Weiden P. "Atypical antipsychotic drugs and long-term outcome in schizophrenia." *Journal of Clinical Psychiatry* 57, supplement 11 (1996):53-60.

[68] Keefe, R. "Do novel antipsychotics improve cognition?" *Psychiatric Annals* 29 (1999):623-629.

[69] Arana, G. "An overview of side effects caused by typical antipsychotics." *Journal of Clinical Psychiatry* 61, supplement 8 (2000):5-13.

[70] Waddington, J. "Mortality in schizophrenia." *British Journal of Psychiatry* 173 (1998):325-329.

[71] Joukamaa, M, et al. Schizophrenia, neuroleptic medication and mortality. *British Journal of Psychiatry* 188 (2006):122-127.

[72] Healy, D et al. "Lifetime suicide rates in treated schizophrenia." *British Journal of Psychiatry* 188 (2006):223-228.

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VI. The Research Literature on Atypical Antipsychotics

16. The conventional wisdom today is that the "atypical" antipsychotics that have been brought to market—Risperdal, Zyprexa, and Seroquel, to name three—are much better and safer than Haldol, Thorazine and the other older drugs. However, it is now clear that the new drugs have no such advantage, and there is even evidence suggesting that they are worse than the old ones.

17. Risperdal, which is manufactured by Janssen, was approved in 1994. Although it was hailed in the press as a "breakthrough "medication, the FDA, in its review of the clinical trial data, concluded that there was no evidence that this drug was better or safer than Haldol (haloperidol.) The FDA told Janssen: "We would consider any advertisement or promotion labeling for RISPERDAL false, misleading, or lacking fair balance under section 501 (a) and 502 (n) of the ACT if there is presentation of data that conveys the impression that risperidone is superior to haloperidol or any other marketed antipsychotic drug product with regard to safety or effectiveness."[73]

18. After Risperdal (risperidone) was approved, physicians who weren't funded by Janssen were able were able to conduct independent studies of the drug. They concluded that risperidone, in comparison to Haldol, caused a higher incidence of Parkinsonian symptoms; that it was more likely to stir akathisia; and that many patients had to quit taking the drug because it didn't knock down their psychotic symptoms.[74, 75, 76, 77, 78] Jeffrey Mattes, director of the Psychopharmacology Research Association, concluded in 1997: "It is possible, based on the available studies, that risperidone is not

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[73] FDA approval letter from Robert Temple to Janssen Research Foundation, December 21, 1993.
[74] Rosebush, P. "Neurologic side effects in neuroleptic-naïve patients treated with haloperidol or risperidone." *Neurology* 52 (1999):782-785.
[75] Knable, M. "Extrapyramidal side effects with risperidone and haloperidol at comparable D2 receptor levels." *Psychiatry Research: Neuroimaging Section* 75 (1997):91-101.
[76] Sweeney, J. "Adverse effects of risperidone on eye movement activity." *Neuropsychopharmacology* 16 (1997):217-228.
[77] Carter, C. "Risperidone use in a teaching hospital during its first year after market approval." *Psychopharmacology Bulletin* 31 (1995):719-725.
[78] Binder, R. "A naturalistic study of clinical use of risperidone." *Psychiatric Services* 49 (1998):524-6.

as effective as standard neuroleptics for typical positive symptoms."[79] Letters also poured into medical journals linking risperidone to neuroleptic malignant syndrome, tardive dyskinesia, tardive dystonia, liver toxicity, mania, and an unusual disorder of the mouth called "rabbit syndrome."

19. Zyprexa, which is manufactured by Eli Lilly, was approved by the FDA in 1996. This drug, the public was told, worked in a more "comprehensive" manner than either risperidone or haloperidol, and was much "safer and more effective" than the standard neuroleptics. However, the FDA, in its review of the trial data for Zyprexa, noted that Eli Lilly had designed its studies in ways that were "biased against haloperidol." In fact, 20 of the 2500 patients treated with Zyprexa in the trials died. Twenty-two percent of the Zyprexa patients suffered a "serious" adverse event, compared to 18 percent of the Haldol patients. There was also evidence that Zyprexa caused some sort of metabolic dysfunction, as patients gained nearly a pound per week. Other problems that showed up in Zyprexa patients included Parkinsonian symptoms, akathisia, dystonia, hypotension, constipation, tachycardia, seizures, liver abnormalities, white blood cell disorders, and diabetic complications. Moreover, two-thirds of the Zyprexa patients were unable to complete the trials either because the drugs didn't work or because of intolerable side effects.[80]

20. There is now increasing recognition in scientific circles that the atypical antipsychotics are no better than the old drugs, and may in fact be worse. Specifically:

a) In 2000, a team of English researchers led by John Geddes at the University of Oxford reviewed results from 52 studies, involving 12,649 patients. They concluded: "There is no clear evidence that atypicals are more effective or are better tolerated than conventional antipsychotics." The English researchers noted that Janssen, Eli Lilly and other manufacturers of atypicals had used various ruses in their clinical trials to make their new drugs look better than the old ones. In particular, the drug companies had used "excessive doses of the comparator drug."[81]

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[79] Mattes, J. "Risperidone: How good is the evidence for efficacy?" *Schizophrenia Bulletin* 23 (1997):155-161.
[80] See Whitaker, R. *Mad in America*. New York: Perseus Press (2002):279-281.
[81] Geddes, J. "Atypical antipsychotics in the treatment of schizophrenia." *British Medical Journal* 321 (2000):1371-76.

b) In 2005, a National Institute of Mental Health study found that that were "no significant differences" between the old drugs and the atypicals in terms of their efficacy or how well patients tolerated them. Seventy-five percent of the 1432 patients in the study were unable to stay on antipsychotics owing to the drugs' "inefficacy or intolerable side effects," or for other reasons.[82]

c) In 2007, a study by the British government found that schizophrenia patients had better "quality of life" on the old drugs than on the new ones.[83] This finding was quite startling given that researchers had previously determined that patients medicated with the old drugs had a "very poor" quality of life.

20. There is also growing evidence that the atypicals may be exacerbating the problem of early death. Although the atypicals may not clamp down on dopamine transmission quite as powerfully as the old standard neuroleptics, they also block a number of other neurotransmitter systems, most notably serotonin and glutamate. As a result, they may cause a broader range of physical ailments, with diabetes and metabolic dysfunction particularly common for patients treated with Zyprexa. In a 2003 study of Irish patients, 25 of 72 patients (35%) died over a period of 7.5 years, leading the researchers to conclude that the risk of death for schizophrenics had "doubled" since the introduction of the atypical antipsychotics.[84]

VII. Conclusion

21. In summary, the research literature reveals the following:

a) Antipsychotics increase the likelihood that a person will become chronically ill.

b) Long-term recovery rates are much higher for unmedicated patients than for those who are maintained on antipsychotic drugs.

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[82] Lieberman, J, et al. "Effectiveness of antipsychotic drugs in patients with schizophrenia." *New England Journal of Medicine* 353 (2005):1209-1233.
[83] Davies, L, et al. "Cost-effectiveness of first- v. second-generation antipsychotic drugs." *The British Journal of Psychiatry* 191 (2007):14-22.
[84] Morgan, M, et al. "Prospective analysis of premature morbidity in schizophrenia in relation to health service engagement." *Psychiatry Research* 117 (2003):127-35.

c) Antipsychotics cause a host of debilitating physical, emotional and cognitive side effects, and lead to early death.

d) The new "atypical" antipsychotics are not better than the old ones in terms of their safety and tolerability, and quality of life may even be worse on the new drugs than on the old ones.

The foregoing makes clear that the continued forced drugging of Mr. Bigley is not in his best interests.

(B)There is a Less Intrusive Alternative Available

Mr. Whitaker's Affidavit discusses successful less intrusive alternatives. In addition, the affidavit of Ronald Bassman, PhD filed in the same case, a certified copy of which is filed herewith, testifies to less intrusive alternatives, and included citations to the scientific literature. In particular, Dr. Bassman testifies:

> In the above concepts promoting recovery there is a conspicuous absence of psychiatric medication. Psychologist Courtenay Harding, principal researcher of the "Vermont Longitudinal Study," has empirically demonstrated that people do recover from long-term chronic disorders such as schizophrenia at a minimum rate of 32 % and as high as 60%. These studies have consistently found that half to two thirds of patients significantly improved or recovered, including some cohorts of very chronic cases. The 32 % for full recovery is with one of the five criteria being *no longer taking any psychiatric medication*. Dr. Harding in delineating the seven myths of schizophrenia, addresses the myth about psychiatric medication. Myth number 5. Myth: Patients must be on medication all their lives. Reality: It may be a small percentage who need medication indefinitely. According to Harding and Zahniser, the myths limit the scope and effectiveness of treatments available to patients.

(citations omitted, italics in original, underlining added)

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Sarah Porter, who happened to be in Anchorage, was qualified as an expert in the area of alternative treatments and testified to the following:[85]

> A. I've worked in the mental health [field] in New Zealand for the last 15 years in a variety of roles. I'm currently employed as a strategic advisor by the Capital and Coast District Health Board. I'm currently doing a course of study called the Advanced Leadership and Management in Mental Health Program in New Zealand. And, in fact, the reason I'm here is, I won a scholarship through that program to study innovative programs that are going on in other parts of the world so that I could bring some of that information back to New Zealand. I also have personal experience of using mental health services which dates back to 1976 when I was a relatively young child. . . . set up and run a program in New Zealand which operates as an alternative to acute mental health services. It's called the KEYWA Program. That's spelled K-E-Y-W-A. Because it was developed and designed to operate as an alternative to the hospital program that currently is provided in New Zealand. That's been operating since December last year, so it's a relatively new program, but our outcomes to date have been outstanding, and the funding body that provided with the resources to do the program is extremely excited about the results that we've been able to achieve, with people receiving the service and helping us to assist and [starting] out more similar programs in New Zealand.
>
> Q You're a member of the organization called INTAR, is that correct?
>
> A I am a member of INTAR, which is the International Network of Treatment Alternatives for Recovery. And I'm also a member of the New Zealand Mental Health Foundation, which is an organization in New Zealand that's charged with the responsibility for promotion of mental health and prevention of mental disability in New Zealand.
>
> Q Okay. Are there -- can you describe a little bit what INTAR is about?
>
> A INTAR is an international network of people who are interested in promoting the knowledge about, and availability of access to alternatives to traditional and mainstream approaches to treating mental distress. And INTAR is really interested in identifying successful methods of working with people experiencing distress to promote mental well being, and, in particular,

[85] Tr. 9/5/2007:73-81.

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alternatives to the use of mainstream medical model or medication type treatments.

Q And are there people in INTAR that are actually running those kind of programs?

A There are. There's a wide variety of people doing that. And some of them are, also, themselves, interestingly, have backgrounds in psychiatry and psychology.

Q . . . Are there members of INTAR who are psychiatrists?

A There are. Indeed. Yes, indeed.

Q Do you know -- do you remember any of their names?

A Dr. Peter Stastny is a psychiatrist, Dr. Pat [Bracken], who manages the mental health services in West Cork, Ireland, and also in parts of England, as a psychiatrist. . .

Q Okay. Is it fair to say that all these people believe that there should be other methods of treating people who are diagnosed with mental illness than insisting on medication?

A Absolutely, there are. And that's quite a strong theme, in fact, for -- for that group, and I believe that it's based on the fact that there is now growing recognition that medication is not a satisfactory answer for a significant proportion of the people who experience mental distress, and that for some people...it creates more problems than solutions. . . .

Q. Now, I believe you testified that you have experience dealing with those sorts of people as well, is that correct?

A I do.

Q And would that include someone who has been in the system for a long time, who is on and off drugs, and who might refuse them?

A Yes. Absolutely. We've worked with people in our services across the spectrum. People who have had long term experience of using services and others for whom it's their first presentation.

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Q And when you say "long term use of services," does that include -- does that mean they need medication?

A Unfortunately, in New Zealand the primary form of treatment, until very recent times, has been medication, through the lack of alternatives. . . . And we're just now beginning to develop alternatives. They'd offer people real choice and options in terms of what is available instead of medication that might enable people to further address the issues which are raised by the concerns related to their mental state.

Q And I think I understood you to say that the program that you run along that line has had very good outcomes, is that correct?

A It has. The outcomes to date have been outstanding. The feedback from services users and from other people working with the services -- both, peoples families and the clinical personnel working with those people has supported the approach that we have taken.

Q And is -- and I think you said that, in fact, it's been so impressive that the government is looking at expanding that program with more funding?

A Indeed. And, in fact, right across New Zealand they are now looking at what can be done to create -- make resources available to set up...more such services in New Zealand. . .

Q Is there a philosophy that you might describe in terms of how -- that would go along with this kind of alternative approach?

A The way that I would describe that is that it's -- it's really about relationships. It's about building a good therapeutic relationship with the person in distress and supporting that person to recognize and come to terms with the issues that are going on in their life, in such a way that builds a therapeutic alliance and is based on negotiation, rather than the use of force or coercion, primarily...

A ...because we recognize that the use of force and coercion actually undermines the therapeutic relationship and decreases the likelihood of compliance in the long term with whatever kinds of treatment or support has been implicated for the person. So we have created and set up our service along the lines of making relationship and negotiation the primary basis for working with the person and supporting the person to reflect on and reconsider what's going on to create what might be defined as a crisis, and to

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devise strategies and plans for how the person might be with the issues and challenges that they face in their life. . . .

Q Now, you mentioned -- I think you said that coercion creates problems. Could you describe those kind of problems?

A Well, that's really about the fact that [there is] growing recognition -- I think worldwide, but particularly in New Zealand, that coercion, itself, creates trauma and further distress for the person, and that that, in itself, actually undermines the benefits of the treatment that is being provided in a forced context. And so our aiming and teaching is to be able to support the person to resolve the issues without actually having to trample...on the person's autonomy, or hound them physically or emotionally in doing so.

Q And I think you testified that would be --include people who have been in the system for a long time, right?

A It does, indeed. Yes.

Q And would that include people who have been coerced for a long time?

A In many cases, yes. . . .

Q And -- and have you seen success in that approach?

A We have. It's been phenomenal, actually. Jim, I've been -- personally, I -- I had high hopes that it would work, but I've...been really impressed how well, in fact, it has worked.

The affidavit of Paul Comils, a certified copy of which is filed herewith shows a less intrusive alternative is available.

It is expected Mr. Whitaker, Ms. Porter and Dr. Bassman can be available for further testimony and cross-examination by telephone and Paul Comils in person.

API may not avoid its obligation to provide a less intrusive alternative by choosing to not make it available. *Wyatt v. Stickney*, 344 F.Supp. 387, 392 (M.D.Ala.1972) ("no default can be justified by a want of operating funds."), affirmed, *Wyatt v. Anderholt*, 503

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F.2d 1305, 1315 (5th Cir. 1974)(state legislature is not free to provide social service in a way that denies constitutional right). In *Wyatt* the federal courts required the State of Alabama to spend funds in specific ways to provide constitutionally adequate services.

Having invoked its awesome power to confine Respondent and having sought to exercise its similarly awesome power to forcibly medicate him against his will "for his own good," Respondent's constitutional right to a less intrusive alternative has sprung into being. This is what *Myers* holds. *Wyatt* holds that API may not avoid its obligation to do so merely by choosing not to provide the less intrusive alternative, *i.e.*, providing a social service that denies Respondent's right to a less intrusive alternative.

Neither should API be allowed to again discharge its obligation to provide a less intrusive alternative by discharging Mr. Bigley from the hospital so it can pick him up at a later point when PsychRights is not available to represent him.

IV. Procedural Issues

In addition to the substantive issues of *best interests* and *less intrusive alternative*, there are a some procedural issues which are hereby raised at this time.

(A) Objection to Referral to the Probate Master.

First, Mr. Bigley objects to the referral of the forced drugging petition to the Probate Master pursuant to Probate Rule 2(c). There are many reasons why the referral to the Probate Master should not be maintained.

(1) Objections to an Unfavorable Recommendation Will Be Filed

For the substantive reasons that (i) the forced drugging is not in Mr. Bigley's best interests, and (ii) there is a less intrusive alternative available, objections under Probate

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Rule 2(f) will be filed to an unfavorable recommendation. Mr. Bigley respectfully suggests both practicality and the Superior Court taking its obligations to consider both of these *Myers* requirements seriously, dictate that it handle the case directly.

(2) Probate Rule 2(b)(3)(D) is Invalid

Another reason why the referral to the Probate Master should not be maintained is that Probate Rule 2(b)(3)(D), providing that the master's recommendation to grant the forced drugging petition is effective pending superior court review is invalid.

In *Myers v. Alaska Psychiatric Institute*, 138 P.3d 238, 254 (Alaska 2006), the Alaska Supreme Court held:

> [A] *court* may not permit a treatment facility to administer psychotropic drugs unless the *court* makes findings that comply with all applicable statutory requirements and, in addition, expressly finds by clear and convincing evidence that the proposed treatment is in the patient's best interests and that no less intrusive alternative is available.

(emphasis added).

Probate Rule 2(b)(3)(D) making the Probate Master's recommendation to approve the forced drugging petition effective before Superior Court approval is therefore invalid.

In *Wetherhorn v. Alaska Psychiatric Institute*, 156 P.3d 371, 381 (Alaska 2007), the Alaska Supreme Court held:

> The expedited process required for involuntary commitment proceedings is aimed at mitigating the infringement of the respondent's liberty rights that begins the moment the respondent is detained involuntarily. In contrast, so long as no drugs have been administered, the rights to liberty and privacy implicated by the right to refuse psychotropic medications remain intact. Therefore, in the absence of an emergency, there is no reason why the statutory protections should be neglected in the interests of speed.

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Probate Rule 2(b)(3)(D) impermissibly dispenses with statutory protections as well as the constitutional protections *Wetherhorn* requires.[86] Because these proceedings are normally conducted in a *pro forma* manner, with respondents immediately forcibly drugged, which the Alaska Supreme Court has equated with electroshock and lobotomy,[87] without a meaningful opportunity to present a defense, and before even the Superior Court has approved it, as required by Alaska Statutes, let alone given a chance for Supreme Court review, Mr. Bigley feels he must make his objection to the employment of Probate Rule 2(b)(3)(D) prophylactically now in the event the referral to the Probate Master is maintained and he recommends approval of the forced drugging petition.

If the referral to the Probate Master is maintained, and the Probate Master recommends granting the forced drugging petition, in the alternative, Mr. Bigley prophylactically moves for a stay pursuant to Probate Rule 2(f)(2), pending Superior Court review.

In the alternative to that, Mr. Bigley prophylactically moves for a one week stay to seek relief in the Supreme Court. This motion is supported by the foregoing discussion and evidence regarding best interests and a less intrusive alternative.

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[86] Moreover, because Probate Rule 2(b)(3)(D) only makes the Probate Master's determinations as to capacity to give informed consent effective pending Superior Court Review and does not make the Probate Master's recommendations as to best interests and less intrusive alternatives required by *Myers* effective pending Superior Court review, it does not authorize the hospital to forcibly drug Respondent before Superior Court review after *Myers*.

[87] *See*, *Myers* 138 P3d at 242; *Wetherhorn*, 156 P.3d at 382.

(3) Civil Rule 53(d)(1)'s Requirement of a Transcript is Violated As a Matter of Course

Civil Rule 53(d)(1) requires a transcript accompany the Probate Master's report. This requirement is routinely ignored. Mr. Bigley is entitled to have this rule followed and referral should not be maintained when this Court expects the Probate Master to violate the rule.[88]

(B)The Forced Drugging Petition is Premature

In *Myers v. Alaska Psychiatric Institute,* the Alaska Supreme Court explained involuntary commitments and forced drugging involve two separate steps:[89]

> To treat an unwilling and involuntarily *committed mental patient* with psychotropic medication, the state must initiate the second step of the process by filing a second petition, asking the court to approve the treatment it proposes to give.

This was reiterated in *Wetherhorn v. Alaska Psychiatric Institute,*[90]:

> Unlike involuntary commitment petitions, there is no statutory requirement that a hearing be held on a petition for the involuntary administration of psychotropic drugs within seventy-two hours of a respondent's initial detention. The expedited process required for involuntary commitment proceedings is aimed at mitigating the infringement of the respondent's liberty rights that begins the moment the respondent is detained involuntarily. In contrast, so long as no drugs have been administered, the rights to liberty and privacy implicated by the right to refuse psychotropic medications remain intact. Therefore, in the absence of an emergency, there is no reason why the statutory protections should be neglected in the interests of speed.

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[88] The failure of the Probate Masters to comply with Civil Rule 53(d)(1) being fatal to a superior court approval without a transcript is on appeal in S-12677.
[89] 138 P.2d 238, 242-3 (Alaska 2006), emphasis added.
[90] 156 P.3d 371, 382 (Alaska 2007), footnotes omitted.

Patient: BIGLEY, William S.
Case #: 00-56-65
Social History/Page 2

The patient has not received his GED, nor has he had any training of any trades nor any college. He has been employed with Alaska Lumber and Pulp since 1973 in Sitka and is presently on his vacation from this job. He has never been in the armed services.

The patient enjoys reading as a hobby, and enjoys hiking and picnicking as recreational activities.

Patient's religious preference is Nazarene.

The patient has no legal problems, although his mother states that they have attempted to lower his child support monies down because the mother is asking for more. The patient presently pays $400.00 a month for both daughters in child support monies and another $400.00 for her house trailer payments.

FAMILY HISTORY: The patient's two daughters live in Sitka, Alaska, with the mother, who gained custody since their divorce of last year (1979). The daughters are ages 5 and 3, and the ex-wife, Peggy, is a 33-year-old, German born, white female.

The patient's biological father passed away in 1965 in Sitka, Alaska, at the age of 37 from heart and diabetic diseases.

The patient's mother, Rosalie Sivering is 49-years-old and presently lives in Anchorage. She has a 12th grade education and one year of college. She had been living in Anchorage and had not seen her son since his divorce of last year.

Mrs. Sivering's present husband is Mr. Carl Sivering, age 44, who has just retired from the Army. He is presently looking for work. They had been stationed in Anchorage since 1971 when he retired.

The patient has one brother, Richard Bigley, 28 years old, is married, and lives in Sitka and also works for the same pulp company where Bill works.

There are no behavioral, physical, or mental problems within the family, and the family relationships are fine.

POST HOSPITAL RESOURCES: Patient will return to Sitka upon discharge. He will continue to work with the Alaska Lumber and Pulp. He will continue to live with his brother, as he has been. His box number is 1355, Sitka, Alaska. His followup will be with Dr. Laughridge of the Sitka Mental Health Clinic.

AXIS IV: Psychosocial Stressors: Unresolved and ongoing reaction to divorce, ex-wife has custody of two daughters, pays large child support and trailer payments to ex-wife.

Patient: BIGLEY, William S.
Case #: 00-56-65
Social History/Page 3

Severity: 4, moderate.

AXIS V: Highest level of adaptive functioning during past year: 3, good.

Annie Bowen

Annie Bowen, MSW

AB:dh

d: 4/22/80
t: 4/25/80

SAU
Randy Gager, NA III
4/15/80

ADMISSION DATA BASE

EATING	Reports sporadic eating habits. "Whenever I'm hungry". Twenty-three pound weight loss in last 4 months. No food allergies reported.
SLEEPING	Last 5 days extremely difficult to sleep. No recurring dreams or nightmares. Occasional nap.
ELIMINATION HABITS	No problems reported.
BODY POSTURE	Erect sitting and standing. No problem with gait.
GROOMING & HYGIENE	Whenever needed, usually X3 weekly. Disheveled appearance.
MENSES	N/A
PROSTHETIC DEVICES	One crown.
TIME ALONE & ACTIVITIES	Normal amount. Feels comfortable when alone. No hobbies.
INTERACTIONS	Has friends, visits when he feels like it. Good eye contact. Responses are guarded.
MEMORY--RECENT AND PAST	Both appear intact.
MEDICATIONS	Denies recent use of street drugs or ETOH.
ACTING OUT	Would rather communicate than fight.
(ADMISSION) WHAT PATIENT THINKS HIS PROBLEM IS	"It's complicated".

RG/sjb

Patient: BIGLEY, William
Case # : 00-56-65

d: 4/15/80
t: 4/17/80

SAU
Randy Gager, NA III
4/30/80

DISCHARGE ASSESSMENT NOTE

EATING	Patient normally consumed 3 regular sized meals per day, normal pace. Infrequent snacking noted during the day. Normal consumption of liquids. No food allergies reported.
SLEEPING	Eight to ten hours of uneventful sleep at night. No complaints of recurring dreams or nightmares. Normally once asleep stays asleep. Several hour naps throughout the day.
ELIMINATION HABITS	No problems reported.
BODY POSTURE	Erect sitting and standing. No problem with gait.
GROOMING & HYGIENE	Usually showered with change of clothing X3 weekly, hair is clean, but uncombed at this time.
MENSES	N/A
PROSTHETIC DEVICES	Patient wears one crown.
TIME ALONE & ACTIVITIES	Occasionally normal amount of time spent alone, usually sits in day room, but interactions are minimal. Occasionally would enter into unit activities such as pool or ping pong, but short attention was exhibited.
INTERACTIONS	Speaks when spoken to. Minimal initiation of interactions, but speaks clearly and effectively. Good eye contact.
MEMORY--RECENT AND PAST	Both appear intact.
MEDICATIONS	Patient will be discharged with a two weeks' supply of Haldol 10 mg. taken b.i.d. and Cogentin 2 mg. b.i.d.
ACTING OUT	Patient was on suicide awareness for several days after admission, but no suicidal attempts made. Patient at this time denies suicidal and homicidal ideation. Has been cooperative with the staff throughout his admission.

Patient: BIGLEY, William
Case # : 00-56-65
Discharge Assessment Note/Page 2

(DISCHARGE) WHAT PATIENT VERBALIZES AS FOLLOW-UP CARE

Patient reports he will spend approximately one week with his parents in Anchorage, then plans on returning to Sitka where he does have employment.

RG/sjb

d: 4/30/80
t: 5/1/80

The Alaska Supreme Court thus specifically held it is a two-step process wherein the forced drugging petition cannot proceed before the involuntary commitment process has been completed:

> Alaska requires a two-step process before psychotropic drugs may be administered involuntarily in a non-crisis situation: the State must first petition for the respondent's commitment to a treatment facility, and then petition the court to approve the medication it proposes to administer. The second step requires that the State prove by clear and convincing evidence that: (1) the *committed patient* is currently unable to give or withhold informed consent;[91]

Both *Myers* and *Wetherhorn* specifically referred to these two steps and to a "committed" patient. In *Myers* this Court held the Forced Drugging Petition is filed *after* a commitment has been granted.[92] Thus, only after a commitment order has been signed by the *Superior Court Judge* may a forced drugging petition be filed.

(C) The Forced Drugging Petition Is Defective and at a Minimum, API should Be Ordered to Conform it to the Requirements of *Myers*

In *Myers* 138 P.3d at 254, with respect to the required best interest element the Alaska Supreme Court held:

> At a minimum, we think that courts should consider the information that our statutes direct the treatment facility to give to its patients in order to ensure the patient's ability to make an informed treatment choice. As codified in AS 47.30.837(d)(2), these items include:
>
> * * *
>
> (B) information about *the proposed medication*, its purpose, the method of its administration, the recommended ranges of dosages, possible side effects and benefits, ways to treat side effects, and risks of other conditions, such as tardive dyskinesia;

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[91] 156 P.3d at 382, emphasis added.
[92] 138 P.3d at 242-3.

(C) a review of the patient's history, including medication history and previous side effects from medication;

(D) *an explanation of interactions with other drugs*, including over-the-counter drugs, street drugs, and alcohol; . . .[93]

The Alaska Supreme Court also cited with approval the Supreme Court of Minnesota's requirement considering the following factors:

(1) the extent and duration of changes in behavior patterns and mental activity effected by the treatment;

(2) the risks of adverse side effects;

. . . ; and

(5) the extent of intrusion into the patient's body and the pain connected with the treatment.[94]

All of these factors are drug and dose dependent and the last one relates to the manner of administration. Thus, *Myers* specifically requires a drug by drug, dose by dose, and manner of administration determination by the Court.

Sell v. United States, 539 U.S. 166, 123 S.Ct. 2174 (2003), a forced drugging to make one competent to stand trial case, based on the requirements of the United States Constitution, also requires a drug by drug analysis ("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."). [95]

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[93] 138 P.3d 252, emphasis added.

[94] *Id.*

[95] While *Sell* is a competence to stand trial case, the U.S. Supreme Court used the same sort of standard constitutional law compelling state interest, further state interest and least intrusive alternative analysis the Alaska Supreme Court employed in *Myers* and is fully applicable here with respect to this issue.

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API has not changed its forced drugging petition form to comply with *Myers*. It is therefore defective and should be dismissed for that reason. In the alternative, API should be required to file an amended petition comporting with the requirements of *Myers*. A failure to do so is a violation of Mr. Bigley's due process rights.

V. Motion for Settlement Conference

Mr. Bigley has been abused enough. What API has done to him for 28 years and some 75 admissions should not be allowed to continue. What API has done to Mr. Bigley for 28 years and some 75 admissions is not working and something different should be tried. Mr. Bigley hereby moves the Court to order a settlement conference to discuss a better approach for Mr. Bigley. Mr. Cornils affidavit describes a less intrusive alternative and it seems preferable for the parties to get together to try and work something out before the forced medication petition is heard.

DATED: March 6, 2008.

Law Project for Psychiatric Rights

By: _____
James B. Gottstein, Esq.
ABA # 7811100

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406 G Street, Suite 206
Anchorage, Alaska 99501
(907) 274-7686 Phone ~ (907) 274-9493 Fax

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

In The Matter of the Necessity for the)
Hospitalization of William S. Bigley,)
Respondent,)
)

Case No. 3AN 08-00247 PR

APPENDIX TO SUBMISSION FOR REPRESENTATION HEARING

ALASKA PSYCHIATRIC INSTITUTE

HOSPITAL RECORD

SOCIAL HISTORY

Patient: BIGLEY, William S. Date: 4/18/80
Case #: 00-56-65

IDENTIFYING DATA: This is the first API admission for this 27-year-divorced, Aleut/native male who is a mill hand from Sitka, Alaska, committed under Title 47.

PRESENTING PROBLEM: Dr. South's admitting note states "First API admission for a 27-year-old, divorced, native or part-native male, mill hand, from Sitka committed under Title 47. He was reportedly divorced recently, wife gained custody of two daughters, ages 4 and 5. Patient reportedly has been threatening and bizarre, subject to auditory hallucinations (he reportedly removed a crown from a tooth because it contained a 'transmitter'). He is guarded and defensive, unwilling to discuss any of these matters, but he does not directly deny them, simply says 'I don't want to talk about it,' or 'I've talked to people about that already.' He wants to see a priest--he reportedly stated he had killed someone in Sitka but this was believed to be a delusion. He looks depressed and near tears, denies he is depressed but says 'I'm just sad,' also 'Hurt.' Denies suicide inclinations. Correctly oriented. Appears anxious in that he sighs frequently, but he sits very quietly looking dejected. Denies hallucinations. Insight and judgment impaired." Diagnosis: Schizophreniform disorder.

PATIENT'S SUBJECTIVE SYMPTOMS: When I asked patient why he thought he was here, he said he had just gotten divorced and consequently had a nervous breakdown.

The following history was given mainly by the patient's mother, as well as by the patient. The mother is Mrs. Sivering.

PREVIOUS PSYCHIATRIC TREATMENT: The patient says he has never had any mental health hospitalizations; however, a letter from Dr. Laughridge, Ph.D., states patient was hospitalized in Sitka for 48 hours and responded well to Thorazine. He did not follow through with his meds after discharge.

PERSONAL HISTORY: The patient was born January 15, 1953, on Kodiak island. He moved to Juneau in 1954, moved to Sitka in 1960, and to Anchorage in 1966. He returned to Sitka in 1968. He has lived in Sitka since.

The childhood illnesses the patient had were chickenpox, measles, and mumps. He has been in no accidents, has had no operations, and has no allergies.

The patient's relationships as a child were normal and average. His relationship's as an adolescent were fine. He went as far as the 10th grade having dropped out of school because he says he could not handle it. His peer relationships as an adult have been normal and average.

DISCHARGE SUMMARY

PATIENT: BIGLEY, William
CASE #: 00-56-65

DATE OF ADMISSION: 4/15/80
DATE OF DISCHARGE: 4/30/80

IDENTIFYING DATA: This was the first API admission for this 27-year-old, divorced, Aleut native male who is a millhand from Sitka, Alaska, committed under Title 47.

REASON FOR & CONDITION ON ADMISSION: Patient was admitted reportedly having been threatening and bizarre, subject to auditory hallucinations. For example, he mentioned that he had removed a crown from a tooth because it contained a transmitter. On admission, he was guarded and defensive, unwilling to discuss any of these matters, but he did not directly deny them. He simply said he did not want to talk about it. He wanted to see a priest. He reportedly had stated that he killed someone in Sitka, but this was believed to be a delusion. He was very recently divorced and his wife gained custody of his two daughters, ages 4 and 5. On admission, he was very depressed, near tears and made statements, such as "I'm very sad and I hurt." He denied suicidal ideations. His orientation was intact. He denied hallucinations and his insight and judgment were impaired.

COURSE IN THE HOSPITAL: Patient responded well to the unit routine and participated in the ward activities. He was treated with Haldol 10 mg. b.i.d. which was started on 4/15/80 and on 4/17/80 after he developed some extrapyramidal problems, Cogentin 2 mg. p.o. b.i.d. was added. Physical examination did not reveal any significant abnormalities. Laboratory findings included a CBC, which showed an RBC of 5.22, hemoglobin of 15.7, hematocrit of 44.9, and a normal differential. Urinalysis was normal. RPR was non-reactive. A throat culture after 48 hours showed positive staph aureus, sensitive to a number of antibiotics. Patient's depression improved rather rapidly and with no further indication of hallucinations, and delusions, while he was in the hospital. Towards the end of hospital treatment, his affect became pleasant and cooperative. He was interacting well on the unit and was anxious to be discharged.

CONDITION ON DISCHARGE: Patient was markedly improved. He was discharged to the care of his parents.

FINAL DIAGNOSIS:

Axis I: Schizophreniform disorder, 295.40.

Axis II: All disturbances limited to Axis I.

Axis III: None.

Axis IV: Psychosocial stressors: Unresolved and ongoing reaction to divorce, ex-wife has custody of two daughters, pays large child support and trailer payments to ex-wife. Severity: 4, moderate.

PATIENT: BIGLEY, William
CASE #: 00-56-65

Axis V: Highest level of adaptive functioning during the past year: 3, good.

PROGNOSIS: Somewhat guarded depending upon the type of follow-up treatment patient will receive in dealing with his recent divorce.

POST HOSPITAL PLAN: Medications and recommendations: Patient was to stay for one week with his parents in Anchorage before returning to Sitka where he will seek help either from the Mental Health Center or from the social worker at the P.H.S. Hospital in Mt. Edgecumbe. Medication: Discharge medication - Haldol 10 mg. b.i.d., Cogentin 2 mg. b.i.d.

RA/ojb

Robert Alberts, M.D.
Staff Psychiatrist

D. 5/5/80
T. 5/7/80

ALASKA PSYCHIATRIC INSTITUTE

HOSPITAL RECORD

DISCHARGE SUMMARY

PATIENT: BIGLEY, William Stanley
CASE # : 00-56-65

ADMISSION DATE: 2/27/81
DISCHARGE DATE: 5/04/81

IDENTIFYING DATA: William Bigley is a 28 year old, Aleut/Indian/Caucasian, divorced, father, employed in a pulp mill industry in Sitka, Alaska. He is admitted to API for his third hospitalization at API. The present admission results from referral from the Sitka Jail per court order issued by Magistrate Marilyn Hanson, requesting psychiatric evaluation and observation. Additionally, a physician's certificate filed by Robert Hunter, M.D., as well as an application for judicial commitment filed by Michael Boyd (Mental Health Worker, Sitka, Alaska), also accompanies patient.

REASON FOR, AND CONDITION ON, ADMISSION: It should be mentioned that the patient himself, at no time throughout the course of this hospitalization, identified that he had psychiatric problems or needs. From the very outset, he persisted in viewing his difficulties as purely situational in nature, and interpreted any problems that he might be struggling with as resulting from the direct acts of persons other than himself.

He admits that during the several hour period prior to referral to API, he had been jailed in the Sitka Jail because he had failed to answer a traffic citation. Notes which accompany him from the jail indicate that Mr. Bigley behaved in a peculiar fashion while in jail and, in fact, refused to leave the jail when he was offered an opportunity to do so. He seemed to be preoccupied with fearful thoughts that he might be harmed by persons outside of the jail. For this reason, and the fact that he refused to communicate in a logical or coherent way, he was referred for psychiatric hospitalization at this time.

At the time of admission to the hospital, Mr. Bigley refuses to look at the admitting physician. He sits in a very stiff fashion with his head and neck markedly extended as he sometimes gazes at the ceiling, but more often closes his eyes and refuses to respond to specific questions. He does respond with occasional monosyllabic replies or with very abrupt answers to specific questions. He volunteers some information which takes a form of a flood of accusations directed at the examining physician as well as the Sitka police. He also expresses angry thoughts about other persons in the Sitka community who he neglects to identify by name. He reveals loosely structured delusional ideas, which have to do with his being involved in some sort of special mission to deal with "aliens". These notions are mixed up with ideas about wanting to travel to Easter Island as part of his mission to save the world from destruction. He refers to wanting to incarcerate all "junkies" on Alcatraz Island. These observations are mentioned through clenched teeth and interspersed with long periods of absolute mute, near catatonia. He denies active auditory hallucinations or visual hallucinations.

He becomes angry when queried as to why he was jailed in the first place. He does not respond to suggestions that he might be sad or lonely, even though he is close to tears during parts of the interview. He does not reveal absolute impairment of recent or remote memory, but it is impossible to test his sensorium with accuracy because of failure of cooperation.

It should be noted that Mr. Bigley has undergone two previous psychiatric hospitalizations at API, all within the past 12 months. His first hospitalization was from 4/15/80 through 4/30/80, at which time he was thought to suffer from schizophreniform disorder. His acute symptoms were thought to result from a recent separation and divorce from his wife. A subsequent hospitalization from 9/20/80 until 10/20/80 was for schizophrenic disorder, paranoid, subchronic with acute exacerbation. On both previous occasions of hospitalization he was treated with anti-psychotic medication - Haldol and eventually made a suitable recovery. It was noted that his response to medication was very slow to develop.

COURSE IN HOSPITAL: The patient refused to undergo a physical examination throughout his entire hospitalization until only a few days prior to discharge. On 5/1/81, a physical examination reveals no abnormalities, but for several primitive reflexes which were elicited on neurological exam. A urinalysis was normal, but other laboratory studies were not secured during this hospitalization. A chest x-ray is normal on 3/2/81.

No psychological studies were secured during this hospitalization.

Initially, Mr. Bigley was admitted to the Adult Admission Unit, but after several hours was transferred to the Security Unit while clarification of his legal status was established. It was found that no criminal charges were pending against him, for which reason, on 3/2/81 he was referred back to the Adult Admission facility. He was started on Haldol medication 10 mg. b.i.d. on the day of admission, which the drug was increased to 20 mg. t.i.d. on 3/3/81. Cogentin 2 mg. b.i.d. was initiated for relief of EPS. Throughout the first three hospital weeks there was essentially no change in his mental condition. He interacted passively and indifferently to interaction with other patients. He was irritable, demanding, and sometimes openly threatening in interactions with unit staff members. From time to time he would play pool or otherwise engage in unit activity or recreation, but remained for the most part withdrawn and uninvolved in unit activities.

Patient: BIGLEY, William Stanley
Case # : 00-56-65
Discharge Summary/Page 3

The medication seemed not to have noticeable favorable effects throughout the first several hospital weeks, despite the fact that there were a variety of unpleasant EPS side effects. He was transferred to the longer term, locked, adult treatment unit on 3/10/81 because of continuing frank paranoid delusions and threatened angry assaultiveness.

On 3/26/81 a judicial hearing determined that there would be granted a 30 day extension during which time treatment efforts would continue, following which there would be a further hearing concerning the possibility of judicial commitment. Mr. Bigley was furiously angry that he was deprived of his right to freedom outside the hospital, but despite his persistent anger and occasional verbal threats, he never became physically assaultive, nor did he abuse limited privileges away from the locked unit.

After the first six hospital weeks he continued to believe that he had some special mission involving Easter Island - drug addicts and alien visitors to the Earth. When these views were gently challenged he became extremely angry, usually walking away from whoever questioned his obviously disordered thoughts.

Mr. Bigley often was visibly despondent and several times was close to tears as he discussed the forlorn hopelessness of his situation. He was unwilling to relate his despondency to issues other than his forced confinement, and specifically denied that he was still troubled by the recent divorce from his wife. Ludiomil was started in a dosage up to 150 mg. q. d. on 3/26/81. At the same time Haldol was decreased to 40 mg. h.s. After four days of use of Ludiomil, Mr. Bigley's thought processes seemed more fragmented, he seemed more intensely irritable, and angrily demanding, for which reason the Lud'omil was discontinued. Haldol was once again increased to 20 mg. t.i.d., on 4/3/81. Efforts to decrease or discontinue Cogentin were unsuccessful, so that he required relief of EPS with regular use of Cogentin. On 4/27/81 the Haldol was discontinued in favor of what was hoped to be the less sedative Navane 40 mg. h.s. He required intravenous Cogentin on the day after Navane was started, but thereafter, responded well to Navane with less sluggishness and waxy, bodily movements. His spirits improved, that he was able to be quietly pleasant in his interactions with unit staff members for the first time. He had reached maximum benefit from hospitalization, and arrangments were made for discharge.

CONDITION AT DISCHARGE: Improved. There was no longer evidence of acute psychotic thinking or behavior at the time of discharge.

IDENTIFYING DATA: This is the 68th API admission for this 54-year-old, unmarried Alaska Native nonveteran, unemployed male of Nazarene religious preference. He was admitted on an Ex Parte filed by his guardian.

PRESENTING PROBLEM: The patient allegedly was at risk of going hungry because he would not cooperate with efforts to provide him groceries. The patient was also very emotionally labile and was creating public disturbances and allegedly had twice required police escort away from areas that he had been causing disturbances.

HISTORY OF PRESENT ILLNESS: This patient left API previously on January 3 "Against Medical Advice." At that time, he did not quite meet criteria for going forward with an extended commitment period. The patient quit taking medications immediately upon discharge and did not follow-up one time with outpatient psychiatric appointments. The patient's guardian attempted to work with the patient regarding providing him with groceries and also a case manager from Anchorage Community Mental Health Services tried to work with the patient apparently. However, the patient would only work with his new attorney and appeared to decide that there was no reason at all that he should work with anyone who was professionally trained to assist him with his mental health care. The patient apparently became increasingly labile and was demonstrating aggressive verbal behavior in public places. This was a marked contrast from the patient's mental status just before leaving API when he was quite calm and even tempered.

The patient has been engaged in a legal battle in an effort to free himself from guardianship ever since he was solicited by his current attorney during his last hospitalization. The attorney's influence on the patient has been remarkable and has considerably worsened his functioning, as well as his prognosis because he has fed into the patient's delusional grandiosity. The patient is no longer to work with outpatient mental health resources at all, and is no longer willing to work at all with his guardian.

The patient claims that he has frozen foods in his freezer, and that he is able to provide for his nutritional needs, and he still has housing and is safe from the weather outdoors. Apparently, the patient may have been getting small amounts of money from his attorney in order to secure groceries. The patient says that he wants his guardian to provide him with money in small amounts periodically so that he can go get his own groceries. The patient is paranoid about his guardian and thinks that he is trying to ruin his life. The patient is extremely delusional and brings up governmental conspiracies and talks about the number of people that are eaten alive everyday in this country, etc., etc. The patient essentially trusts no one except apparently now, he trusts his new attorney.

The patient has a history of caffeine abuse and nicotine dependence. His caffeine abuse has tended to exacerbate his mental status in the past.

The patient was supposed to be taking Depakote 500 mg in the morning and 750 q. h.s., as well as Prilosec 20 mg daily, quetiapine 300 mg p.o. b.i.d., and risperidone Consta 50 mg IM every two weeks. These were the medications that he was stabilized on while in API. The patient required

ALASKA PSYCHIATRIC INSTITUTE

HOSPITAL RECORD

Patient: BIGLEY, William Stanley
Case # : 00-56-65
Discharge Summary/Page 4

FINAL DIAGNOSIS:

Axis I: Schizophrenic disorder, paranoid, subchronic with acute exacerbation, 295.33.

Axis II: Diagnosis confined to Axis I.

Axis III: No significant diagnosis.

Axis IV: Psychosocial Stressors: Severity: 4, moderate.

Axis V: Highest level of adaptive functioning past year: 4, fair, with moderate impairment of his social and work capability.

PROGNOSIS: Guarded. There had been three separate hospitalizations for acute paranoid illness in less than 12 months. The initial acute psychotic reaction might have been accounted for on the basis of overwhelming situational stress in the form of divorce. The lingering and recurring nature of the problem however, and the fact that Mr. Bigley refuses to recognize the need for continued hospitalization is discouraging.

POST HOSPITAL PLAN: Patient will be followed at the Sitka Mental Health Clinic. Will continue Navane 30 mg. h.s., Artane 2 mg. b.i.d.

Robert Marshall

RM/sjb

Robert Marshall, M.D.
Staff Psychiatrist

d: 5/18/81
t: 5/20/81

ALASKA PSYCHIATRIC INSTITUTE
HOSPITAL RECORD

REASONS FOR & CONDITION ON ADMISSION: As recorded on the Admission Data Base for 02/22/07:

"IDENTIFYING DATA: This is the 68th API admission for this 54-year-old, unmarried Alaska Native nonveteran, unemployed male of Nazarene religious preference. He was admitted on an Ex Parte filed by his guardian.

PRESENTING PROBLEM: The patient allegedly was at risk of going hungry because he would not cooperate with efforts to provide him groceries. The patient was also very emotionally labile and was creating public disturbances and allegedly had twice required police escort away from areas that he had been causing disturbances.

HISTORY OF PRESENT ILLNESS: This patient left API previously on January 3 "Against Medical Advice." At that time, he did not quite meet criteria for going forward with an extended commitment period. The patient quit taking medications immediately upon discharge and did not follow-up one time with outpatient psychiatric appointments. The patient's guardian attempted to work with the patient regarding providing him with groceries and also a case manager from Anchorage Community Mental Health Services tried to work with the patient apparently. However, the patient would only work with his new attorney and appeared to decide that there was no reason at all that he should work with anyone who was professionally trained to assist him with his mental health care. The patient apparently became increasingly labile and was demonstrating aggressive verbal behavior in public places. This was a marked contrast from the patient's mental status just before leaving API when he was quite calm and even tempered.

The patient has been engaged in a legal battle in an effort to free himself from guardianship ever since he was solicited by his current attorney during his last hospitalization. The attorney's influence on the patient has been remarkable and has considerably worsened his functioning, as well as his prognosis because he has fed into the patient's delusional grandiosity. The patient is no longer to work with outpatient mental health resources at all, and is no longer willing to work at all with his guardian.

The patient claims that he has frozen foods in his freezer, and that he is able to provide for his nutritional needs, and he still has housing and is safe from the weather outdoors. Apparently, the patient may have been getting small amounts of money from his attorney in order to secure groceries. The patient says that he wants his guardian to provide him with money in small amounts periodically so that he can go get his own groceries. The patient is paranoid about his guardian and thinks that he is trying to ruin his life. The patient is extremely delusional and brings up governmental conspiracies and talks about the number of people

that are eaten alive everyday in this country, etc., etc. The patient essentially trusts no one except apparently now, he trusts his new attorney.

The patient has a history of caffeine abuse and nicotine dependence. His caffeine abuse has tended to exacerbate his mental status in the past.

The patient was supposed to be taking Depakote 500 mg in the morning and 750 q. h.s., as well as Prilosec 20 mg daily, quetiapine 300 mg p.o. b.i.d., and risperidone Consta 50 mg IM every two weeks. These were the medications that he was stabilized on while in API. The patient required the combination of quetiapine and risperidone Consta due to noncompliance with oral medications combined with the lack of efficacy of risperidone Consta by itself. The combination of medications that he was on were working quite well prior to discharge. The patient was calm on that combination of medications and able to sit through a conversation even though he would express his opposing viewpoint and his dislike of his guardian and his plan to get rid of his guardian. He did not express much in the way of delusions on that combination of medication and certainly was not getting upset when he was talking about things.

See what well means on page 2.

Contradicted by page 2

MENTAL STATUS EXAMINATION: The patient is angry. He insists that API dragged him off the streets and ordered him into the hospital. He expresses a dislike of his guardian. He states that he is a billionaire. He says there are 300 people a day being beaten in the United States. He is delusional about the government. He denies hallucinations. He denies suicidal or homicidal ideations. He admits that he has been somewhat disruptive in some places since he left the hospital. He insists he has the ability to take care of himself and that he has food at home. However, he says he is hungry and asks for double portions of meals. He complains that he was given an emergency shot the night of his admission. It is difficult to do a cognitive examination because the patient is uncooperative, but he will say that it is February 2007, and he can recall what was served at breakfast. He is alert. He does not appear to be suffering from delirium. His mood is dysphoric. His general affect is hostile. He is very labile and he jumps up screaming and threatens to throw the examiner out of the room but does nothing physical about it. Eventually, the patient calms down and has a rather intense discussion about the grocery issues, but becomes less hostile. Later on in the hallway, the patient resumes his affect and hostile threatening mannerisms. The patient has very loose associations and is tangential in his thinking. He is quite paranoid. He seems unable to process information when it is attempted to explain to him how he can help himself get out of the hospital today, and he perseverates with his delusional talk."

Where is documentation of necessity. Myers and/or

ADMITTING DIAGNOSIS:

Axis I:	Schizoaffective Disorder. Bipolar Type.
	Caffeine Intoxication.
	Nicotine Dependence.
Axis II:	No diagnosis.
Axis III:	Gastroesophageal reflux disease.
	History of anorexia.
Axis IV:	Stressors: Other psychosocial and environmental problems.
Axis V:	GAF: 20.

COURSE IN HOSPITAL: The patient was medication compliant only after the Court ordered medications on February 27, 2007. The patient complained the Depakote increased his appetite. He began to improve after that dosage was adjusted and was calmer, but still delusional. He finally agreed to work with his new case manager, who he quickly took a liking to and took some passes with. He went to visit his apartment and was happy with that. The patient was having some problems with nausea and vomiting in the last three or four days and his Depakote dose was reduced, even though his Depakote level was only 84. His oral risperidone was stopped, as he was on the Risperdal shots. His vital signs were stable and he had no fever.

The patient had potentially reached the maximum benefits from hospital care and it was decided, even though his medication dosages had just been changed, to discharge him on an Early Release, which he was insisting upon. It was felt that if the patient was non medication compliant, this might encourage him to comply, otherwise he would have to come back to API.
It was explained repeatedly to the patient that he was required to take medications, but he continued to say that because he had a lawyer, that he would not have to take medications.

Physical examination and laboratory findings on admission were within normal limits.

CONDITION ON DISCHARGE: The patient was delusional. He thought he was a billionaire and that he had a jet plane. He also thought he had pneumonia. He was not labile and was relatively cooperative. He had no insight and poor judgment still. His speech was pressured. He had loosening of associations. Cognitive exam was essentially normal. He was paranoid and guarded. His mood was essentially euthymic. He was not nauseated at the time of discharge. He continued to have such impaired judgment that it was felt he was not capable of giving informed consent, even at the time of discharge.

FINAL DIAGNOSIS:

Axis I: Schizoaffective Disorder, Bipolar Type.

Caffeine Abuse.

Nicotine Dependence.

Axis II: Paranoid Personality Traits.

Axis III: Gastroesophageal reflux disease, by history.

Axis IV: Stressors: Other psychosocial and environmental problems (involved with a new attorney)

Axis V: GAF: 35.

PROGNOSIS: Poor.

POST HOSPITAL PLAN, MEDICATIONS, & RECOMMENDATIONS: The patient is to be given Risperdal Consta 50 mg IM every 14 days and his last shot was on March 8, 2007. He is to continue quetiapine 300 mg p.o. b.i.d. and divalproex ER 500 mg every morning and 250 mg every night. It should be noted that this dose was recently decreased due to nausea, despite a Depakote level of 84. He was given a three day supply of his medications and has an appointment with his prescriber on March 16, 2007. He is to have general medical follow up if he has further nausea, and he should have a Depakote level within a week. He should be returned to API if he begins to decompensate. He should limit his caffeine intake.

Diet and activity are not restricted, other than he should limit caffeine intake.

William A. Worrall, MD
Staff Psychiatrist

WAW/mh/DISCH/25870F
d. 03/21/07
t. 03/23/07 (draft)
drft. 03/23/07

the combination of quetiapine and risperidone Consta due to noncompliance with oral medications combined with the lack of efficacy of risperidone Consta by itself. The combination of medications that he was on were working quite well prior to discharge. The patient was calm on that combination of medications and able to sit through a conversation even though he would express his opposing viewpoint and his dislike of his guardian and his plan to get rid of his guardian. He did not express much in the way of delusions on that combination of medication and certainly was not getting upset when he was talking about things.

PERTINENT MEDICAL PROBLEMS: The patient has gastroesophageal reflux disease but is not taking medications for this. He says that he is healthy. He has a 4-pound weight loss since his last admission over a 3-month period.

USE OF DRUGS/ALCOHOL RELATING TO CURRENT ADMISSION: None currently except for caffeine and nicotine.

PERTINENT PERSONAL HISTORY: The patient refused to live in an assisted living facility and ended up in an independent living situation again, and consequently he did not comply with medications or any outpatient appointments. The patient insists that he is a billionaire and that he owns his own jet plane. He has no family support. He survives on disability checks and has a guardian to help him manage his funds and make medical decisions although psychiatric medications still require either the patient's consent or a court order.

MENTAL STATUS EXAMINATION: The patient is angry. He insists that API dragged him off the streets and ordered him into the hospital. He expresses a dislike of his guardian. He states that he is a billionaire. He says there are 300 people a day being beaten in the United States. He is delusional about the government. He denies hallucinations. He denies suicidal or homicidal ideations. He admits that he has been somewhat disruptive in some places since he left the hospital. He insists he has the ability to take care of himself and that he has food at home. However, he says he is hungry and asks for double portions of meals. He complains that he was given an emergency shot the night of his admission. It is difficult to do a cognitive examination because the patient is uncooperative, but he will say that it is February 2007, and he can recall what was served at breakfast. He is alert. He does not appear to be suffering from delirium. His mood is dysphoric. His general affect is hostile. He is very labile and he jumps up screaming and threatens to throw the examiner out of the room but does nothing physical about it. Eventually, the patient calms down and has a rather intense discussion about the grocery issues, but becomes less hostile. Later on in the hallway, the patient resumes his affect and hostile threatening mannerisms. The patient has very loose associations and is tangential in his thinking. He is quite paranoid. He seems unable to process information when it is attempted to explain to him how he can help himself get out of the hospital today, and he perseverates with his delusional talk.

ASSETS: General fund of knowledge, average intelligence, physical health.

ADMITTING DIAGNOSIS:

Axis I: Schizoaffective Disorder, Bipolar Type.

Caffeine Intoxication.

Nicotine Dependence.

Axis II: No diagnosis.

Axis III: Gastroesophageal reflux disease.

History of anorexia.

Axis IV: Stressors: Other psychosocial and environmental problems.

Axis V: GAF: 20.

Preliminary Treatment Plan: The patient will be offered medications but he refuses any medications. He refuses to stay in the hospital. His guardian insists that the patient meets grave disability criteria and is unable to provide for his needs for his own safety. We will seek court clarification as to whether the patient is gravely disabled or not. We will seek a medication petition so that we can treat him, as otherwise there would be no benefit from him being hospitalized. We will attempt to help the patient resolve a plan for provisioning of his groceries. We will attempt to encourage the patient to accept an assisted living facility placement with 24-hour supervision. There appears to be nothing we can do about the unfortunate chain of events in which the patient has become involved in litigation and this process has produced considerable detriment in his functioning due to the encouragement of his delusional grandiosity by the process.

Discharge Criteria: The patient will be able to come up with a safe plan for his housing and food, etc., outside of the hospital and will have a considerable improvement in his affective regulation, and ability to interact with others.

Estimated Length of Stay: Thirty days if the patient is found gravely disabled.

William Worrall, MD
Staff Psychiatrist

WW/pal/ADB/25515F
d. 02/23/07
t. 02/26/07 (Draft)
drft. 03/02/07

Anchorage Community Mental Health Services

Medical Progress Note

Medication Compliance: suspected poor

Medication Response: poor

Change In Allergies: none

Side Affects: none identified

Review of Tests: none

Assessment: Bill presents grossly disorganized. Medication adherence is suspected to be poor. Early Release expires 3/25, and if depakote level indicates nonadherence, we will proceed with application to have Early Release revoked.

Plan: Will check depakote level today. If level is now subtherapeutic, will proceed with application for revocation of Early Release.

Next Appointment: Other - to be arranged

Clinician Signature: Lucy Curtiss MD **Date:** 03/16/2007

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
AT _____

In the Matter of the Necessity for the Hospitalization of:

William Biggs,
Respondent.

Case No. 3AN-07-247PR

NOTICE TO OUTPATIENT TO RETURN TO TREATMENT FACILITY WHERE COMMITTED)

To: William Biggs
1555 Nechinstat #7
Anchorage, AK 99501

It has been determined that you can no longer be treated at ACMHS as an outpatient because you are likely to cause harm to yourself or others or are gravely disabled.

You must return to the treatment facility to which you were committed, API, at 2900 Providence Dr. Anchorage, Alaska, within 24 hours after you receive this notice.

3-19-07
Date

Signature of Provider of Outpatient Care

1500 3-19-07
Date & Time respondent was served this notice

Scott A. Ranney
Printed Name

Assistant Attorney General
Title

I certify that on 3-19-07 a copy of this notice was mailed or delivered to:

court
respondent
respondent's attorney
attorney general
respondent's guardian (if any)
inpatient treatment facility: API

By: _____
Outpatient Care Provider

**Fax to Probate, API and Public Defender Agency (Attn: Liz Brennan) Original must be mailed or delivered to Probate Court

MC-425 (12/87)(cs)
NOTICE TO OUTPATIENT TO RETURN TO TREATMENT FACILITY WHERE COMMITTED

AS 47.30.795(c)

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
AT ANCHORAGE

In the Matter of the Necessity for the Hospitalization of:	)	
WILLIAM BIGLEY, Respondent.	)	Case No. 3AN-07-0207 PR

Order

A Order for 30 Day Commitment to Alaska Psychiatric Institute on the respondent, William Bigley, was signed by Judge Jack Smith on March 2, 2007. William Bigley left Alaska Psychiatric Institute on March 14, 2007, on a Condition of Early Release. Alaska Psychiatric Institute notified the Court on March 20, 2007, that the respondent is not in compliance with the Conditions of Early Release.

IT IS HEREBY ORDERED that any peace officer take the respondent into custody and transport the respondent, William Bigley, to the Alaska Psychiatric Institute.

3/20/07
Date

Superior Court Judge
MICHAEL L. WOLVERTON

I certify that on 3/20/07 copy of this order was sent to: AG, PD, API, RESP, AST

Clerk: m

Recommended for approval on a

March 20, 2007

Probate Master

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA AT _____

In the Matter of the Necessity for the Hospitalization of:

William Bigler, Respondent.

Case No. 3AN-07-247PR

State Trooper Directions for Service

Under the authority of AS 47.30.870, the Department of Health and Social Services will bear the costs, or reimburse the transporting agency for the costs, of transportation of the respondent to Alaska Psychiatric Institute as required to carry out the Order listed below:

[X] Ex Parte Order (Temporary Custody for Emergency Examination/Treatment)
Petition for Initiation of Involuntary Commitment

[ ] Order for Screening Investigation
Petition for Initiation of Involuntary Commitment

To Serve: RESPONDENT NAMED ABOVE

Address where respondent is at this time 1555 Arctic Blvd. #7

Phone -0- Apt.No. _____ Date of Birth 1-15-53

Race N. American Height 5'6" Weight _____ Hair Black Eyes _____

Physical Characteristics (clothing, scars, other identifiable marks) _____

Are there weapons at the residence? Unk Kind? -0-

Is respondent on medication? Yes Kind? Non-Compliant at this time

Does respondent have a history of violence? No Explain -0-

Is there anyone at the residence? No Relationship? -0-

Contact Person Steve Young/Guardian ~ OPA Phone 269-3541

RETURN OF SERVICE

I hereby certify that _____, a State Trooper or Peace Officer, picked up the respondent named above at:

_____, in _____,
(Address, street number, rural route, milepost, etc.) (City)

Alaska, in the _____ Judicial District, on _____, 19____, and transported the respondent to Alaska Psychiatric Institute.

I certify the documents listed above were served at Alaska Psychiatric Institute on _____, _____, _____, 19____.
(Name) (Title) (Date Served)

Return Date _____

Commissioner of Public Safety

By _____

Printed Name _____

Title _____

AST 12-343 (6/89) (cs)

ALASKA PSYCHIATRIC HOSPITAL

Report Contact

AT

William S

Reguarding: BIGLEY ,BILL

Date: 03/19/2007

Time: 15:42

Patient Type: Prior Patient

APH No.: 00 56 65

Adult

Person Making Referral:

SCOTT

Agency:

ACMHS

Phone # of Agency:

City/State:

Seeking: Information Only

Contact Type: Telephone Contact

Legal:

Still Pending

Brief Statement of Problem or Situtation

Caller said blood test on pt. showed he is off his depakote. He has been served with notice to return to API.

RdR
3/20/07

DISTRIBUTION

ORIGINAL: Medical Record Services
COPIES TO:

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- [ ] **Admissions Screening Office**
- [ ] **Nursing Office**
- [ ] **Director - C.E.O.**
- [ ] **SCCC - E.S.U.**
- [ ] **Unit Social Worker**_____
- [ ] _____
- [ ] _____

Time Spent on Contact:

Recorded By:
LLS_LAUREL_L_SILBERSCHMIDT, LCSW
BIGLEY ,BILL

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

In the Matter of the Necessity for the Hospitalization of:	)	
WILLIAM BIGLEY,	)	
Respondent.	)	
	)	Case No. 3AN-07-598 PR

SPECIAL VERDICT FORM
(Commitment)

We, the jury in the above entitled case, find the following on the questions submitted to us with respect to the involuntary confinement of William Bigley to a mental hospital:

Q1. **Has the Petitioner proven by clear and convincing evidence that William Bigley is mentally ill?**

6 (Number of jurors answering yes)

_____ (Number of jurors answering no)

If less than five jurors answered yes to Q1, Mr. Bigley does not meet the criteria for involuntary civil commitment and you should write "Verdict for the Respondent, William Bigley" on the verdict line, sign and return this form. In that case, do not answer any further questions on this form.

Q2. **Has the Petitioner proven by clear and convincing evidence that as a result of mental illness Mr. Bigley is in danger of physical harm arising from such complete neglect of basic needs for food, clothing, shelter, or personal safety as to render serious accident, illness, or death highly probable if care by another is not taken?**

_____ (Number of jurors answering yes)

6 (Number of jurors answering no)

Q3. **Has the Petitioner proven by clear and convincing evidence that Mr. Bigley will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason or behavior causing a substantial deterioration of the person's previous ability to function independently, such that he is unable to survive safely in freedom?**

_____ (Number of jurors answering yes)

6 (Number of jurors answering no)

If less than five jurors answered yes to both Q2 and Q3, Mr. Bigley does not meet the criteria for involuntary civil commitment and you should write "Verdict for the Respondent, William Bigley" on the verdict line, sign and return this form. In that case, do not answer any further questions on this form.

Q4. **Has the Petitioner proven by preponderance of the evidence that Mr. Bigley's mental condition would be improved by the course of treatment it seeks?**

_____ (Number of jurors answering yes)

_____ (Number of jurors answering no)

If less than five jurors answered yes to Q4, Mr. Bigley does not meet the criteria for involuntary civil commitment and you should write "Verdict for the Respondent, William Bigley" on the verdict line, sign and return this form. In that case, do not answer any further questions on this form.

Q5. **Has the Petitioner proven by preponderance of the evidence that there is no less restrictive alternative available to Mr. Bigley?**

_____ (Number of jurors answering yes)

_____ (Number of jurors answering no)

If less than five jurors answered yes to this question, Mr. Bigley does not meet the criteria for involuntary civil commitment and you should write "Verdict for the Respondent, William Bigley" on the verdict line, sign and return this form. In that case, do not answer any further questions on this form.

Q6. **Has the Petitioner proven by preponderance of the evidence that Mr. Bigley has received appropriate and adequate care and treatment during his 30-Day Commitment?**

_____ (Number of jurors answering yes)

_____ (Number of jurors answering no)

If less than five jurors answered yes to this question, Mr. Bigley does not meet the criteria for involuntary civil commitment and you should write "Verdict for the Respondent, William Bigley" on the verdict line, sign and return this form. In that case, do not answer any further questions on this form.

If at least five jurors answered yes to:

A. Q1, Q2, and/or Q3, Q4, Q5, Q6,

Mr. Bigley meets the criteria for involuntary confinement to a mental hospital and you should write "Verdict for the Petitioner, State of Alaska" on the verdict line, sign and return.

Verdict: Verdict for the Respondent, William Bigley

Now date and sign your verdict form and notify the bailiff.

DATED: 6/26/07

Printed name of foreperson Jane S. Kurth

Signature of foreperson Jane S. Kurth

[redacted]

COURSE IN HOSPITAL: [redacted]. The patient refused medications. The patient was continued on medications based on the existing court order after consultation with the attorney general's office. The patient soon started cooperating with oral medications, including Depakote. He wanted to be off Zyprexa because he thought it made him hungry and his medication was changed to Seroquel [redacted]

ALASKA PSYCHIATRIC INSTITUTE

DATE	TIME	ORDER	NURSE SIGNATURE
3-21-07	1134	Pt for court ordered meds	
		90 day TX / med petition renewal	Filed
		Risperidone Consta 50 mg IM q 2 wks starting 3/22/07	
		Quetiapine 300mg po BID	
		Divalproex ER 500mg po BID	
		repeat Depakote level Monday if compliant	
		If refuses scheduled BID meds (any): give ziprasidone 20mg IM up to BID 2x/24 hrs	
		Oral PRN: olanzapine zydis 10mg po q 1 hr prn agitated state NTE 3x 24 hrs	
		If refuses use IM back up: olanzapine IM 10mg q 1 hr NTE 3x/24 hrs for agitated state for safety of self/others	
		[illegible signature]	
3/21/07	1105	Olanzapine 10mg + lorazepam 2mg IM Now	
		TORB Dr Worrall/[illegible]	
		[illegible signature] 3-22-07 1000	[illegible signature]
3-22-07	1010	Pt to go c̄ maths for security to court at 330 downtown for 90 day hearing. Start at 330 UNLESS case is continued	
		[illegible signature]	

BIGLEY,
WILLIAM S
03/21/2007 00-56-65
01/15/1953

Please write or print legibly.

Please use ball point pen.

ORDER SHEET
API Form #06-6010A Rev. 12/02

To remove copy while set is in chart, lift form by bottom stub, reach under, & pull copy towards you. Tear off at proper perforation.

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

In The Matter of the Necessity for the)
Hospitalization of William S. Bigley,)
Respondent,)
William Worral, MD,)
Petitioner)
Case No. 3AN 07-1064 P/S

AFFIDAVIT OF ROBERT WHITAKER

STATE OF MASSACHUSETTS)
) ss.
SUFFOLK COUNTY)

By Robert Whitaker

I. Personal Background

1. As a journalist, I have been writing about science and medicine, in a variety of forums, for about 20 years. My relevant experience is as follows:

a) From 1989 to 1994, I was the science and medical writer for the *Albany Times Union* in Albany, New York.

b) During 1992-1993, I was a fellow in the Knight Fellowship for Science Writers at the Massachusetts Institute of Technology.

c) From 1994-1995, I was director of publications at Harvard Medical School.

d) In 1994, I co-founded a publishing company, CenterWatch, that reported on the clinical development of new drugs. I directed the company's editorial operations until late 1998, when we sold the company. I continued to write freelance articles for the *Boston Globe* and various magazines during this period.

e) Articles that I wrote on the pharmaceutical industry and psychiatry for the *Boston Globe* and *Fortune* magazine won several national awards, including the George Polk Award for medical writing in 1999, and the National Association of Science Writers award for best magazine article that same year. A series I wrote for the *Boston Globe* on problems in psychiatric research was a finalist for the Pulitzer Prize in Public Service in 1999.

f) Since 1999, I have focused on writing books. My first book, *Mad in America*, reported on our country's treatment of the mentally ill throughout its history, and explored in particular why schizophrenia patients fare so much worse in the United States and other developed countries than in the poor countries of the world. The book was picked by *Discover* magazine as one of the best science books of 2002; the American Library Association named it as one of the best histories of 2002.

2. Prior to writing *Mad in America*, I shared conventional beliefs about the nature of schizophrenia and the need for patients so diagnosed to be on antipsychotic medications for life. I had interviewed many psychiatric experts who told me that the drugs were like "insulin for diabetes" and corrected a chemical imbalance in the brain.

3. However, while writing a series for the *Boston Globe* during the summer of 1998, I came upon two studies that looked at long-term outcomes for schizophrenia patients that raised questions about this model of care. First, in 1994, Harvard researchers reported that outcomes for schizophrenia patients in the United States had declined in the past 20 years and were now no better than they had been in 1900.[1] Second, the World Health Organization twice found that schizophrenia patients in the poor countries of the world fare much better than in the U.S. and other "developed" countries, so much so that they concluded that living in a developed country was a

[1] Hegarty, J, et al. "One hundred years of schizophrenia: a meta-analysis of the outcome literature." *American Journal of Psychiatry* 151 (1994):1409-16.

"strong predictor" that a person so diagnosed would never recover.[2,3] Although the WHO didn't identify a reason for that disparity in outcomes, it did note a difference in the use of antipsychotic medications between the two groups. In the poor countries, only 16% of patients were regularly maintained on antipsychotic medications, whereas in the U.S. and other rich countries, this was the standard of care, with 61% of schizophrenia patients staying on the drugs continuously. (Exhibit 1)

4. I wrote *Mad in America*, in large part, to investigate why schizophrenia patients in the U.S. and other developed countries fare so poorly. A primary part of that task was researching the scientific literature on schizophrenia and antipsychotic drugs.

II. Overview of Research Literature on Schizophrenia and Standard Antipsychotic Medications

5. Although the public has often been told that people with schizophrenia suffer from too much "dopamine" in the brain, researchers who investigated this hypothesis during the 1970s and 1980s were unable to find evidence that people so diagnosed have, in fact, overactive dopamine systems. Within the psychiatric research community, this was widely acknowledged in the late 1980s and early 1990s. As Pierre Deniker, who was one of the founding fathers of psychopharmacology, confessed in 1990: "The dopaminergic theory of schizophrenia retains little credibility for psychiatrists."[4]

6. Since people with schizophrenia have no known "chemical imbalance" in the brain, antipsychotic drugs cannot be said to work by "balancing" brain chemistry. These drugs are not like "insulin for diabetes." They do not serve as a corrective to a known biological abnormality. Instead, Thorazine and other standard antipsychotics (also known as

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[2] Leff, J, et al. "The international pilot study of schizophrenia: five-year follow-up findings." *Psychological Medicine* 22 (1992):131-45.

[3] Jablensky, A, et al. "Schizophrenia: manifestations, incidence and course in different cultures, a World Health Organization ten-country study." *Psychological Medicine* 20, monograph supplement, (1992):1-95.

[4] Deniker, P. "The neuroleptics: a historical survey." *Acta Psychiatrica Scandinavica* 82, supplement 358 (1990):83-87.

neuroleptics) work by powerfully blocking dopamine transmission in the brain. Specifically, these drugs block 70% to 90% of a particular group of dopamine receptors known as D2 receptors. This thwarting of normal dopamine transmission is what causes the drugs to be so problematic in terms of their side effects.

8. Psychiatry's belief in the necessity of using the drugs on a continual basis stems from two types of studies.

a) First, research by the NIMH has shown that the drugs are more effective than placebo in curbing psychotic symptoms over the short term (six weeks).[5]

b) Second, researchers have found that if patients abruptly quit taking antipsychotic medications, they are at high risk of relapsing. [6]

9. Although the studies cited above provide a rationale for continual drug use, there is a long line of evidence in the research literature, one that is not generally known by the public or even by most psychiatrists, that shows that these drugs, over time, produce these results:

a) They increase the likelihood that a person will become chronically ill.
b) They cause a host of debilitating side effects.
c) They lead to early death.

III. Evidence Revealing Increased Chronicity of Psychotic Symptoms

10. In the early 1960s, the NIMH conducted a six-week study of 344 patients at nine hospitals that documented the efficacy of antipsychotics in knocking down psychosis

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[5] Cole, J, et al. "Phenothiazine treatment in acute schizophrenia." *Archives of General Psychiatry* 10 (1964):246-61.
[6] Gilbert, P, et al. "Neuroleptic withdrawal in schizophrenic patients." *Archives of General Psychiatry* 52 (1995):173-188.

over a short term. (See footnote five, above). The drug-treated patients fared better than the placebo patients over the short term. However, when the NIMH investigators followed up on the patients one year later, they found, much to their surprise, that it was the drug-treated patients who were more likely to have relapsed/ This was the first evidence of a paradox: Drugs that were effective in curbing psychosis over the short term were making patients more likely to become psychotic over the long term.[7]

11. In the 1970s, the NIMH conducted three studies that compared antipsychotic treatment with "environmental" care that minimized use of the drugs. In each instance, patients treated without drugs did better over the long term than those treated in a conventional manner.[8, 9, 10] Those findings led NIMH scientist William Carpenter to conclude that "antipsychotic medication may make some schizophrenic patients more vulnerable to future relapse than would be the case in the natural course of the illness."

12. In the 1970s, two physicians at McGill University, Guy Chouinard and Barry Jones, offered a biological explanation for why this is so. The brain responds to neuroleptics and their blocking of dopamine receptors as though they are a pathological insult. To compensate, dopaminergic brain cells increase the density of their D2 receptors by 40% or more. The brain is now "supersensitive" to dopamine, and as a result, the person has become more *biologically* vulnerable to psychosis than he or she would be naturally. The two Canadian researchers wrote: "Neuroleptics can produce a dopamine supersensitivity that leads to both dyskinetic and psychotic symptoms. An implication is that the tendency

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[7] Schooler, N, et al. "One year after discharge: community adjustment of schizophrenic patients." *American Journal of Psychiatry* 123 (1967):986-95.

[8] Rappaport, M, et al. "Are there schizophrenics for whom drugs may be unnecessary or contraindicated?" *Int Pharmacopsychiatry* 13 (1978):100-11.

[9] Carpenter, W, et al. "The treatment of acute schizophrenia without drugs." *American Journal of Psychiatry* 134 (1977):14-20.

[10] Bola J, et al. "Treatment of acute psychosis without neuroleptics: two-year outcomes from the Soteria project." *Journal of Nervous Mental Disease* 191 (2003):219-29.

toward psychotic relapse in a patient who had developed such a supersensitivity is determined by more than just the normal course of the illness. [11]

13. MRI-imaging studies have powerfully confirmed this hypothesis. During the 1990s, several research teams reported that antipsychotic drugs cause atrophy of the cerebral cortex and an enlargement of the basal ganglia.[12, 13, 14] In 1998, investigators at the University of Pennsylvania reported that the drug-induced enlargement of the basal ganglia is "associated with greater severity of both negative and positive symptoms." In other words, they found that the drugs cause morphological changes in the brain that are associated with a worsening of the very symptoms the drugs are supposed to alleviate.[15]

IV. Research Showing that Recovery Rates are Higher for Non-Medicated Patients than for Medicated Patients.

14. The studies cited above show that the drugs increase the chronicity of psychotic symptoms over the long term. There are also now a number of studies documenting that long-term recovery rates are much higher for patients off antipsychotic medications. Specifically:

a) In 1994, Courtenay Harding at Boston University reported on the long-term outcomes of 82 chronic schizophrenics discharged from Vermont State Hospital in the late 1950s. She found that one-third of this cohort had recovered

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[11] Chouinard, G, et al. "Neuroleptic-induced supersensitivity psychosis." *American Journal of Psychiatry* 135 (1978):1409-10. Also see Chouinard, G, et al. "Neuroleptic-induced supersensitivity psychosis: clinical and pharmacologic characteristics." *American Journal of Psychiatry* 137(1980):16-20.

[12] Gur, R, et al. "A follow-up magnetic resonance imaging study of schizophrenia." *Archives of General Psychiatry* 55 (1998):142-152.

[13] Chakos M, et al. "Increase in caudate nuclei volumes of first-episode schizophrenic patients taking antipsychotic drugs." *American Journal of Psychiatry* 151 (1994):1430-6.

[14] Madsen A, et al. "Neuroleptics in progressive structural brain abnormalities in psychiatric illness." *The Lancet* 352 (1998): 784-5.

[15] Gur, R, et al. "Subcortical MRI volumes in neuroleptic-naive and treated patients with schizophrenia." *American Journal of Psychiatry* 155 (1998):1711-17.

completely, and that all who did shared one characteristic: They had all stopped taking antipsychotic medication. The notion that schizophrenics needed to stay on antipsychotics all their lives was a "myth," Harding said.[16, 17, 18]

b) In the World Health Organization studies, 63% of patients in the poor countries had good outcomes, and only one-third became chronically ill. In the U.S. countries and other developed countries, only 37% of patients had good outcomes, and the remaining patients did not fare so well. In the undeveloped countries, only 16% of patients were regularly maintained on antipsychotics, versus 61% of patients in the developed countries.

c) In response to this body of literature, physicians in Switzerland, Sweden and Finland have developed programs that involve minimizing use of antipsychotic drugs, and they are reporting much better results than what we see in the United States.[19, 20, 21, 22] In particular, Jaako Seikkula recently reported that five years after initial diagnosis, 82% of his psychotic patients are symptom-free, 86% have returned to their jobs or to school, and only 14% of his patients are on antipsychotic medications.[23]

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[16] Harding, C. "The Vermont longitudinal study of persons with severe mental illness," *American Journal of Psychiatry* 144 (1987):727-34.

[17] Harding, C. "Empirical correction of seven myths about schizophrenia with implications for treatment." *Acta Psychiatrica Scandinavica* 90, suppl. 384 (1994):140-6.

[18] McGuire, P. "New hope for people with schizophrenia," *APA Monitor* 31 (February 2000).

[19] Ciompi, L, et al. "The pilot project Soteria Berne." *British Journal of Psychiatry* 161, supplement 18 (1992):145-53.

[20] Cullberg J. "Integrating psychosocial therapy and low dose medical treatment in a total material of first-episode psychotic patients compared to treatment as usual." *Medical Archives* 53 (199):167-70.

[21] Cullberg J. "One-year outcome in first episode psychosis patients in the Swedish Parachute Project. *Acta Psychiatrica Scandinavica* 106 (2002):276-85.

[22] Lehtinen V, et al. "Two-year outcome in first-episode psychosis according to an integrated model. *European Psychiatry* 15 (2000):312-320.

[23] Seikkula J, et al. Five-year experience of first-episode nonaffective psychosis in open-dialogue approach. *Psychotherapy Research* 16/2 (2006): 214-228.

d) This spring, researchers at the University of Illinois Medical School reported on the long-term outcomes of schizophrenia patients in the Chicago area since 1990. They found that 40% of those who refused to take their antipsychotic medications were recovered at five-year and 15-year followup exams, versus five percent of the medicated patients.[24]

V. Harmful Side Effects from Antipsychotic Medications

15. In addition to making patients chronically ill, standard antipsychotics cause a wide range of debilitating side effects. Specifically:

a) Tardive dyskinesia. The most visible sign of tardive dyskinesia is a rhythmic movement of the tongue, which is the result of permanent damage to the basal ganglia, which controls motor movement. People suffering from tardive dyskinesia may have trouble walking, sitting still, eating, and speaking. In addition, people with tardive dyskinesia show accelerated cognitive decline. NIMH researcher George Crane said that tardive dyskinesia resembles "in every respect known neurological diseases, such as Huntington's disease, dystonia musculorum deformans, and postencephalitic brain damage."[25] Tardive dyskinesia appears in five percent of patients treated with standard neuroleptics in one year, with the percentage so afflicted increasing an additional five percent with each additional year of exposure.

[24] Harrow M, et al. "Factors involved in outcome and recovery in schizophrenia patients not on antipsychotic medications." *Journal of Nervous and Mental Disease* 195 (2007): 406-414.

[25] Crane, G. "Clinical psychopharmacology in its 20th year," *Science* 181 (1973):124-128. Also see American Psychiatric Association, *Tardive Dyskinesia: A Task Force Report* (1992).

b) Akathisia. This is an inner restlessness and anxiety that many patients describe as the worst sort of torment. This side effect has been linked to assaultive, murderous behavior.[26, 27, 28, 29, 30]

c) Emotional impairment. Many patients describe feeling like "zombies" on the drugs. In 1979, UCLA psychiatrist Theodore van Putten reported that most patients on antipsychotics were spending their lives in "virtual solitude, either staring vacantly at television, or wandering aimlessly around the neighborhood, sometimes stopping for a nap on a lawn or a park bench . . . they are bland, passive, lack initiative, have blunted affect, make short, laconic replies to direct questions, and do not volunteer symptoms . . . there is a lack not only of interaction and initiative, but of any activity whatsoever.[31] The quality of life on conventional neuroleptics, researchers agreed, is "very poor."[32]

d) Cognitive impairment. Various studies have found that neuroleptics reduce one's capacity to learn and retain information. As Duke University scientist Richard Keefe said in 1999, these drugs may "actually prevent adequate learning effects and worsen motor skills, memory function, and executive abilities, such as problem solving and performance assessment."[33]

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[26] Shear, K et al. "Suicide associated with akathisia and depot fluphenazine treatment," *Journal of Clinical Psychopharmacology* 3 (1982):235-6.

[27] Van Putten, T. "Behavioral toxicity of antipsychotic drugs." *Journal of Clinical Psychiatry* 48 (1987):13-19.

[28] Van Putten, T. "The many faces of akathisia," *Comprehensive Psychiatry* 16 91975):43-46.

[29] Herrera, J. "High-potency neuroleptics and violence in schizophrenia," *Journal of Nervous and Mental Disease* 176 (1988):558-561.

[30] Galynker, I. "Akathisia as violence." *Journal of Clinical Psychiatry* 58 (1997):16-24.

[31] Van Putten, T. "The board and care home." *Hospital and Community Psychiatry* 30 (1979):461-464.

[32] Weiden P. "Atypical antipsychotic drugs and long-term outcome in schizophrenia." *Journal of Clinical Psychiatry* 57, supplement 11 (1996):53-60.

[33] Keefe, R. "Do novel antipsychotics improve cognition?" *Psychiatric Annals* 29 (1999):623-629.

d) Other side effects of standard neuroleptics include an increased incidence of blindness, fatal blood clots, arrhythmia, heat stroke, swollen breasts, leaking breasts, obesity, sexual dysfunction, skin rashes and seizures, and early death.[34, 35, 36] Schizophrenia patients now commit suicide at 20 times the rate they did prior to the use of neuroleptics.[37]

VI. The Research Literature on Atypical Antipsychotics

16. The conventional wisdom today is that the "atypical" antipsychotics that have been brought to market—Risperdal, Zyprexa, and Seroquel, to name three—are much better and safer than Haldol, Thorazine and the other older drugs. However, it is now clear that the new drugs have no such advantage, and there is even evidence suggesting that they are worse than the old ones.

17. Risperdal, which is manufactured by Janssen, was approved in 1994. Although it was hailed in the press as a "breakthrough "medication, the FDA, in its review of the clinical trial data, concluded that there was no evidence that this drug was better or safer than Haldol (haloperidol.) The FDA told Janssen: "We would consider any advertisement or promotion labeling for RISPERDAL false, misleading, or lacking fair balance under section 501 (a) and 502 (n) of the ACT if there is presentation of data that conveys the impression that risperidone is superior to haloperidol or any other marketed antipsychotic drug product with regard to safety or effectiveness."[38]

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[34] Arana, G. "An overview of side effects caused by typical antipsychotics." *Journal of Clinical Psychiatry* 61, supplement 8 (2000):5-13.

[35] Waddington, J. "Mortality in schizophrenia." *British Journal of Psychiatry* 173 (1998):325-329.

[36] Joukamaa, M, et al. Schizophrenia, neuroleptic medication and mortality. *British Journal of Psychiatry* 188 (2006):122-127.

[37] Healy, D et al. "Lifetime suicide rates in treated schizophrenia." *British Journal of Psychiatry* 188 (2006):223-228.

[38] FDA approval letter from Robert Temple to Janssen Research Foundation, December 21, 1993.

18. After Risperdal (risperidone) was approved, physicians who weren't funded by Janssen were able were able to conduct independent studies of the drug. They concluded that risperidone, in comparison to Haldol, caused a higher incidence of Parkinsonian symptoms; that it was more likely to stir akathisia; and that many patients had to quit taking the drug because it didn't knock down their psychotic symptoms.[39, 40, 41, 42, 43] Jeffrey Mattes, director of the Psychopharmacology Research Association, concluded in 1997: "It is possible, based on the available studies, that risperidone is not as effective as standard neuroleptics for typical positive symptoms."[44] Letters also poured into medical journals linking risperidone to neuroleptic malignant syndrome, tardive dyskinesia, tardive dystonia, liver toxicity, mania, and an unusual disorder of the mouth called "rabbit syndrome."

19. Zyprexa, which is manufactured by Eli Lilly, was approved by the FDA in 1996. This drug, the public was told, worked in a more "comprehensive" manner than either risperidone or haloperidol, and was much "safer and more effective" than the standard neuroleptics. However, the FDA, in its review of the trial data for Zyprexa, noted that Eli Lilly had designed its studies in ways that were "biased against haloperidol." In fact, 20 of the 2500 patients treated with Zyprexa in the trials died. Twenty-two percent of the Zyprexa patients suffered a "serious" adverse event, compared to 18 percent of the Haldol patients. There was also evidence that Zyprexa caused some sort of metabolic dysfunction, as patients gained nearly a pound per week. Other problems that showed up in Zyprexa patients included Parkinsonian symptoms, akathisia, dystonia, hypotension,

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[39] Rosebush, P. "Neurologic side effects in neuroleptic-naïve patients treated with haloperidol or risperidone." *Neurology* 52 (1999):782-785.

[40] Knable, M. "Extrapyramidal side effects with risperidone and haloperidol at comparable D2 receptor levels." *Psychiatry Research: Neuroimaging Section* 75 (1997):91-101.

[41] Sweeney, J. "Adverse effects of risperidone on eye movement activity." *Neuropsychopharmacology* 16 (1997):217-228.

[42] Carter, C. "Risperidone use in a teaching hospital during its first year after market approval." *Psychopharmacology Bulletin* 31 (1995):719-725.

[43] Binder, R. "A naturalistic study of clinical use of risperidone." *Psychiatric Services* 49 (1998):524-6.

[44] Mattes, J. "Risperidone: How good is the evidence for efficacy?" *Schizophrenia Bulletin* 23 (1997):155-161.

constipation, tachycardia, seizures, liver abnormalities, white blood cell disorders, and diabetic complications. Moreover, two-thirds of the Zyprexa patients were unable to complete the trials either because the drugs didn't work or because of intolerable side effects.[45]

20. There is now increasing recognition in scientific circles that the atypical antipsychotics are no better than the old drugs, and may in fact be worse. Specifically:

a) In 2000, a team of English researchers led by John Geddes at the University of Oxford reviewed results from 52 studies, involving 12,649 patients. They concluded: "There is no clear evidence that atypicals are more effective or are better tolerated than conventional antipsychotics." The English researchers noted that Janssen, Eli Lilly and other manufacturers of atypicals had used various ruses in their clinical trials to make their new drugs look better than the old ones. In particular, the drug companies had used "excessive doses of the comparator drug."[46]

b) In 2005, a National Institute of Mental Health study found that that were "no significant differences" between the old drugs and the atypicals in terms of their efficacy or how well patients tolerated them. Seventy-five percent of the 1432 patients in the study were unable to stay on antipsychotics owing to the drugs' "inefficacy or intolerable side effects," or for other reasons.[47]

c) In 2007, a study by the British government found that schizophrenia patients had better "quality of life" on the old drugs than on the new ones.[48] This finding was

[45] See Whitaker, R. *Mad in America*. New York: Perseus Press (2002):279-281.
[46] Geddes, J. "Atypical antipsychotics in the treatment of schizophrenia." *British Medical Journal* 321 (2000):1371-76.
[47] Lieberman, J, et al. "Effectiveness of antipsychotic drugs in patients with schizophrenia." *New England Journal of Medicine* 353 (2005):1209-1233.
[48] Davies, L, et al. "Cost-effectiveness of first- v. second-generation antipsychotic drugs." *The British Journal of Psychiatry* 191 (2007):14-22.

quite startling given that researchers had previously determined that patients medicated with the old drugs had a "very poor" quality of life.

20. There is also growing evidence that the atypicals may be exacerbating the problem of early death. Although the atypicals may not clamp down on dopamine transmission quite as powerfully as the old standard neuroleptics, they also block a number of other neurotransmitter systems, most notably serotonin and glutamate. As a result, they may cause a broader range of physical ailments, with diabetes and metabolic dysfunction particularly common for patients treated with Zyprexa. In a 2003 study of Irish patients, 25 of 72 patients (35%) died over a period of 7.5 years, leading the researchers to conclude that the risk of death for schizophrenics had "doubled" since the introduction of the atypical antipsychotics.[49]

VII. Conclusion

21. In summary, the research literature reveals the following:

a) Antipsychotics increase the likelihood that a person will become chronically ill.

b) Long-term recovery rates are much higher for unmedicated patients than for those who are maintained on antipsychotic drugs.

c) Antipsychotics cause a host of debilitating physical, emotional and cognitive side effects, and lead to early death.

[49] Morgan, M, et al. "Prospective analysis of premature morbidity in schizophrenia in relation to health service engagement." *Psychiatry Research* 117 (2003):127-35.

d) The new "atypical" antipsychotics are not better than the old ones in terms of their safety and tolerability, and quality of life may even be worse on the new drugs than on the old ones.

DATED this 4 day of September, 2007, in Cambridge, Massachusetts.

Robert B. Whitaker
Robert Whitaker

SUBSCRIBED AND SWORN TO before me this 4th day of September, 2007.

Notary Public in and for Massachusetts
My Commission Expires: August 6, 2013

TENZIN DEMAY
Notary Public
COMMONWEALTH OF MASSACHUSETTS
My Commission Expires
August 6, 2013

State of Alaska)
)ss
Third Judicial District)

I, James B. Gottstein, hereby affirm that this reproduction of Affidavit of Robert Whitaker, to which this is appended, is a true, correct and complete photocopy of the original filed in 3AN 07-1064PR.

Dated: March 6, 2008

James B. Gottstein

SUBSCRIBED AND SWORN TO before me this 6th day of March, 2008.

STATE OF ALASKA
NOTARY PUBLIC
Lisa E. Smith
My Commission Expires April 23, 2011

Lisa E. Smith
Notary Public in and for Alaska
My Commission expires: 4/23/2011

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

In The Matter of the Necessity for the)
Hospitalization of William S. Bigley,)
Respondent,)
William Worral, MD,)
Petitioner)
Case No. 3AN 07-1064 P/S

AFFIDAVIT OF RONALD BASSMAN, PhD

STATE OF NEW YORK)
) ss.
ALBANY COUNTY)

Is Medication for Serious Mental Illnesses the Only Choice For All People?
By Ronald Bassman, PhD

Albert Einstein once said that the definition of insanity is doing the same thing over and over again and expecting different results.

Today, the primary treatment for people who are diagnosed with serious mental illness is psychiatric medications regardless of effectiveness.[1] Institutions are filled with those who have failed to progress despite numerous trials on medications over the course of many years.[2] Current treatments for serious mental illnesses ignore research evidence showing debilitating conditions arising from the use of psychiatric medications.[3] Adults with serious mental illness treated in public systems die about 25 years earlier than Americans overall, a gap that's widened since the early 1990s when major mental disorders cut life spans by 10 to 15 years.[4] Along with shorter life spans, people taking psychiatric medication typically have medication-caused disabilities that make it extremely difficult for them to find employment and to become fully integrated members of the community. Not only do they show impairment in cognitive and motor abilities but also must live with physical distortions of appearance that make them extremely reluctant to be seen in public places.

Founded in 1988, the Tardive Dyskinesia/Tardive Dystonia National Association has received thousand of letters and inquiries from individuals taking psychiatric medications and who struggle with the adverse effects. Tardive dyskinesia, dystonia and akathisia are late appearing neurological movement disorders caused by psychoactive

drugs.[5] The following letters were received by the Tardive Dyskinesia/Tardive Dystonia National Association:[6]

"Tremors and spasms make my arms do a sort of jitterbug. Spasms in my neck pull my head to the side. My tongue sticks out as often as every thirty seconds."

- T.D. Survivor, Washington, DC

"Having TD is being unable to control my arms, fingers and sometimes my facial muscles; having a spastic digestive tract and trouble breathing. Getting food from my plate to my mouth and chewing it once there can be a real chore. I've bitten my tongue so severely it's scarred. I often bite it hard enough to bleed into the food I'm trying to eat. I no longer drink liquids without drooling."

- T.D. Survivor, New York

"I've always tried to feel better and I felt how could any prescribed medicine meant to help me, do more damage than the illness itself."

- T.D, Survivor, Louisiana

I am a person who was first diagnosed with schizophrenia paranoid type and then after another hospitalization diagnosed with schizophrenia chronic type and who was prescribed numerous psychiatric drugs including Thorazine Stelazine and Mellaril. I have been drug-free for more than thirty years. Having had personal experience with psychiatric medication and recovered after withdrawing from the prescribed drugs, I have subsequently worked as a psychologist to develop and promote alternative healing practices.[7] I have written and published articles in professional journals and in 2005 co-founded the International Network of Treatment Alternatives for Recovery.[8]

Research, my own and others, in addition to the numerous personal accounts of recovery without psychiatric medications, coupled with the documented adverse effects demand that we respect a person's choice -- choices which are based on personal experience and preference for other methods of coping and progressing toward recovery and re-integration into the community.[9] Psychiatric medication is and should be only one of many treatment choices for the individual with serious mental illness. And when it is clear that medications are not effective, it is necessary and only humane to offer other options for the individual to choose. Primary to the recovery process is personal choice.

The National Research Project for the Development of Recovery Facilitating System Performance Indicators concluded that, "Recovery from mental illness can best be understood through the lived experience of persons with psychiatric disabilities." The Research Project listed the following themes as instrumental to recovery:

*Recovery is the reawakening of hope after despair.

*Recovery is breaking through denial and achieving understanding and acceptance.

*Recovery is moving from withdrawal to engagement and active participation in life.

*Recovery is active coping rather than passive adjustment.

*Recovery means no longer viewing oneself primarily as a mental patient and reclaiming a positive sense of self.

*Recovery is a journey from alienation to purpose.
*Recovery is a complex journey.
*Recovery is not accomplished alone—it involves support and partnership.[10]

Research describing what people want and need is very similar to what everyone wants and needs. The best practices of psychosocial rehabilitation highlight the following:

1. Recovery can occur without professional intervention. The consumer/survivors rather than professionals are the keys to recovery.

2. Essential is the presence of people who believe in and stand by the person in need of recovery. Of critical importance is a person or persons whom one can trust to be there in times of need.

3. Recovery is not a function of one's theory about the causes of mental illness. And recovery can occur whether one views the condition as biological or not.

4. People who experience intense psychiatric symptoms episodically are able to recover. Growth and setbacks during recovery make it feel like it is not a linear process. Recovery often changes the frequency and duration of symptoms for the better. The process does not feel systematic and planned.

5. Recovery from the consequences of the original condition may be the most difficult part of recovery. The disadvantages, including stigma, loss of rights, discrimination and disempowering treatment services can combine to hinder a person's recovery even if he or she is asymptomatic.[11]

In the above concepts promoting recovery there is a conspicuous absence of psychiatric medication. Psychologist Courtenay Harding, principal researcher of the "Vermont Longitudinal Study," has empirically demonstrated that people do recover from long-term chronic disorders such as schizophrenia at a minimum rate of 32 % and as high as 60%.[12] These studies have consistently found that half to two thirds of patients significantly improved or recovered, including some cohorts of very chronic cases. The 32 % for full recovery is with one of the five criteria being *no longer taking any psychiatric medication.* Dr. Harding in delineating the seven myths of schizophrenia, addresses the myth about psychiatric medication. Myth number 5. **Myth: Patients must be on medication all their lives. Reality: It may be a small percentage who need medication indefinitely.** According to Harding and Zahniser, the myths limit the scope and effectiveness of treatments available to patients.[13]

The most important principle of the medical profession is one that has stood the test of time. "First do **no harm.**" When it is clear that psychiatric medications have been ineffective and/or harmful in the treatment of a particular individual, and when that person objects to another treatment course with psychiatric drugs, it is wrong to continue on this course against the expressed wishes of that individual. One must consider the

statement attributed to Albert Einstein at the beginning of this affidavit. Let us work with people to implement their informed choices for alternative services and not continue trying to implement a treatment that has not worked.

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[3]Jeffrey A. Lieberman, M.D., T. Scott Stroup, M.D., M.P.H., Joseph P. McEvoy, M.D., Marvin S. Swartz, M.D., Robert A. Rosenheck, M.D., Diana O. Perkins, M.D., M.P.H., Richard S.E. Keefe, Ph.D., Sonia M. Davis, Dr.P.H., Clarence E. Davis, Ph.D., Barry D. Lebowitz, Ph.D., Joanne Severe, M.S., John K. Hsiao, M.D., for the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) Investigators Effectiveness of Antipsychotic Drugs in Patients with Chronic Schizophrenia, Vol.353:1209-1223, No.12, 2005.

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[12] Harding C.M., Brooks G.W., Ashikaga T., Strauss J.S. and Breier A. The Vermont longitudinal study of persons with severe mental illness, I: Methodology, study sample, and overall status 32 years later. Am J Psychiatry; 144:718-726, 1987.

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DATED this 4 day of September, 2007, in Albany, New York.

Ronald Bassman, PhD

SUBSCRIBED AND SWORN TO before me this 4th day of September 2007.

CAROL D. ROSSI
Notary Public, State of New York
Qualified in Albany County
No. 01RO6106782
Commission Expires March 15, 2008

Notary Public in and for New York
My Commission Expires: 03/15/2008

State of Alaska)
)ss
Third Judicial District)

I, James B. Gottstein, hereby affirm that this reproduction of Affidavit of Ronald Bassman, PhD, to which this is appended, is a true, correct and complete photocopy of the original filed in 3AN 07-1064PR.

Dated: March 6, 2008

James B. Gottstein

SUBSCRIBED AND SWORN TO before me this 6th day of March, 2008.

STATE OF ALASKA
NOTARY PUBLIC
Lisa E. Smith
My Commission Expires April 23, 2011

Notary Public in and for Alaska
My Commission expires: 4/23/2011

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

In The Matter of the Necessity for the)
Hospitalization of William S. Bigley,)
Respondent,)
William Worral, MD,)
Petitioner)

Case No. 3AN 07-1064 P/S

AFFIDAVIT OF PAUL A. CORNILS

STATE OF ALASKA)
) ss.
THIRD JUDICIAL DISTRICT)

I, Paul A. Cornils, being first duly sworn under oath do hereby state as follows:

A. My name is Paul Cornils and I am the Program Manager for CHOICES, Inc., which stands for Consumers Having Ownership in Creating Effective Services. I have almost 10 years experience working in the field of behavioral health with adults and children including 8 years as a case manager with people who are diagnosed with serious and persistent mental illness.

B. I first began Respondent Bill Bigley in January of 2007, under contract with the Law Project for Psychiatric Rights (PsychRights®). When the cost of services exceeded $5,000 PsychRights said it could not afford to continue paying and Mr. Bigley informed me he did not want to work with me anymore so services were discontinued.

C. CHOICES began working with Mr. Bigley again in July of this year at the request of the Office of Public Advocacy (OPA), Mr. Bigley's Guardian and has continues to do so.

D. Mr. Bigley is so angry at being put under a guardianship that he takes extreme measures to try to get rid of his guardianship. As a result, he is mostly refusing to cooperate in virtually any way with the Guardian.

E. For example, Mr. Bigley rips up checks from the Guardian made out to Vendors on his behalf, trying to force the Guardian to give him his money directly and as part of his effort to eliminate the guardianship.

F. Mr. Bigley has also refused various offers of "help" from the Guardian, such as grocery shopping in a similar attempt to get out from under the guardianship.

G. He exhibits the same types of behavior to me, but I have a different approach, which involves negotiation and discussion, does not involve coercion and where the natural consequences of Mr. Bigley's actions are allowed to occur.

H. This is very important because after people are labeled with a mental illness everything is attributed to the mental illness and the person no longer takes responsibility for his or her actions.

I. Taking responsibility for one's actions is a core tenet of CHOICES' approach.

J. Another tenet of the CHOICES' approach is what is known as a "Relapse Plan." In fact, there is a whole curriculum called the "WRAP," developed by Mary Ellen Copeland, used around the world, which stands for Wellness Recovery Action Plan, of which a Relapse Plan is a part. Other aspects are learning how to deal with one's difficulties in ways that do not create as many problems. I am a trained WRAP Facilitator.

K. With Mr. Bigley, however, I have used Anger Management, Moral Reconation Therapy (MRT) and elements of Peer Support, all of which I have taken training in and have received certification as the most beneficial techniques for Mr. Bigley at this time.

L. It is my belief that if the CHOICES approach were consistently used with Mr. Bigley and there are sufficient community support resources there is a good chance he will be able to live successfully in the community.

M. I understand Mr. Bigley, through his attorney Jim Gottstein, has moved for an injunction as follows:

> 1. Mr. Bigley be allowed to come and go from API as he wishes, including being given, food, good sleeping conditions, laundry and toiletry items.
>
> 2. If involuntarily at a treatment facility in the future, be allowed out on passes at least once each day for four hours with escort by staff members who like him, or some other party willing and able to do so.
>
> 3. Only the Medical Director of API may authorize the administration of psychotropic medication pursuant to AS 47.30.838 (or any other justification for involuntary administration of medication, other than under AS 47.30.839), after consultation with James B. Gottstein, Esq., or his successor.
>
> 4. API shall procure and pay for a reasonably nice two bedroom apartment that is available to Mr. Bigley should he choose it.[1] API shall first attempt to negotiate an acceptable abode, and failing that procure it and make it available to Mr. Bigley.
>
> 5. At API's expense, make sufficient staff available to be with Mr. Bigley to try keep him out of trouble.
>
> 6. The foregoing may be contracted for from an outpatient provider.

[1] API may seek to obtain a housing subsidy from another source, but such source may not be his Social Security Disability income.

N. It makes perfect sense. With respect to Number 1, Mr. Bigley's problems in the community revolve around the expression of his extreme anger, and has caused the loss of housing options. Currently, it is my understanding even the Brother Francis Shelter is not available to him. There needs to be a safe and comfortable place for Mr. Bigley to sleep when he doesn't have any other option. Even though he is never actually violent, there is no other option in Anchorage of which I am aware that is in a position to deal with his yelling and screaming.

O. Frankly, it is unlikely that Mr. Bigley would avail himself of the option because of the way he has been locked up and treated there so much in his life, but the option should be available to him.

P. Number 2, is more likely unless and until Mr. Bigley gets his behavior within a socially acceptable range. Mr. Bigley seems to always be okay on pass when he is there so he should be given such passes.

Q. With respect to Number 4, housing is a huge issue for Mr. Bigley. He demands a relatively nice apartment and will choose homelessness over one that does not meet his requirements. Currently, under his Guardianship regime, he is only given about $60 per week for food and $50 per week for spending money. That is an unreasonably small amount. I don't know if the State should be required to support Mr. Bigley's housing to the extent requested by Mr. Gottstein, but it should in a reasonable amount as necessary.

R. With respect to Number 5, right now, it would be very beneficial to have someone with Mr. Bigley for an extended period of time during the day to help him meet his needs and stay out of trouble.

S. Currently, it would probably take more than Medicaid allows to provide what is needed.

T. Using CHOICES' approach, it is my opinion there is a reasonable prospect that within a year to eighteen months Mr. Bigley could get by with far less services and be within the normal Medicaid range.

U. There is also a reasonable prospect that this will never be achieved.

V. With respect to Number 6, CHOICES could be such an outpatient provider, but would need to increase its staffing level in order to be able to do so properly, which would take at least a little bit of time.

FURTHER YOUR AFFIANT SAYETH NAUGHT.

DATED September 12, 2007.

By: Paul A. Cornils
Paul A. Cornils

SUBSCRIBED AND SWORN TO before me this 12th day of September, 2007.

STATE OF ALASKA
NOTARY PUBLIC
Lisa E. Smith
My Commission Expires April 23, 2011

Lisa E. Smith
Notary Public in and for Alaska
My Commission Expires: 4/23/2011

State of Alaska)
)ss
Third Judicial District)

I, James B. Gottstein, hereby affirm that this reproduction of Affidavit of Paul Comils, to which this is appended, is a true, correct and complete photocopy of the original filed in 3AN 07-1064PR.

Dated: March 6, 2008

James B. Gottstein

SUBSCRIBED AND SWORN TO before me this 6th day of March, 2008.

Notary Public in and for Alaska
My Commission expires: 4/23/2011

STATE OF ALASKA
NOTARY PUBLIC
Lisa E. Smith
My Commission Expires April 23, 2011

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

In The Matter of the Necessity for the Hospitalization of William Bigley,

Respondent

Case No. 3AN 08-00493PR

MOTION TO VACATE APPOINTMENT OF PUBLIC DEFENDER AGENCY WITH RESPECT TO AS 47.30.839 PETITION

The Respondent in this matter, William Bigley, by and through counsel the Law Project for Psychiatric Rights (PsychRights) hereby moves to vacate the appointment of the Public Defender Agency with respect to the AS 47.30.839 forced drugging petition presumably filed in this case. This motion is accompanied by a memorandum in support.

DATED: April 29, 2008.

Law Project for Psychiatric Rights

By: _____
James B. Gottstein
ABA # 7811100

LAW PROJECT FOR PSYCHIATRIC RIGHTS, INC.
406 G Street, Suite 206
Anchorage, Alaska 99501
(907) 274-7686 Phone ~ (907) 274-9493 Fax

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

In The Matter of the Necessity for the Hospitalization of William Bigley,

Respondent

Case No. 3AN 08-00493PR

MEMORANDUM IN SUPPORT OF MOTION TO VACATE APPOINTMENT OF PUBLIC DEFENDER AGENCY WITH RESPECT TO AS 47.30.839 PETITION

The Respondent in this matter, William Bigley, by and through counsel, the Law Project for Psychiatric Rights (PsychRights), has moved to vacate the appointment of the Public Defender Agency with respect to the AS 47.30.839 forced drugging petition filed in this case (Motion). The grounds for the Motion follow.

I. PsychRights Represents Respondent

PsychRights represents the Respondent with respect to any AS 47.30.838 or AS 47.30.839 forced drugging. The attorney for the Alaska Psychiatric Institute (API) was informed by e-mail of this representation on Saturday, April 26, 2008,[1] and upon his failure to respond, the Chief Executive Officer of API was informed directly (with a copy to API's attorney), whereupon API's attorney responded, "I have received your emails and will communicate to you as appropriate."

API then apparently filed a forced drugging petition under AS 47.30.839 without informing the Court that PsychRights was representing Respondent and the Court

[1] Exhibit A. PsychRights has also formally filed a limited entry of appearance herein.

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406 G Street, Suite 206
Anchorage, Alaska 99501
(907) 274-7686 Phone ~ (907) 274-9493 Fax

appointed the Public Defender Agency.[2] This is frankly an outrage. The Respondent has the absolute statutory[3] and constitutional right[4] to counsel of his choice if such is available to him. The practice of immediately appointing the Public Defender Agency when a forced drugging petition is filed under AS 47.30.839 is improper. The Court is required to first determine if the Public Defender Agency should be appointed under AS 47.30.839(c).

Moreover, the AS 47.30.839 petition is premature. In *Myers v. Alaska Psychiatric Institute,* the Alaska Supreme Court explained involuntary commitments and forced drugging involve two separate steps:[5]

> To treat an unwilling and involuntarily *committed mental patient* with psychotropic medication, the state must initiate the second step of the process by filing a second petition, asking the court to approve the treatment it proposes to give.

This was reiterated in *Wetherhorn v. Alaska Psychiatric Institute*,[6]:

> Unlike involuntary commitment petitions, there is no statutory requirement that a hearing be held on a petition for the involuntary administration of psychotropic drugs within seventy-two hours of a respondent's initial detention. The expedited process required for involuntary commitment proceedings is aimed at mitigating the infringement of the respondent's liberty rights that begins the moment the respondent is detained involuntarily. In contrast, so long as no drugs have been administered, the rights to liberty and privacy implicated by the right to refuse psychotropic medications remain intact. Therefore, in the absence of an

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(907) 274-7686 Phone ~ (907) 274-9493 Fax

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[2] The undersigned was also served with a subpoena to testify in this proceeding.
[3] AS 47.30.839(c).
[4] Just last year, the U.S. Supreme Court addressed the fundamental nature of this right in the criminal context in *United States v. Gonzalez-Lopez*, ___ U.S. ___, 126 S.Ct. 2557 (2006). While civil commitment and forced drugging are not criminal proceedings, as in criminal cases, incarceration is involved, and as the Alaska Supreme Court has recently recognized, forced psychiatric drugging can be and have been equated with forced electroshock and lobotomy. *Myers* at 242 (Alaska 2006); *Wetherhor*, 156 P.3d at 382.
[5] 138 P.2d 238, 242-3 (Alaska 2006), emphasis added.
[6] 156 P.3d 371, 382 (Alaska 2007), footnotes omitted.

emergency, there is no reason why the statutory protections should be neglected in the interests of speed.

The Alaska Supreme Court thus specifically held it is a two-step process wherein the forced drugging petition cannot proceed before the involuntary commitment process has been completed:

> Alaska requires a two-step process before psychotropic drugs may be administered involuntarily in a non-crisis situation: the State must first petition for the respondent's commitment to a treatment facility, and then petition the court to approve the medication it proposes to administer. The second step requires that the State prove by clear and convincing evidence that: (1) the *committed patient* is currently unable to give or withhold informed consent;[7]

Both *Myers* and *Wetherhorn* specifically referred to these two steps and to a "committed" patient.[8] In *Myers* the Alaska Supreme Court held the Forced Drugging Petition is filed *after* a commitment has been granted.[9] Thus, only after a commitment order has been signed by the *Superior Court Judge* may a forced drugging petition be filed, at which point whether the Public Defender Agency should be appointed has to be heard and decided by the Court. In this case, of course, it would be improper to appoint the Public Defender Agency because the respondent is already represented.

DATED: April 30, 2008.

Law Project for Psychiatric Rights

By: _____
James B. Gottstein, ABA # 7811100

LAW PROJECT FOR PSYCHIATRIC RIGHTS, INC.
406 G Street, Suite 206
Anchorage, Alaska 99501
(907) 274-7686 Phone ~ (907) 274-9493 Fax

[7] 156 P.3d at 382, emphasis added.
[8] AS 47.30.839(c) also makes this clear by making the appointment of counsel for a forced drugging petition under AS 47.30.839 completely different than for a 30 day commitment petition under AS 47.30.700(a).
[9] 138 P.3d at 242-3.

Subject: RE: [Fwd: Mr. B.]
From: "Twomey, Timothy M (LAW)" <tim.twomey@alaska.gov>
Date: Tue, 29 Apr 2008 08:31:58 -0800
To: Jim Gottstein <jim.gottstein@psychrights.org>, "Adler, Ronald M (HSS)" <ronald.adler@alaska.gov>, "Kraly, Stacie L (LAW)" <stacie.kraly@alaska.gov>
CC: "Beecher, Linda R (DOA)" <linda.beecher@alaska.gov>, "Brennan, Elizabeth (DOA)" <elizabeth.brennan@alaska.gov>, "Gillilan-Gibson, Kelly (DOA)" <kelly.gillilan-gibson@alaska.gov>

Jim – I have received your emails and will communicate to you as appropriate.
Thank you. Tim

Tim Twomey (907) 269-5168 direct

From: Jim Gottstein [mailto:jim.gottstein@psychrights.org]
Sent: Tuesday, April 29, 2008 8:24 AM
To: Adler, Ronald M (HSS); Kraly, Stacie L (LAW)
Cc:
Twomey, Timothy M (LAW); Beecher, Linda R (DOA); Brennan, Elizabeth (DOA); Gillilan-Gibson, Kelly (DOA); jim.gottstein@psychrights.org
Subject: [Fwd: Mr. B.]
Importance: High

Hi Ron,

In the absence of any response to the below from Mr. Twomey and therefore not knowing who might be representing the hospital, I am forwarding the below e-mail to you and advising you that I am representing Mr. Bigley with respect to forced drugging (presumably under AS 47.30.838 and/or AS 47.30.839) unless and until otherwise notified. Thus, any forced drugging petition must be served on me. My fax number is 274-9493. Please forward this to whoever is representing the hospital with respect to Mr. Bigley regarding any proceedings that have arisen or might arise out of Mr. Bigley's current admission. I will also need a copy of Mr. Bigley's chart, updated daily.

Please also note that I made a formal proposal to Mr. Twomey, which was required to be presented to the appropriate decision maker(s) at API, unless prior discussions with your attorney left it clear the proposal will be unacceptable. Even if so, I think it is imperative that all parties get together to try and work out an approach for Mr. Bigley that comports with his rights.

-------- Original Message --------
Subject: Mr. B.
Date: Sat, 26 Apr 2008 11:38:47 -0800
From: Jim Gottstein <jim.gottstein@psychrights.org>
Organization: Law Project for Psychiatric Rights
To: Russo, Elizabeth M H (DOA) <elizabeth.russo@alaska.gov>, Twomey, Timothy M (LAW) <tim.twomey@alaska.gov>, Gillilan-Gibson, Kelly (DOA) <kelly.gillilan-gibson@alaska.gov>, Beecher, Linda R (DOA) <linda.beecher@alaska.gov>, Brennan, Elizabeth (DOA) <elizabeth.brennan@alaska.gov>
CC:jim.gottstein@psychrights.org

Hi Tim, Elizabeth, Linda, Beth and Kelly,

Mr. Bigley is back in API. Unless and until otherwise notified, I am representing him with respect to forced drugging, including prospective proceedings.

With respect to his current admission, in thinking about things, it seems to me there is a pretty high likelihood that because:

(a) he had lost his housing and wasn't willing to accept the housing offered by OPA,
(b) he wasn't allowed at the shelter,
(c) there was a $#@)*&% blizzard late Friday afternoon, and
(d) API was preferable to a snowbank or jail,

he acted the way he had to act at OPA in order to get sent to API. I don't think he should have to act that way to access API. Therefore, I propose the following:

1. He be allowed to come and go from API as he wishes, including being given food, good sleeping conditions, laundry, washing facilities, toiletry items, etc.

2. If brought to API on a PoA or *Ex Parte*, absent compelling concern about the safety of doing so, he be allowed out on pass each day for at least four hours, with or without escort. Actually, it seems to me that most of the time he ought to be let out each morning with him not being required to return. If he gets brought back for his behavior in the community then the process can be repeated. That way he has a place to sleep, get his food, wash, etc.

This, of course, doesn't apply if he gets charged criminally, but since he is considered incompetent to stand trial with no prospects for becoming competent, they aren't hanging on to him, which tends to land him back at API.

Of course, the Guardian will continue to work with him to provide a more suitable arrangement for all concerned.

Tim, I understand Dr. Gomez is his treating physician. This is a formal proposal and I will appreciate your conveying it to him and/or whoever else might be necessary to approve it. I will, of course, be pleased to meet to discuss why I think this approach should be adopted and have the Guardian and Public Defender Agency involved if they so desire.

--

James B. (Jim) Gottstein, Esq.
President/CEO

Law Project for Psychiatric Rights
406 G Street, Suite 206
Anchorage, Alaska 99501
USA
Phone: (907) 274-7686) Fax: (907) 274-9493
jim.gottstein[[at]]psychrights.org
http://psychrights.org/

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
AT ANCHORAGE

RECEIVED
MAY 12 2008

In the Matter of the Necessity For the Hospitalization of: William Bigley, Respondent	Case No. 3AN-08-00403 PR

ORDER REGARDING REPRESENTATION

The Public Defender Agency was appointed to represent Mr. Bigley in the above matter. So far, the Agency has represented Mr. Bigley in regard to the Petition for 30 Day Commitment. A recommendation in that phase of the case will be issued today. The Agency is required to continue representing Mr. Bigley through the commitment phase, specifically the filing of any objections to the master's recommendation and any hearing associated with those objections. The public defender is not required to consult with Mr. Gottstein. The public defender appointment will be considered terminated once the issue of objections is resolved.

Jim Gottstein filed a limited entry of appearance indicating his plan to represent Mr. Bigley in regard to the Petition for Court Approval of Administration of Psychotropic Medication. On April 30, 2008 the Court refused to allow Mr. Gottstein to enter the appearance because the medication petition was not in a posture to be decided. Since the master's recommendation as to the commitment petition is complete, Mr. Gottstein's entry of appearance will b considered operative as to the medication petition.

DATED this 2 day of May 2008.

Lucinda M Burney
LUCINDA MCBURNEY
SUPERIOR COURT MASTER

I certify that on 5-2-08
a copy of the foregoing was
mailed/hand delivered to: PD/AG/GAL/API
Clerk/Secretary/

- Manifests a current intent to carry out plans of serious harm to another.

While Mr. Bigley's condition has deteriorated greatly, none of the professionals testified that they think he is likely to assault anyone. In fact, they are more concerned that he is likely to be harmed by someone else by inciting them. While other members of the public are disturbed by and frightened of Mr. Bigley, he has limited himself so far to angry verbal expressions. He has never attempted to strike or harm someone.
As noted above, Mr. Bigley has been preoccupied by natural and man made catastrophes. He has talked about blowing things up. None of the professionals involved with him believe his thoughts are organized enough to carry out any sort of plan. The finding at the hearing that Mr. Bigley presents a danger to others is hereby vacated.

Danger to Self

13. The State also argued that Mr. Bigley presents a danger to himself, largely because his behavior places him in danger of being assaulted or worse. To find that Mr. Bigley is a danger to self the court would have to find he is a person who:

- Poses a substantial risk of harm to others as manifested by recent behavior causing, attempting, or threatening that harm.

Mr. Bigley's behavior gets him into trouble, but there is no evidence that he is making an attempt to get himself killed. This is not a "suicide by cop" situation. He tends to provoke others but it appears to incidental to being his anger and agitation.

Gravely Disabled

14. The State has also argued again that Mr. Bigley is gravely disabled. According to AS.47.30.915 (7) "gravely disabled" means a condition in which a person, as a result of mental illness

- (A) is in danger of physical harm arising from such complete neglect of basic needs for food, clothing shelter or personal safety as to render serious accident, illness or death highly probable if care by another is not taken or
- (B) will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional or physical distress and this distress is associated with significant impairment of judgment, reason or behavior causing a substantial deterioration of the person's previous ability to function independently

15. The State filed two earlier petitions (March and April 2008) and both alleged that Mr. Bigley was gravely disabled. In both instances the Court denied the petition. Perhaps the biggest change since the first April petition was filed has been Mr. Bigley's

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
AT ANCHORAGE

RECEIVED
MAY 12 2008

In the Matter of the Necessity For the Hospitalization of :	)	
William Bigley, Respondent.	)	Case No. 3AN-08-00493 PR
	)	ORDER FOR 30-DAY COMMITMENT

FINDINGS

A petition for 30-day commitment was filed on April 29, 2008.

A hearing was held on April 30, 2008, to inquire into the mental condition of the respondent. Respondent was personally present at the hearing and was represented by Elizabeth Brennan, attorney. Representing the State was Timothy Twomey.

Having considered the allegations of the petition, the evidence presented and the arguments of counsel, the court finds by clear and convincing evidence:

1. Respondent is mentally ill and, as a result, is
   - ☐ likely to cause harm to himself / herself or others.
   - X gravely disabled.

2. Respondent has been advised of and refused voluntary treatment.

3. Respondent is a resident of the State of Alaska.

4. Respondent was given verbal notice that if commitment or other involuntary treatment beyond the 30 days is sought, respondent will have the right to a full hearing or jury trial.

5. Alaska Psychiatric Institute, or a designated treatment facility closer to the respondent's home, is an appropriate treatment facility.* No less restrictive facility would adequately protect the respondent and the public.

*If space is available, and upon acceptance by another treatment facility, the respondent shall be places by the department at the designated treatment facility closest to the respondent's home pursuant to AS 47.30.760, unless the court orders otherwise.

6. The facts which support the above conclusions are:

See attached Findings of Fact

ORDER

Therefore, it is ordered that respondent, _____, is committed to Alaska Psychiatric Institute, for a period of time not to exceed 30 days. If space is available, and upon acceptance by another treatment facility, the respondent shall be placed at the designated treatment facility closest to the respondent's home.

5/5/08
Date

Mark Rindner
Superior Court Judge ~~Morse~~ Rindner

I certify that on 5/7/08
A copy of this order was sent
To:
Respondent AG
Respondent's attorney PD
Attorney General APD
Treatment facility

Clerk: dlk

Recommend for approval
Lucinda McBurney 5-2-08
Lucinda McBurney Date 5-2-08

cc: AG/PD/APD

NOTICE OF RIGHTS

To: Respondent

YOU ARE HEREBY GIVEN NOTICE that if commitment or other involuntary treatment beyond the 30 days is sought, you shall have the right to a full hearing or jury trial.

Findings of Fact

Diagnosis

1. Dr. Lawrence Maile, Clinical Director of the Forensic Evaluation Unit at A.P.I., testified that the respondent's diagnosis is paranoid schizophrenia. He has had multiple admissions at A.P.I. with a consistent diagnosis. He experiences delusions such as believing his food and water are poisoned and that he has God like powers. He has little to no insight about his mental illness or his behavior. His thinking and remarks are influenced heavily by current events He can get preoccupied with insisting that he is not responsible for a catastrophic event and then later claims responsibility for the event and threatens to repeat it.

Recent history prior to April 25, 2008

2. In the last several months Mr. Bigley has behaved in a manner that concerns those who deal with him. He does not have a prior history of assaultive behavior. He has started to act aggressively with people by advancing on them, glaring at them, speaking in a loud angry voice, using profanity and making verbal threats. He has behaved this way with strangers and people familiar to him. There have been incidents in which he nearly incited persons with limited self control to physically attack him. He has not actually assaulted anyone. Professionals used to dealing with him such as the public guardian and Dr. Maile testified they are not afraid for their safety. However, his behavior is unpredictable enough that they are more vigilant than usual.

3. The most recent petitions filed to commit Mr. Bigley are connected to his behavior at the First National Bank of Anchorage. Mr. Bigley has funds in a bank account held by the bank. Mr. Bigley also has a public guardian. Mr. Bigley apparently used to be able to get money from the bank by himself. At some point Mr. Bigley had difficulty waiting in line at the bank by himself and could be disruptive. Mr. Bigley's public guardian then tried accompanying him and waiting in line with him. That strategy worked for a while and then failed. The guardian then tried a type of pre-paid card that could be used like a credit card. Mr. Bigley tended to lose the cards. When he had cash he sometimes gave it away.

4. Over the last few months, however, his behavior at the bank has been so disruptive the bank manager has told him he cannot come back. Kimberley Frensley, the bank manager, testified that she ended up being the only person dealing with Mr. Bigley because the rest of the employees are afraid of him. Although they have had an amiable relationship in the past she too is now afraid of him. Events came to a head in the second week of April 2008. Mr. Bigley had already been told not to return to the bank and the bank issued a no trespassing order. The public guardian came to the bank to cash a check for Mr. Bigley. Mr. Bigley followed him into the bank and made straight for Ms. Frensley. He seemed angry and aggressive to Ms. Frensley and was demanding to know where his money way. He was swearing and making verbal

threats. The police finally had to be called to remove him. He came back several hours later, saying "they" couldn't do anything to him and "I'm back!" Another employee who was reportedly larger than Mr. Bigley became irate and challenged Mr. Bigley. They were shouting at each other and she succeeded in pushing him out the front door and locking it. The police removed him again.

5. Mr. Bigley's disruptive behavior is displayed in other settings. James Gottstein, one of his attorneys, testified he has called the police to remove Mr. Bigley from his office. He likes to visit the office but he talks constantly and loudly. Mr. Gottstein said when he acts that way his office cannot get any work done. Furthermore, his demeanor and behavior scares other tenants in the building. Mr. Gottstein testified that it used to be enough to tell him he would call the police and he would leave. In April, Mr. Gottstein had to resort to calling the police several times.

6. On April 17, 2008 the State filed a petition for commitment alleging that Mr. Bigley was gravely disabled based upon the above facts. That effort was unsuccessful. Events that occurred on Friday, April 25, 2008 prompted the filing of the current petition.

Events since April 25, 2008

7. On April 25, Mr. Bigley returned to the bank. By this time the bank had hired security guards because of Mr. Bigley. They met him at the front door and he never got inside. They were able to make him leave without calling the police. He also visited the office of the public guardian. His assigned guardian was in Kodiak and Mr. Bigley's former guardian, Steven Young substituted for him. Mr. Young testified that Mr. Bigley was very difficult to work with that day.

8. Mr. Young learned that Mr. Bigley had lost his housing at the motel where he was staying. Mr. Young called around to different motels trying to find another place for him to stay. Mr. Bigley smokes and that made it more difficult. He finally found a room at a motel on Tudor and made arrangements to pay for it. Mr. Bigley refused to go. . He was agitated about a story in the newspaper and said the only thing he was willing to do was go to the airport and get on an airplane. He refused the motel room because it was not a plane. Mr. Bigley had difficulty explaining himself because he seemed to be unable to pronounce the first half of words. He was aggressive and shouting and his words were not complete. Mr. Bigley did not seem to recognize Mr. Young. He reportedly was not eating or drinking anything. Mr. Young tried to give him money for food and a bus pass. Mr. Bigley spit on what was offered and said he did not need to eat. Mr. Young said he had never seen Mr. Bigley in such a bad state. He was so agitated that they called the police and the officers filed a POA.

9. Mr. Bigley has had a difficult stay so far at A.P.I. He has refused to eat or drink although he apparently ate something on the day of the hearing. He usually is housed in one of the less restrictive units but his behavior has been too disruptive on that unit. Dr. Maile testified that Mr. Bigley has intimidated other residents who then try

to retaliate physically. He was moved to a more secure unit, Taku, because of this. He repeated the behavior on Taku and was then placed in locked seclusion.

10. Mr. Bigley's demeanor and behavior were remarkable at the hearing on April 30, 2008. From the outset he talked virtually non stop. For most of the hearing he sat in the back of the courtroom near to Mr. Gottstein. He spoke loudly enough that it was not only possible to hear what he was saying but that to some degree he was louder than the witness. Mr. Gottstein, Ms. Brennan and the court made futile attempts to get him to lower his voice. Mr. Bigley was not trying to disrupt the proceedings but he also seemed completely unaware of the effect of his monologue. Generally he was not speaking to any specific person. At times Mr. Bigley appeared to be listening to the proceedings and some of his remarks were in reaction to the testimony. For instance, when Mr. Young was testifying about the motel on Tudor, he yelled out "rat hole". However he also made remarks about the Pebble Mine and other current events that were not on topic. At one point Mr. Bigley moved up to the counsel next to his counsel, Ms. Brennan. He unbuttoned his shirt and displayed his bare chest. Ms. Brennan gestured to him and he then buttoned up.

Least restrictive alternatives

11. Mr. Young, the public guardian and Dr. Maile both testified that there is no less restrictive treatment alternative than A.P.I. Both agreed that Mr. Bigley has done much better in the past, particularly when he was on medication. Both agreed that Mr. Bigley has seriously decompensated in the past few months. Mr. Gottstein testified that Mr. Bigley has had problems maintaining housing. He is banned from the Brother Francis Shelter. Mr. Gottstein stated that many people with mental health issues dislike being at A.P.I. so much that they will live year round in the woods and do fine. Mr. Bigley is not one of those people. He behaves in such a way that he gets arrested or taken to A.P.I. He also likes to talk and needs a place where people will listen to him. Mr. Gottstein named two programs that could be of assistance to Mr. Bigley – "Choices" and the Kiana Club House. Mr. Gottstein acknowledged he called Choices and that they have no funding to help Mr. Bigley. Neither of these programs is extensive enough to help provide Mr. Bigley with the basic necessities.

Statutory discussion

Danger to others

12. The State argued that Mr. Bigley presents a danger to others, based on his aggressive behavior. That argument was adopted by the court in oral findings made at the conclusion of the hearing. To find that Mr. Bigley presents a danger to others the statute requires a finding that the respondent is:

- Is likely in the near future to cause physical injury, physical abuse, or substantial property damage to another person, or

loss of housing. It is not clear why he had to leave the motel where he was staying but it appears to have been behavior related. Mr. Bigley evidently has sufficient funds to pay for housing. On April 25 he refused the offer of a place to stay for reasons with meaning only to him. He reportedly has no money with him to pay for anything and no means of transportation. He emphasized his refusal by spitting on the items. The availability of the basic necessities of food and shelter are meaningless if Mr. Bigley's mental illness compels him to refuse. Several of the witnesses testified that Mr. Bigley is eating only sporadically. On April 25, when he refused money for food, he stated he "did not need to eat". One of Mr. Bigley's delusions is that his food and water are poisoned. There was concern about his physical condition and dehydration upon his latest admission to API. The Court has had no prior contact with Mr. Bigley and cannot compare his current physical condition to any prior time. He did appear quite thin and is a slightly built man as well.

16. Without any place to live, Mr. Bigley is basically on the streets. He might be exhibiting aggressive behavior in public places regardless of whether he has a place to live or not. However, he does seem compelled to come in contact with people and then becomes disruptive. The witness' testimony described him as angry and threatening. Dr. Maile is concerned that one of the people he goads or incites will retaliate and injure Mr. Bigley. He testified that, in his present state, the chances of Mr. Bigley coming to harm or injury is almost 100%. His delusion about his connection with news events appears to cause extreme distress. Witnesses describe him as being preoccupied with what was in the paper on that Friday. He sounds fearful that people will blame him for catastrophic events but also uses the events to bolster his delusion.

17. There is clear and convincing evidence that Mr. Bigley is gravely disabled under subsections A or B of AS 47.30.915(7). No less restrictive alternative exists because he cannot or will not avail himself of the help available to him in the community. His mental illness has clearly caused a substantial deterioration of his ability to function independently. There appears to be no friend, relative or associate who is willing to tolerate his behavior.

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

In the Matter of the Necessity for the Hospitalization of:	)
WILLIAM BIGLEY,	)
Respondent.	) Case No. 3AN-08-493 PR

MOTION TO SET EXPEDITED HEARING ON CAPACITY TO GIVE INFORMED CONSENT

The Department of Health and Social Services, Division of Behavioral Health, Alaska Psychiatric Institute ("API"), through the Office of the Attorney General, moves the court for an expedited hearing in the above-captioned matter to address the Petition for Court Approval of Administration of Psychotropic Medication [AS 47.30.839] filed with the court on or about April 29, 2008. Master McBurney conducted a hearing regarding API's Petition for 30-Day Commitment filed that same date on April 30, 2008. When making her findings, Master McBurney stated that she was recommending the commitment petition be granted and she was forwarding the file to a superior court judge to conduct the hearing on capacity to give informed consent. Judge Rindner signed the commitment order. Upon investigation, API's counsel was informed that a hearing to address the medication petition has not been scheduled. Judge Rindner's office suggested that something be filed requesting a hearing.

Alaska Statute 47.30.839(e) states that within 72 hours after filing a petition, the court shall hold a hearing to determine the patient's capacity to give or withhold informed consent. As the petition was filed over a week ago, API moves the court to expeditiously set a hearing.

DATED: 5/7/08

TALIS J. COLBERG
ATTORNEY GENERAL

By: _____
Timothy M. Twomey
Assistant Attorney General
Alaska Bar No. 0505033

DEPARTMENT OF LAW
OFFICE OF THE ATTORNEY GENERAL
ANCHORAGE BRANCH
1031 W. FOURTH AVENUE, SUITE 200
ANCHORAGE, ALASKA 99501
PHONE: (907) 269-5100

825 W. 4TH AVE., ANCHORAGE, AK 99501 FAX: 264-0518

ALASKA COURT SYSTEM
Sharon L. Gleason
Superior Court Judge

Fax

To: T. Twomey, K. Gillian-Gibson, E. Russo, J. Gottstein, Vassar, API **From:** Judge Sharon L. Gleason

Fax: 258-6872, 868-2588, 269-3535, 274-9493, 338-0711, 269-7128 **Pages:** 1, plus coversheet

Phone: **Date:** 05/9/08

Re: 3AN-08-493 PR **CC:**

☐ **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

• **Comments:**

Scheduling Order

EV

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

In the Matter of the Necessity for the Hospitalization of:

WILLIAM BIGLEY,

Respondent.

CASE NO: 3AN-08-493 PR

ORDER ON EXPEDITED HEARING ON CAPACITY TO GIVE INFORMED CONSENT

Judge Rindner, the assigned judge in this matter, is currently out of town and unavailable to hear this motion in the near term. Therefore, at the request of his chambers, Judge Sharon L. Gleason will hold a hearing on the Motion on Capacity to Give Informed Consent in the above captioned case on **May 12, 2008 from 10:00 a.m. to 1:30 p.m.** in courtroom 603 of the Nesbett Courthouse, 825 West Fourth Avenue, Anchorage, Alaska.

DATED this 9th day of May, 2008.

Sharon L. Gleason
Judge of the Superior Court

I certify that on 5-8-08
a copy of this order was faxed to:
AG, PD, GAL, Gottstein, API, Vassar
Clerk:

P301cv (7/05)
Order Closing Estate

PR 12 (c)
AS 13.16.630

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

In The Matter of the Necessity for the)
Hospitalization of William Bigley,)
)
Respondent)
Case No. 3AN 08-00493PS

NOTICE OF FILING CERTIFIED COPIES

Respondent hereby gives notice that certified copies of the following documents have been filed with the Court:

1. Affidavit of Paul A. Cornils.
2. Affidavit of Ronald Bassman, PhD.
3. Affidavit of Robert Whitaker

DATED: May 13, 2008.

Law Project for Psychiatric Rights

By: _____
James B. Gottstein
ABA # 7811100

LAW PROJECT FOR PSYCHIATRIC RIGHTS, INC.
406 G Street, Suite 206
Anchorage, Alaska 99501
(907) 274-7686 Phone ~ (907) 274-9493 Fax

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

In The Matter of the Necessity for the)
Hospitalization of William S. Bigley,)
Respondent,)
William Worral, MD,)
Petitioner)
Case No. 3AN 07-1064 P/S

AFFIDAVIT OF PAUL A. CORNILS

STATE OF ALASKA)
) ss.
THIRD JUDICIAL DISTRICT)

I, Paul A. Cornils, being first duly sworn under oath do hereby state as follows:

A. My name is Paul Cornils and I am the Program Manager for CHOICES, Inc., which stands for Consumers Having Ownership in Creating Effective Services. I have almost 10 years experience working in the field of behavioral health with adults and children including 8 years as a case manager with people who are diagnosed with serious and persistent mental illness.

B. I first began Respondent Bill Bigley in January of 2007, under contract with the Law Project for Psychiatric Rights (PsychRights®). When the cost of services exceeded $5,000 PsychRights said it could not afford to continue paying and Mr. Bigley informed me he did not want to work with me anymore so services were discontinued.

C. CHOICES began working with Mr. Bigley again in July of this year at the request of the Office of Public Advocacy (OPA), Mr. Bigley's Guardian and has continues to do so.

D. Mr. Bigley is so angry at being put under a guardianship that he takes extreme measures to try to get rid of his guardianship. As a result, he is mostly refusing to cooperate in virtually any way with the Guardian.

E. For example, Mr. Bigley rips up checks from the Guardian made out to Vendors on his behalf, trying to force the Guardian to give him his money directly and as part of his effort to eliminate the guardianship.

F. Mr. Bigley has also refused various offers of "help" from the Guardian, such as grocery shopping in a similar attempt to get out from under the guardianship.

G. He exhibits the same types of behavior to me, but I have a different approach, which involves negotiation and discussion, does not involve coercion and where the natural consequences of Mr. Bigley's actions are allowed to occur.

H. This is very important because after people are labeled with a mental illness everything is attributed to the mental illness and the person no longer takes responsibility for his or her actions.

I. Taking responsibility for one's actions is a core tenet of CHOICES' approach.

J. Another tenet of the CHOICES' approach is what is known as a "Relapse Plan." In fact, there is a whole curriculum called the "WRAP," developed by Mary Ellen Copeland, used around the world, which stands for Wellness Recovery Action Plan, of which a Relapse Plan is a part. Other aspects are learning how to deal with one's difficulties in ways that do not create as many problems. I am a trained WRAP Facilitator.

K. With Mr. Bigley, however, I have used Anger Management, Moral Reconation Therapy (MRT) and elements of Peer Support, all of which I have taken training in and have received certification as the most beneficial techniques for Mr. Bigley at this time.

L. It is my belief that if the CHOICES approach were consistently used with Mr. Bigley and there are sufficient community support resources there is a good chance he will be able to live successfully in the community.

M. I understand Mr. Bigley, through his attorney Jim Gottstein, has moved for an injunction as follows:

> 1. Mr. Bigley be allowed to come and go from API as he wishes, including being given, food, good sleeping conditions, laundry and toiletry items.
>
> 2. If involuntarily at a treatment facility in the future, be allowed out on passes at least once each day for four hours with escort by staff members who like him, or some other party willing and able to do so.
>
> 3. Only the Medical Director of API may authorize the administration of psychotropic medication pursuant to AS 47.30.838 (or any other justification for involuntary administration of medication, other than under AS 47.30.839), after consultation with James B. Gottstein, Esq., or his successor.
>
> 4. API shall procure and pay for a reasonably nice two bedroom apartment that is available to Mr. Bigley should he choose it.[1] API shall first attempt to negotiate an acceptable abode, and failing that procure it and make it available to Mr. Bigley.
>
> 5. At API's expense, make sufficient staff <u>available</u> to be with Mr. Bigley to try keep him out of trouble.
>
> 6. The foregoing may be contracted for from an outpatient provider.

[1] API may seek to obtain a housing subsidy from another source, but such source may not be his Social Security Disability income.

N. It makes perfect sense. With respect to Number 1, Mr. Bigley's problems in the community revolve around the expression of his extreme anger, and has caused the loss of housing options. Currently, it is my understanding even the Brother Francis Shelter is not available to him. There needs to be a safe and comfortable place for Mr. Bigley to sleep when he doesn't have any other option. Even though he is never actually violent, there is no other option in Anchorage of which I am aware that is in a position to deal with his yelling and screaming.

O. Frankly, it is unlikely that Mr. Bigley would avail himself of the option because of the way he has been locked up and treated there so much in his life, but the option should be available to him.

P. Number 2, is more likely unless and until Mr. Bigley gets his behavior within a socially acceptable range. Mr. Bigley seems to always be okay on pass when he is there so he should be given such passes.

Q. With respect to Number 4, housing is a huge issue for Mr. Bigley. He demands a relatively nice apartment and will choose homelessness over one that does not meet his requirements. Currently, under his Guardianship regime, he is only given about $60 per week for food and $50 per week for spending money. That is an unreasonably small amount. I don't know if the State should be required to support Mr. Bigley's housing to the extent requested by Mr. Gottstein, but it should in a reasonable amount as necessary.

R. With respect to Number 5, right now, it would be very beneficial to have someone with Mr. Bigley for an extended period of time during the day to help him meet his needs and stay out of trouble.

S. Currently, it would probably take more than Medicaid allows to provide what is needed.

T. Using CHOICES' approach, it is my opinion there is a reasonable prospect that within a year to eighteen months Mr. Bigley could get by with far less services and be within the normal Medicaid range.

U. There is also a reasonable prospect that this will never be achieved.

V. With respect to Number 6, CHOICES could be such an outpatient provider, but would need to increase its staffing level in order to be able to do so properly, which would take at least a little bit of time.

FURTHER YOUR AFFIANT SAYETH NAUGHT.

DATED September 12, 2007.

By: Paul A. Comils
Paul A. Comils

SUBSCRIBED AND SWORN TO before me this 12th day of September, 2007.

STATE OF ALASKA
NOTARY PUBLIC
Lisa E. Smith
My Commission Expires April 23, 2011

Lisa E. Smith
Notary Public in and for Alaska
My Commission Expires: 4/23/2011

State of Alaska)
)ss
Third Judicial District)

I, James B. Gottstein, hereby affirm that this reproduction of Affidavit of Paul Cornils, to which this is appended, is a true, correct and complete photocopy of the original filed in 3AN 07-1064PR.

Dated: May 13, 2008

James B. Gottstein

SUBSCRIBED AND SWORN TO before me this 13th day of May, 2008.

STATE OF ALASKA
NOTARY PUBLIC
Lisa E. Smith
My Commission Expires April 23, 2011

Lisa E. Smith
Notary Public in and for Alaska
My Commission expires: 4/23/2011

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

In The Matter of the Necessity for the)
Hospitalization of William S. Bigley,)
Respondent,)
William Worral, MD,)
Petitioner)
Case No. 3AN 07-1064 P/S

AFFIDAVIT OF RONALD BASSMAN, PhD

STATE OF NEW YORK)
) ss.
ALBANY COUNTY)

Is Medication for Serious Mental Illnesses the Only Choice For All People?
By Ronald Bassman, PhD

Albert Einstein once said that the definition of insanity is doing the same thing over and over again and expecting different results.

Today, the primary treatment for people who are diagnosed with serious mental illness is psychiatric medications regardless of effectiveness.[1] Institutions are filled with those who have failed to progress despite numerous trials on medications over the course of many years.[2] Current treatments for serious mental illnesses ignore research evidence showing debilitating conditions arising from the use of psychiatric medications.[3] Adults with serious mental illness treated in public systems die about 25 years earlier than Americans overall, a gap that's widened since the early 1990s when major mental disorders cut life spans by 10 to 15 years.[4] Along with shorter life spans, people taking psychiatric medication typically have medication-caused disabilities that make it extremely difficult for them to find employment and to become fully integrated members of the community. Not only do they show impairment in cognitive and motor abilities but also must live with physical distortions of appearance that make them extremely reluctant to be seen in public places.

Founded in 1988, the Tardive Dyskinesia/Tardive Dystonia National Association has received thousand of letters and inquiries from individuals taking psychiatric medications and who struggle with the adverse effects. Tardive dyskinesia, dystonia and akathisia are late appearing neurological movement disorders caused by psychoactive

drugs.[5] The following letters were received by the Tardive Dyskinesia/Tardive Dystonia National Association:[6]

"Tremors and spasms make my arms do a sort of jitterbug. Spasms in my neck pull my head to the side. My tongue sticks out as often as every thirty seconds."

- T.D. Survivor, Washington, DC

"Having TD is being unable to control my arms, fingers and sometimes my facial muscles; having a spastic digestive tract and trouble breathing. Getting food from my plate to my mouth and chewing it once there can be a real chore. I've bitten my tongue so severely it's scarred. I often bite it hard enough to bleed into the food I'm trying to eat. I no longer drink liquids without drooling."

- T.D. Survivor, New York

"I've always tried to feel better and I felt how could any prescribed medicine meant to help me, do more damage than the illness itself."

- T.D. Survivor, Louisiana

I am a person who was first diagnosed with schizophrenia paranoid type and then after another hospitalization diagnosed with schizophrenia chronic type and who was prescribed numerous psychiatric drugs including Thorazine Stelazine and Mellaril. I have been drug-free for more than thirty years. Having had personal experience with psychiatric medication and recovered after withdrawing from the prescribed drugs, I have subsequently worked as a psychologist to develop and promote alternative healing practices.[7] I have written and published articles in professional journals and in 2005 co-founded the International Network of Treatment Alternatives for Recovery.[8]

Research, my own and others, in addition to the numerous personal accounts of recovery without psychiatric medications, coupled with the documented adverse effects demand that we respect a person's choice -- choices which are based on personal experience and preference for other methods of coping and progressing toward recovery and re-integration into the community.[9] Psychiatric medication is and should be only one of many treatment choices for the individual with serious mental illness. And when it is clear that medications are not effective, it is necessary and only humane to offer other options for the individual to choose. Primary to the recovery process is personal choice.

The National Research Project for the Development of Recovery Facilitating System Performance Indicators concluded that, "Recovery from mental illness can best be understood through the lived experience of persons with psychiatric disabilities." The Research Project listed the following themes as instrumental to recovery:

*Recovery is the reawakening of hope after despair.

*Recovery is breaking through denial and achieving understanding and acceptance.

*Recovery is moving from withdrawal to engagement and active participation in life.

*Recovery is active coping rather than passive adjustment.

*Recovery means no longer viewing oneself primarily as a mental patient and reclaiming a positive sense of self.

*Recovery is a journey from alienation to purpose.
*Recovery is a complex journey.
*Recovery is not accomplished alone—it involves support and partnership.[10]

Research describing what people want and need is very similar to what everyone wants and needs. The best practices of psychosocial rehabilitation highlight the following:

1. Recovery can occur without professional intervention. The consumer/survivors rather than professionals are the keys to recovery.

2. Essential is the presence of people who believe in and stand by the person in need of recovery. Of critical importance is a person or persons whom one can trust to be there in times of need.

3. Recovery is not a function of one's theory about the causes of mental illness. And recovery can occur whether one views the condition as biological or not.

4. People who experience intense psychiatric symptoms episodically are able to recover. Growth and setbacks during recovery make it feel like it is not a linear process. Recovery often changes the frequency and duration of symptoms for the better. The process does not feel systematic and planned.

5. Recovery from the consequences of the original condition may be the most difficult part of recovery. The disadvantages, including stigma, loss of rights, discrimination and disempowering treatment services can combine to hinder a person's recovery even if he or she is asymptomatic.[11]

In the above concepts promoting recovery there is a conspicuous absence of psychiatric medication. Psychologist Courtenay Harding, principal researcher of the "Vermont Longitudinal Study," has empirically demonstrated that people do recover from long-term chronic disorders such as schizophrenia at a minimum rate of 32 % and as high as 60%.[12] These studies have consistently found that half to two thirds of patients significantly improved or recovered, including some cohorts of very chronic cases. The 32 % for full recovery is with one of the five criteria being *no longer taking any psychiatric medication.* Dr. Harding in delineating the seven myths of schizophrenia, addresses the myth about psychiatric medication. Myth number 5. **Myth: Patients must be on medication all their lives. Reality: It may be a small percentage who need medication indefinitely.** According to Harding and Zahniser, the myths limit the scope and effectiveness of treatments available to patients.[13]

The most important principle of the medical profession is one that has stood the test of time. "First do no harm." When it is clear that psychiatric medications have been ineffective and/or harmful in the treatment of a particular individual, and when that person objects to another treatment course with psychiatric drugs, it is wrong to continue on this course against the expressed wishes of that individual. One must consider the

statement attributed to Albert Einstein at the beginning of this affidavit. Let us work with people to implement their informed choices for alternative services and not continue trying to implement a treatment that has not worked.

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[4] Parks, J. Morbidity and mortality in people with serious mental illness. Fifth National Summit of State Psychiatric Hospital Superintendents, May 6-8, 2007.

[5] Breggin, P. Brain damage, dementia and persistent cognitive dysfunction associated with neuroleptic drugs: Evidence, etiology, implications. Challenging the Therapeutic State: Critical Perspectives on Psychiatry and the Mental health System, ed. David Cohen, Journal of Mind Behavior 11.3-4 p. 425-464. 1990.

[6]Bassman, R. Mental illness and the freedom to refuse treatment: privilege or right. Professional Psychology: Research and Practice, Vol.36, No.5, 488-497, 2005.

[7] Bassman, R. The mental health system: Experiences from both sides of the locked doors. Professional Psychology: Research and Practice, Vol. 28, No. 3, 238-242 1997.

[8] Bassman, R. A Fight to Be: A Psychologist's Experience from Both Sides of the Locked Door. Tantamount Press: Albany, New York, 2007.

[9] Bassman, R. Consumer/Survivors/Ex-patients as change facilitators, in Frese, F. ed. The Role of Organized Psychology in Treatment of the Seriously Mentally Ill, New Directions for Mental Health, No. 88, Winter, p. 93-102, 2000.

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[11]Anthony W. Recovery from mental illness: The guiding vision of the mental health system in the 1990s, An Introduction to Psychiatric Rehabilitation, ed. The Publications Committee of IAPRS, Boston University, 1994.

[12] Harding C.M., Brooks G.W., Ashikaga T., Strauss J.S. and Breier A. The Vermont longitudinal study of persons with severe mental illness, I: Methodology, study sample, and overall status 32 years later. Am J Psychiatry; 144:718-726, 1987.

[13] Harding C.M. Zahniser J.H. Empirical correction of seven myths about schizophrenia with implications for treatment. Acta Psychiatr Scand, 90 (suppl 384): 140-146, 1994.

DATED this 4 day of September, 2007, in Albany, New York.

Ronald Bassman, PhD

SUBSCRIBED AND SWORN TO before me this 4th day of September, 2007.

CAROL D. ROSSI
Notary Public, State of New York
Qualified in Albany County
No. 01RO6106782
Commission Expires March 15, 2008.

Notary Public in and for New York
My Commission Expires: 03/15/2008

State of Alaska)
)ss
Third Judicial District)

I, James B. Gottstein, hereby affirm that this reproduction of Affidavit of Ronald Bassman, PhD, to which this is appended, is a true, correct and complete photocopy of the original filed in 3AN 07-1064PR.

Dated: May 13, 2008

James B. Gottstein

SUBSCRIBED AND SWORN TO before me this 13th day of May, 2008.

STATE OF ALASKA
NOTARY PUBLIC
Lisa E. Smith
My Commission Expires April 23, 2011

Notary Public in and for Alaska
My Commission expires: 4/23/2011

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

In The Matter of the Necessity for the)
Hospitalization of William S. Bigley,)
Respondent,)
William Worral, MD,)
Petitioner)
Case No. 3AN 07-1064 P/S

AFFIDAVIT OF ROBERT WHITAKER

STATE OF MASSACHUSETTS)
) ss.
SUFFOLK COUNTY)

By Robert Whitaker

I. Personal Background

1. As a journalist, I have been writing about science and medicine, in a variety of forums, for about 20 years. My relevant experience is as follows:

a) From 1989 to 1994, I was the science and medical writer for the *Albany Times Union* in Albany, New York.

b) During 1992-1993, I was a fellow in the Knight Fellowship for Science Writers at the Massachusetts Institute of Technology.

c) From 1994-1995, I was director of publications at Harvard Medical School.

d) In 1994, I co-founded a publishing company, CenterWatch, that reported on the clinical development of new drugs. I directed the company's editorial operations until late 1998, when we sold the company. I continued to write freelance articles for the *Boston Globe* and various magazines during this period.

e) Articles that I wrote on the pharmaceutical industry and psychiatry for the *Boston Globe* and *Fortune* magazine won several national awards, including the George Polk Award for medical writing in 1999, and the National Association of Science Writers award for best magazine article that same year. A series I wrote for the *Boston Globe* on problems in psychiatric research was a finalist for the Pulitzer Prize in Public Service in 1999.

f) Since 1999, I have focused on writing books. My first book, *Mad in America*, reported on our country's treatment of the mentally ill throughout its history, and explored in particular why schizophrenia patients fare so much worse in the United States and other developed countries than in the poor countries of the world. The book was picked by *Discover* magazine as one of the best science books of 2002; the American Library Association named it as one of the best histories of 2002.

2. Prior to writing *Mad in America*, I shared conventional beliefs about the nature of schizophrenia and the need for patients so diagnosed to be on antipsychotic medications for life. I had interviewed many psychiatric experts who told me that the drugs were like "insulin for diabetes" and corrected a chemical imbalance in the brain.

3. However, while writing a series for the *Boston Globe* during the summer of 1998, I came upon two studies that looked at long-term outcomes for schizophrenia patients that raised questions about this model of care. First, in 1994, Harvard researchers reported that outcomes for schizophrenia patients in the United States had declined in the past 20 years and were now no better than they had been in 1900.[1] Second, the World Health Organization twice found that schizophrenia patients in the poor countries of the world fare much better than in the U.S. and other "developed" countries, so much so that they concluded that living in a developed country was a

[1] Hegarty, J, et al. "One hundred years of schizophrenia: a meta-analysis of the outcome literature." *American Journal of Psychiatry* 151 (1994):1409-16.

"strong predictor" that a person so diagnosed would never recover.[2,3] Although the WHO didn't identify a reason for that disparity in outcomes, it did note a difference in the use of antipsychotic medications between the two groups. In the poor countries, only 16% of patients were regularly maintained on antipsychotic medications, whereas in the U.S. and other rich countries, this was the standard of care, with 61% of schizophrenia patients staying on the drugs continuously. (Exhibit 1)

4. I wrote *Mad in America*, in large part, to investigate why schizophrenia patients in the U.S. and other developed countries fare so poorly. A primary part of that task was researching the scientific literature on schizophrenia and antipsychotic drugs.

II. Overview of Research Literature on Schizophrenia and Standard Antipsychotic Medications

5. Although the public has often been told that people with schizophrenia suffer from too much "dopamine" in the brain, researchers who investigated this hypothesis during the 1970s and 1980s were unable to find evidence that people so diagnosed have, in fact, overactive dopamine systems. Within the psychiatric research community, this was widely acknowledged in the late 1980s and early 1990s. As Pierre Deniker, who was one of the founding fathers of psychopharmacology, confessed in 1990: "The dopaminergic theory of schizophrenia retains little credibility for psychiatrists."[4]

6. Since people with schizophrenia have no known "chemical imbalance" in the brain, antipsychotic drugs cannot be said to work by "balancing" brain chemistry. These drugs are not like "insulin for diabetes." They do not serve as a corrective to a known biological abnormality. Instead, Thorazine and other standard antipsychotics (also known as

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[2] Leff, J, et al. "The international pilot study of schizophrenia: five-year follow-up findings." *Psychological Medicine* 22 (1992):131-45.

[3] Jablensky, A, et al. "Schizophrenia: manifestations, incidence and course in different cultures, a World Health Organization ten-country study." *Psychological Medicine* 20, monograph supplement, (1992):1-95.

[4] Deniker, P. "The neuroleptics: a historical survey." *Acta Psychiatrica Scandinavica* 82, supplement 358 (1990):83-87.

neuroleptics) work by powerfully blocking dopamine transmission in the brain. Specifically, these drugs block 70% to 90% of a particular group of dopamine receptors known as D2 receptors. This thwarting of normal dopamine transmission is what causes the drugs to be so problematic in terms of their side effects.

8. Psychiatry's belief in the necessity of using the drugs on a continual basis stems from two types of studies.

a) First, research by the NIMH has shown that the drugs are more effective than placebo in curbing psychotic symptoms over the short term (six weeks).[5]

b) Second, researchers have found that if patients abruptly quit taking antipsychotic medications, they are at high risk of relapsing. [6]

9. Although the studies cited above provide a rationale for continual drug use, there is a long line of evidence in the research literature, one that is not generally known by the public or even by most psychiatrists, that shows that these drugs, over time, produce these results:

a) They increase the likelihood that a person will become chronically ill.
b) They cause a host of debilitating side effects.
c) They lead to early death.

III. Evidence Revealing Increased Chronicity of Psychotic Symptoms

10. In the early 1960s, the NIMH conducted a six-week study of 344 patients at nine hospitals that documented the efficacy of antipsychotics in knocking down psychosis

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[5] Cole, J, et al. "Phenothiazine treatment in acute schizophrenia." *Archives of General Psychiatry* 10 (1964):246-61.
[6] Gilbert, P, et al. "Neuroleptic withdrawal in schizophrenic patients." *Archives of General Psychiatry* 52 (1995):173-188.

over a short term. (See footnote five, above). The drug-treated patients fared better than the placebo patients over the short term. However, when the NIMH investigators followed up on the patients one year later, they found, much to their surprise, that it was the drug-treated patients who were more likely to have relapsed/ This was the first evidence of a paradox: Drugs that were effective in curbing psychosis over the short term were making patients more likely to become psychotic over the long term.[7]

11. In the 1970s, the NIMH conducted three studies that compared antipsychotic treatment with "environmental" care that minimized use of the drugs. In each instance, patients treated without drugs did better over the long term than those treated in a conventional manner.[8, 9, 10] Those findings led NIMH scientist William Carpenter to conclude that "antipsychotic medication may make some schizophrenic patients more vulnerable to future relapse than would be the case in the natural course of the illness."

12. In the 1970s, two physicians at McGill University, Guy Chouinard and Barry Jones, offered a biological explanation for why this is so. The brain responds to neuroleptics and their blocking of dopamine receptors as though they are a pathological insult. To compensate, dopaminergic brain cells increase the density of their D2 receptors by 40% or more. The brain is now "supersensitive" to dopamine, and as a result, the person has become more *biologically* vulnerable to psychosis than he or she would be naturally. The two Canadian researchers wrote: "Neuroleptics can produce a dopamine supersensitivity that leads to both dyskinetic and psychotic symptoms. An implication is that the tendency

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[7] Schooler, N, et al. "One year after discharge: community adjustment of schizophrenic patients." *American Journal of Psychiatry* 123 (1967):986-95.

[8] Rappaport, M, et al. "Are there schizophrenics for whom drugs may be unnecessary or contraindicated?" *Int Pharmacopsychiatry* 13 (1978):100-11.

[9] Carpenter, W, et al. "The treatment of acute schizophrenia without drugs." *American Journal of Psychiatry* 134 (1977):14-20.

[10] Bola J, et al. "Treatment of acute psychosis without neuroleptics: two-year outcomes from the Soteria project." *Journal of Nervous Mental Disease* 191 (2003):219-29.

toward psychotic relapse in a patient who had developed such a supersensitivity is determined by more than just the normal course of the illness. [11]

13. MRI-imaging studies have powerfully confirmed this hypothesis. During the 1990s, several research teams reported that antipsychotic drugs cause atrophy of the cerebral cortex and an enlargement of the basal ganglia.[12, 13, 14] In 1998, investigators at the University of Pennsylvania reported that the drug-induced enlargement of the basal ganglia is "associated with greater severity of both negative and positive symptoms." In other words, they found that the drugs cause morphological changes in the brain that are associated with a worsening of the very symptoms the drugs are supposed to alleviate.[15]

IV. Research Showing that Recovery Rates are Higher for Non-Medicated Patients than for Medicated Patients.

14. The studies cited above show that the drugs increase the chronicity of psychotic symptoms over the long term. There are also now a number of studies documenting that long-term recovery rates are much higher for patients off antipsychotic medications. Specifically:

a) In 1994, Courtenay Harding at Boston University reported on the long-term outcomes of 82 chronic schizophrenics discharged from Vermont State Hospital in the late 1950s. She found that one-third of this cohort had recovered

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[11] Chouinard, G, et al. "Neuroleptic-induced supersensitivity psychosis." *American Journal of Psychiatry* 135 (1978):1409-10. Also see Chouinard, G, et al. "Neuroleptic-induced supersensitivity psychosis: clinical and pharmacologic characteristics." *American Journal of Psychiatry* 137(1980):16-20.

[12] Gur, R, et al. "A follow-up magnetic resonance imaging study of schizophrenia." *Archives of General Psychiatry* 55 (1998):142-152.

[13] Chakos M, et al. "Increase in caudate nuclei volumes of first-episode schizophrenic patients taking antipsychotic drugs." *American Journal of Psychiatry* 151 (1994):1430-6.

[14] Madsen A, et al. "Neuroleptics in progressive structural brain abnormalities in psychiatric illness." *The Lancet* 352 (1998): 784-5.

[15] Gur, R, et al. "Subcortical MRI volumes in neuroleptic-naive and treated patients with schizophrenia." *American Journal of Psychiatry* 155 (1998):1711-17.

completely, and that all who did shared one characteristic: They had all stopped taking antipsychotic medication. The notion that schizophrenics needed to stay on antipsychotics all their lives was a "myth," Harding said.[16, 17, 18]

b) In the World Health Organization studies, 63% of patients in the poor countries had good outcomes, and only one-third became chronically ill. In the U.S. countries and other developed countries, only 37% of patients had good outcomes, and the remaining patients did not fare so well. In the undeveloped countries, only 16% of patients were regularly maintained on antipsychotics, versus 61% of patients in the developed countries.

c) In response to this body of literature, physicians in Switzerland, Sweden and Finland have developed programs that involve minimizing use of antipsychotic drugs, and they are reporting much better results than what we see in the United States.[19, 20, 21, 22] In particular, Jaako Seikkula recently reported that five years after initial diagnosis, 82% of his psychotic patients are symptom-free, 86% have returned to their jobs or to school, and only 14% of his patients are on antipsychotic medications.[23]

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[16] Harding, C. "The Vermont longitudinal study of persons with severe mental illness," *American Journal of Psychiatry* 144 (1987):727-34.

[17] Harding, C. "Empirical correction of seven myths about schizophrenia with implications for treatment." *Acta Psychiatrica Scandinavica* 90, suppl. 384 (1994):140-6.

[18] McGuire, P. "New hope for people with schizophrenia," *APA Monitor* 31 (February 2000).

[19] Ciompi, L, et al. "The pilot project Soteria Berne." *British Journal of Psychiatry* 161, supplement 18 (1992):145-53.

[20] Cullberg J. "Integrating psychosocial therapy and low dose medical treatment in a total material of first-episode psychotic patients compared to treatment as usual." *Medical Archives* 53 (199):167-70.

[21] Cullberg J. "One-year outcome in first episode psychosis patients in the Swedish Parachute Project. *Acta Psychiatrica Scandinavica* 106 (2002):276-85.

[22] Lehtinen V, et al. "Two-year outcome in first-episode psychosis according to an integrated model. *European Psychiatry* 15 (2000):312-320.

[23] Seikkula J, et al. Five-year experience of first-episode nonaffective psychosis in open-dialogue approach. *Psychotherapy Research* 16/2 (2006): 214-228.

d) This spring, researchers at the University of Illinois Medical School reported on the long-term outcomes of schizophrenia patients in the Chicago area since 1990. They found that 40% of those who refused to take their antipsychotic medications were recovered at five-year and 15-year followup exams, versus five percent of the medicated patients.[24]

V. Harmful Side Effects from Antipsychotic Medications

15. In addition to making patients chronically ill, standard antipsychotics cause a wide range of debilitating side effects. Specifically:

a) Tardive dyskinesia. The most visible sign of tardive dyskinesia is a rhythmic movement of the tongue, which is the result of permanent damage to the basal ganglia, which controls motor movement. People suffering from tardive dyskinesia may have trouble walking, sitting still, eating, and speaking. In addition, people with tardive dyskinesia show accelerated cognitive decline. NIMH researcher George Crane said that tardive dyskinesia resembles "in every respect known neurological diseases, such as Huntington's disease, dystonia musculorum deformans, and postencephalitic brain damage."[25] Tardive dyskinesia appears in five percent of patients treated with standard neuroleptics in one year, with the percentage so afflicted increasing an additional five percent with each additional year of exposure.

[24] Harrow M, et al. "Factors involved in outcome and recovery in schizophrenia patients not on antipsychotic medications." *Journal of Nervous and Mental Disease* 195 (2007): 406-414.
[25] Crane, G. "Clinical psychopharmacology in its 20th year," *Science* 181 (1973):124-128. Also see American Psychiatric Association, *Tardive Dyskinesia: A Task Force Report* (1992).

b) Akathisia. This is an inner restlessness and anxiety that many patients describe as the worst sort of torment. This side effect has been linked to assaultive, murderous behavior.[26, 27, 28, 29, 30]

c) Emotional impairment. Many patients describe feeling like "zombies" on the drugs. In 1979, UCLA psychiatrist Theodore van Putten reported that most patients on antipsychotics were spending their lives in "virtual solitude, either staring vacantly at television, or wandering aimlessly around the neighborhood, sometimes stopping for a nap on a lawn or a park bench . . . they are bland, passive, lack initiative, have blunted affect, make short, laconic replies to direct questions, and do not volunteer symptoms . . . there is a lack not only of interaction and initiative, but of any activity whatsoever.[31] The quality of life on conventional neuroleptics, researchers agreed, is "very poor." [32]

d) Cognitive impairment. Various studies have found that neuroleptics reduce one's capacity to learn and retain information. As Duke University scientist Richard Keefe said in 1999, these drugs may "actually prevent adequate learning effects and worsen motor skills, memory function, and executive abilities, such as problem solving and performance assessment."[33]

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[26] Shear, K et al. "Suicide associated with akathisia and deport fluphenazine treatment," *Journal of Clinical Psychopharmacology* 3 (1982):235-6.

[27] Van Putten, T. "Behavioral toxicity of antipsychotic drugs." *Journal of Clinical Psychiatry* 48 (1987):13-19.

[28] Van Putten, T. "The many faces of akathisia," *Comprehensive Psychiatry* 16 91975):43-46.

[29] Herrera, J. "High-potency neuroleptics and violence in schizophrenia," *Journal of Nervous and Mental Disease* 176 (1988):558-561.

[30] Galynker, I. "Akathisia as violence." *Journal of Clinical Psychiatry* 58 (1997):16-24.

[31] Van Putten, T. "The board and care home." *Hospital and Community Psychiatry* 30 (1979):461-464.

[32] Weiden P. "Atypical antipsychotic drugs and long-term outcome in schizophrenia." *Journal of Clinical Psychiatry* 57, supplement 11 (1996):53-60.

[33] Keefe, R. "Do novel antipsychotics improve cognition?" *Psychiatric Annals* 29 (1999):623-629.

d) Other side effects of standard neuroleptics include an increased incidence of blindness, fatal blood clots, arrhythmia, heat stroke, swollen breasts, leaking breasts, obesity, sexual dysfunction, skin rashes and seizures, and early death.[34, 35, 36] Schizophrenia patients now commit suicide at 20 times the rate they did prior to the use of neuroleptics.[37]

VI. The Research Literature on Atypical Antipsychotics

16. The conventional wisdom today is that the "atypical" antipsychotics that have been brought to market—Risperdal, Zyprexa, and Seroquel, to name three—are much better and safer than Haldol, Thorazine and the other older drugs. However, it is now clear that the new drugs have no such advantage, and there is even evidence suggesting that they are worse than the old ones.

17. Risperdal, which is manufactured by Janssen, was approved in 1994. Although it was hailed in the press as a "breakthrough "medication, the FDA, in its review of the clinical trial data, concluded that there was no evidence that this drug was better or safer than Haldol (haloperidol.) The FDA told Janssen: "We would consider any advertisement or promotion labeling for RISPERDAL false, misleading, or lacking fair balance under section 501 (a) and 502 (n) of the ACT if there is presentation of data that conveys the impression that risperidone is superior to haloperidol or any other marketed antipsychotic drug product with regard to safety or effectiveness."[38]

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[34] Arana, G. "An overview of side effects caused by typical antipsychotics." *Journal of Clinical Psychiatry* 61, supplement 8 (2000):5-13.

[35] Waddington, J. "Mortality in schizophrenia." *British Journal of Psychiatry* 173 (1998):325-329.

[36] Joukamaa, M, et al. Schizophrenia, neuroleptic medication and mortality. *British Journal of Psychiatry* 188 (2006):122-127.

[37] Healy, D et al. "Lifetime suicide rates in treated schizophrenia." *British Journal of Psychiatry* 188 (2006):223-228.

[38] FDA approval letter from Robert Temple to Janssen Research Foundation, December 21, 1993.

18. After Risperdal (risperidone) was approved, physicians who weren't funded by Janssen were able were able to conduct independent studies of the drug. They concluded that risperidone, in comparison to Haldol, caused a higher incidence of Parkinsonian symptoms; that it was more likely to stir akathisia; and that many patients had to quit taking the drug because it didn't knock down their psychotic symptoms.[39, 40, 41, 42, 43] Jeffrey Mattes, director of the Psychopharmacology Research Association, concluded in 1997: "It is possible, based on the available studies, that risperidone is not as effective as standard neuroleptics for typical positive symptoms."[44] Letters also poured into medical journals linking risperidone to neuroleptic malignant syndrome, tardive dyskinesia, tardive dystonia, liver toxicity, mania, and an unusual disorder of the mouth called "rabbit syndrome."

19. Zyprexa, which is manufactured by Eli Lilly, was approved by the FDA in 1996. This drug, the public was told, worked in a more "comprehensive" manner than either risperidone or haloperidol, and was much "safer and more effective" than the standard neuroleptics. However, the FDA, in its review of the trial data for Zyprexa, noted that Eli Lilly had designed its studies in ways that were "biased against haloperidol." In fact, 20 of the 2500 patients treated with Zyprexa in the trials died. Twenty-two percent of the Zyprexa patients suffered a "serious" adverse event, compared to 18 percent of the Haldol patients. There was also evidence that Zyprexa caused some sort of metabolic dysfunction, as patients gained nearly a pound per week. Other problems that showed up in Zyprexa patients included Parkinsonian symptoms, akathisia, dystonia, hypotension,

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[39] Rosebush, P. "Neurologic side effects in neuroleptic-naïve patients treated with haloperidol or risperidone." *Neurology* 52 (1999):782-785.

[40] Knable, M. "Extrapyramidal side effects with risperidone and haloperidol at comparable D2 receptor levels." *Psychiatry Research: Neuroimaging Section* 75 (1997):91-101.

[41] Sweeney, J. "Adverse effects of risperidone on eye movement activity." *Neuropsychopharmacology* 16 (1997):217-228.

[42] Carter, C. "Risperidone use in a teaching hospital during its first year after market approval." *Psychopharmacology Bulletin* 31 (1995):719-725.

[43] Binder, R. "A naturalistic study of clinical use of risperidone." *Psychiatric Services* 49 (1998):524-6.

[44] Mattes, J. "Risperidone: How good is the evidence for efficacy?" *Schizophrenia Bulletin* 23 (1997):155-161.

constipation, tachycardia, seizures, liver abnormalities, white blood cell disorders, and diabetic complications. Moreover, two-thirds of the Zyprexa patients were unable to complete the trials either because the drugs didn't work or because of intolerable side effects.[45]

20. There is now increasing recognition in scientific circles that the atypical antipsychotics are no better than the old drugs, and may in fact be worse. Specifically:

a) In 2000, a team of English researchers led by John Geddes at the University of Oxford reviewed results from 52 studies, involving 12,649 patients. They concluded: "There is no clear evidence that atypicals are more effective or are better tolerated than conventional antipsychotics." The English researchers noted that Janssen, Eli Lilly and other manufacturers of atypicals had used various ruses in their clinical trials to make their new drugs look better than the old ones. In particular, the drug companies had used "excessive doses of the comparator drug."[46]

b) In 2005, a National Institute of Mental Health study found that that were "no significant differences" between the old drugs and the atypicals in terms of their efficacy or how well patients tolerated them. Seventy-five percent of the 1432 patients in the study were unable to stay on antipsychotics owing to the drugs' "inefficacy or intolerable side effects," or for other reasons.[47]

c) In 2007, a study by the British government found that schizophrenia patients had better "quality of life" on the old drugs than on the new ones.[48] This finding was

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[45] See Whitaker, R. *Mad in America*. New York: Perseus Press (2002):279-281.
[46] Geddes, J. "Atypical antipsychotics in the treatment of schizophrenia." *British Medical Journal* 321 (2000):1371-76.
[47] Lieberman, J, et al. "Effectiveness of antipsychotic drugs in patients with schizophrenia." *New England Journal of Medicine* 353 (2005):1209-1233.
[48] Davies, L, et al. "Cost-effectiveness of first- v. second-generation antipsychotic drugs." *The British Journal of Psychiatry* 191 (2007):14-22.

quite startling given that researchers had previously determined that patients medicated with the old drugs had a "very poor" quality of life.

20. There is also growing evidence that the atypicals may be exacerbating the problem of early death. Although the atypicals may not clamp down on dopamine transmission quite as powerfully as the old standard neuroleptics, they also block a number of other neurotransmitter systems, most notably serotonin and glutamate. As a result, they may cause a broader range of physical ailments, with diabetes and metabolic dysfunction particularly common for patients treated with Zyprexa. In a 2003 study of Irish patients, 25 of 72 patients (35%) died over a period of 7.5 years, leading the researchers to conclude that the risk of death for schizophrenics had "doubled" since the introduction of the atypical antipsychotics.[49]

VII. Conclusion

21. In summary, the research literature reveals the following:

a) Antipsychotics increase the likelihood that a person will become chronically ill.

b) Long-term recovery rates are much higher for unmedicated patients than for those who are maintained on antipsychotic drugs.

c) Antipsychotics cause a host of debilitating physical, emotional and cognitive side effects, and lead to early death.

[49] Morgan, M, et al. "Prospective analysis of premature morbidity in schizophrenia in relation to health service engagement." *Psychiatry Research* 117 (2003):127-35.

d) The new "atypical" antipsychotics are not better than the old ones in terms of their safety and tolerability, and quality of life may even be worse on the new drugs than on the old ones.

DATED this 4 day of September, 2007, in Cambridge, Massachusetts.

Robert B. Whitaker
Robert Whitaker

SUBSCRIBED AND SWORN TO before me this 4th day of September, 2007.

Notary Public in and for Massachusetts
My Commission Expires: August 6, 2013

TENZIN DEMAY
Notary Public
COMMONWEALTH OF MASSACHUSETTS
My Commission Expires
August 6, 2013

State of Alaska)
)ss
Third Judicial District)

I, James B. Gottstein, hereby affirm that this reproduction of Affidavit of Robert Whitaker, to which this is appended, is a true, correct and complete photocopy of the original filed in 3AN 07-1064PR.

Dated: May 13, 2008

James B. Gottstein

SUBSCRIBED AND SWORN TO before me this 13th day of May, 2008.

STATE OF ALASKA
NOTARY PUBLIC
Lisa E. Smith
My Commission Expires April 23, 2011

Lisa E. Smith
Notary Public in and for Alaska
My Commission expires: 4/23/2011

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

In The Matter of the Necessity for the Hospitalization of William Bigley,

Respondent

Case No. 3AN 08-00493PS

NOTICE OF FILING TESTIMONY

The following prior testimony is hereby filed by Respondent in connection with consideration of the current AS 47.30.839 forced drugging petition:

1. Transcript of the March 5, 2003, testimony of Loren Mosher, in 3AN 03-00277 CI;
2. Affidavit of Loren Mosher in 3AN 03-00277 CI; and
3. Transcript of the September 5, 2007, testimony of Sarah Porter in Pages in 3AN 07-1064 PS.

All of this testimony is admissible pursuant to Evidence Rule 804(b)(1). Dr. Mosher is now deceased and therefore unavailable, and the Petitioner not only had the opportunity and similar motive to develop the testimony by direct, cross, or redirect, the Petitioner, it self, had such an opportunity and similar motive.

Ms. Porter lives in New Zealand and is unavailable for that reason. Not only, as with Dr. Mosher, did the Petitioner have the opportunity and similar motive to develop the testimony by direct, cross, or redirect, the testimony was with respect to a previous forced drugging petition against Respondent, which Petitioner abandoned.

DATED: May 13, 2008. Law Project for Psychiatric Rights

By: _____
James B. Gottstein, ABA # 7811100

LAW PROJECT FOR PSYCHIATRIC RIGHTS, INC.
406 G Street, Suite 206
Anchorage, Alaska 99501
(907) 274-7686 Phone ~ (907) 274-9493 Fax

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

In The Matter of the Hospitalization of FAITH J. MYERS	)	Case No. 3AN 03-277 P/S
STATE OF CALIFORNIA	)	
	) ss	
SAN DIEGO COUNTY	)	

Affidavit of Loren R. Mosher, M.D.

Credentials:

I am born and raised in California, a board-certified psychiatrist who received an M.D., with honors, from Harvard Medical School in 1961, where I also subsequently took psychiatric training. I was Clinical Director of Mental Health Services for San Diego County from 7/96 to 11/98and remain a Clinical Professor of Psychiatry at the School of Medicine, University of California at San Diego. From 1988-96 I was Chief Medical Director of Montgomery County Maryland's Department of Addiction, Victim and Mental Health Services and a Clinical Professor of Psychiatry at the Uniformed Services University of the Health Sciences, F. Edward Herbert School of Medicine, Bethesda, Maryland.

From 1968-80 I was the first Chief of the NIMH's Center for Studies of Schizophrenia. While with the NIMH I founded and served as first Editor-in-Chief of the Schizophrenia Bulletin.

From 1970 to 1992 I served as collaborating investigator, then Research Director, of the Palo Alto based, NIMH funded Soteria Project – "Community Alternatives for the Treatment of Schizophrenia". In this role, I was instrumental in developing and researching an innovative, home-like, residential treatment facility for acutely psychotic persons. Continuing my interest in clinical research (1990 - 1996), I was the Principal Investigator of a Center for Mental Health Services (CMHS) research/demonstration grant for the first study to compare clinical outcomes and costs of long term seriously mentally ill public-sector clients randomly assigned (with no psychopathology based exclusion criteria) to a residential alternative to hospitalization or the psychiatric ward of a general hospital (the McPath project). This study's findings, comparable clinical effectiveness with a 40% cost saving favoring the alternative, have important acute care implications.

In 1980, while based at the University of Verona Medical School, I conducted an in-depth study of Italy's revolutionary new mental health system. I documented that the new National Health Service supported system of catchmented community care could stop admissions to large state hospitals, enabling them to be phased down and closed. It

DEFENDANT
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3AN-03-277 P/S
(CASE NUMBER)

was also concluded that where the legally mandated community system was properly implemented there were no adverse consequences for patients or the community.

In addition to over 120 articles and reviews, I have edited books on the Psychotherapy of Schizophrenia and on Milieu Treatment. Our book, Community Mental Health: Principles and Practice, written with my Italian colleague, Dr. Lorenzo Burti, was published by Norton in 1989. A revised, updated, abridged paperback version, Community Mental Health: A Practical Guide, appeared in 1994. It has been translated into five languages. Most recently I founded a consulting company, Soteria Associates, to provide individual, family and mental health system consultation using the breadth of experience described above.

INTRODUCTION:

In many parts of the country thinking about public mental health systems has moved away from the biomedical model, initially to a psychosocial rehabilitation orientation, and more recently to a recovery based model. Each change represents a move toward a more holistic view, increased self-management in treatment, greater emphasis on independent living and community integration and protection of rights of system users. As a whole it means much less hierarchical systems and greater equality of staff and users.

When considering mental health reform it must be recognized that mental health care is a system. Programs making up mental health systems share the following characteristics: They are labor intensive, relationship based and relatively low technology. The system's elements should include: Prompt, accessible, client centered, recovery oriented, quality mental health and rehabilitation services; decent affordable housing; and appropriate, ongoing self-help focused social supports. Because they address basic human needs systems that contain an array of these services have been shown to be both cost effective and voluntarily used. Such systems must be adequately funded but reform must also include attitude change and reorganization into less institutional, human sized programs.

Reform to produce co-ordinated community based systems of care needs guidelines: (1) a shared set of values and (2) common organizational (3) interpersonal and (4) clinical principles. These four elements of a systemic organizational framework can guide the committee's reform deliberations. Because they are non-specific, they are nearly universally applicable.

1. PROGRAM VALUES

- Do no harm
- Treat, and expect to be treated, with dignity and respect.
- Be flexible and responsive
- In general the "user" (client, patient) knows best. We each know more about ourselves than anyone else. This is usually a vast untapped reservoir of valuable information.
- Choice, the right to refuse, informed consent, and voluntarism are essential to program functioning. Without options, freedom of choice is illusory. Involuntary

treatment should be difficult to implement and used only in the direst of circumstances.

- Expression of strong feelings and development of potential are acceptable and expected – and are not usually signs of "illness".
- Whenever possible, legitimate needs (e.g. housing, social, financial etc.) should be filled. Without adequate housing, mental health "treatment" is mostly a waste of time and money.
- Risks are part of the territory; if you don't take chances nothing ever happens.

2. ADMINISTRATIVE PRINCIPLES

- Reliable funding stream
- Catchmented responsibility – no "shift and shaft" allowed
- Responsible, multi-disciplinary, multi-function, mobile teams
- Decentralized authority and responsibility to allow on the spot decision making
- Use of existing community resources
- Multi-purpose mental health/social services centers.
- Non-institutionalization: Residential care (i.e., hospitals and IMD's) is expensive and often creates or reinforces problems. They are, by definition, abnormal environments and should be used sparingly.
- Multi-dimensional outcomes must be monitored and fed back rapidly.
- Citizen/"user" participation is vital for program planning and oversight.

3. RELATIONAL PRINCIPLES

(All help facilitate the development of relationships)

- Positive Expectations
- Atheoretical need to understand – try to find an explanation for what is going on
- Continuity of relationships across contexts
- "Being with"., "standing by attentively" – getting oneself into the other's shoes to better understand "the problem"
- Concrete problem focus (problems, in contrast to diagnoses, generate questions and possible solutions)
- Relational "partnership", doing together (preserves "user" power)
- Expectation of self-help ("users" need not be so in perpetuity)

4. CLINICAL PRINCIPLES

- Contextualization– we all have histories that can only be understood by considering the contexts within which they developed.
- Preservation and enhancement of "user" personal power and control. Mental health professionals do not necessarily know what is best for their clients/patients – their role should be to keep them continually involved as the treatment process unfolds.

- Normalization (Usualization): Culturally sensitive societal norms should be applied when treatment plans are developed. The most "normal", least restrictive, alternative should always be tried first. If you treat people as normal they tend to behave normally.

We have a more than adequate knowledge base to implement reform. More studies and dust gathering reports are not needed. What is needed is the political will, community involvement and financial resources necessary to make change happen.

Loren R Mosher, MD

SUBSCRIBED AND SWORN TO before me this _5th_ day of March, 2003.

Notary Public in and for California
My commission expires: 11.4.04

OFFICIAL SEAL
JANE M. REILLY
NOTARY PUBLIC-CALIFORNIA
COMM. NO. 1279794
SAN DIEGO COUNTY
MY COMM. EXP. NOV. 4, 2004

State of Alaska)
)ss
Third Judicial District)

I, James B. Gottstein, hereby affirm that this reproduction of Affidavit of Loren R. Mosher, M.D., to which this is appended, is a true, correct and complete photocopy of the original document, currently in my possession.

Dated: May 13, 2008

James B. Gottstein

SUBSCRIBED AND SWORN TO before me this 13th day of May, 2008.

STATE OF ALASKA
NOTARY PUBLIC
Lisa E. Smith
My Commission Expires April 23, 2011

Notary Public in and for Alaska
My Commission Expires: 4/23/2011

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT

IN THE MATTER OF F.M.

3AN-02-00277 CI

_____/

VOLUME I

TRANSCRIPT OF PROCEEDINGS

March 5, 2003 -- Pages 1 through 198

March 10, 2003 -- Pages 198 through 223

HEARING REGARDING BURDEN OF PROOF THAT DEFENDANT IS MENTALLY ILL AND REGARDING ADMINISTRATION OF MEDICATION

BEFORE THE HONORABLE MORGAN CHRISTEN

Anchorage, Alaska
March 5, 2003

APPEARANCES:

FOR THE PLAINTIFF: Jeff Killip
Assistant Attorney General
State of Alaska
1031 West 4th Avenue, Suite 200
Anchorage, Alaska 99501

FOR THE DEFENDANT: James B. Gottstein
406 G Street, Suite 206
Anchorage, Alaska 99501

CONTENTS

PROCEEDINGS

4403-41

8:52:51 AM

THE COURT: We're on record in Case No. 3AN-03-277. It's a case regarding Faith Myers. Mr. Gottstein, before I go any further, I'll just state your appearance. Mr. Gottstein is present, for the record, as is Mr. Killip for the State. Your client requested this be an open hearing, is that correct?

MR. GOTTSTEIN: That's correct. She's not here yet, though, and she's supposed to be here. So, I don't know what the hang-up is. Dr. Kletti, wasn't she --?

THE COURT: Right. She has the right to be present.

DR. KLETTI: Right. She was scheduled for transportation to court this morning.

THE COURT: I was told that you all were ready. I didn't realize that you weren't. We need to wait for her. So we'll go ahead and go back off record and do that. Well, actually, maybe I'll take up some housekeeping, first, but we're not going to proceed in substance with her, certainly.

I just have the one exhibit list. Counselor, do you have --

MR. GOTTSTEIN: The respondent's?

THE COURT: Yes. Do you have an exhibit list, Mr.

Killip?

MR. KILLIP: Your Honor, given the accelerated pace, the witnesses just showed up. I had a chance to speak with one for almost an hour yesterday, but there are two more I haven't had a chance to talk with and one of them presented me with some photographs. I don't have an exhibit list that I've generated yet, but I can do it right now.

THE COURT: Okay, that's fine. We can do it when we go off record for a minute. As long as Mr. Gottstein has it and has a chance to take a look, that's fine.

MR. GOTTSTEIN: Your Honor, I would note under AS 47.37.30(a)(6) that the petition must list the prospective witnesses who will testify in support of commitment or involuntary treatment, and only Dr. Hanowell was listed. And I would object to any witness other than the one specifically listed testifying.

THE COURT: All right. The objection is noted, but again, I'm not going to make any substantive ruling until your client gets here. My intention is to stay on record just to get some housekeeping taken care of.

MR. GOTTSTEIN: Can I respond to that, Your Honor?

THE COURT: No, not yet.

MR. GOTTSTEIN: Okay.

THE COURT: Because we're not going to get into

Page 167

THE COURT: Mr. Gottstein?
DIRECT EXAMINATION (continued)
BY MR. GOTTSTEIN:
Q Yeah. Dr. Jackson, can you explain why you failed the exam? Or, you were failed, I guess I should say.
A Well, the Board of Examiners does not send you any kind of feedback, but I was subjected to quite intense cross-examination as to why I would not give a patient with psychotic symptoms medication for life. And I had done extensive research up to that point to prepare myself for -- for my philosophy of treatment. And I was not willing to purger myself in the cross-examination process of board certification exam, so I did not pass that exam.
Q What do you mean by that? You were not prepared to purger yourself?
A I could have lied. I could have told the examiners that the woman in the videotaped interview, who had previously had a case of schizophrenia, needed to be on medication for life, which is what they were attempting to get out of me. Because they kept saying, well, she told you that she had previously been on these medicines. Why won't you give them to her now? And I had done a great deal of research and had very good reasons why I would not continue a person, necessarily on life-long medication. But that, apparently, was not the answer that they were

Page 168

looking for.
I should say that my passed portion of the exam, which was based on a live patient interview in the morning, was based -- I passed that exam, and the reason for that or the tone of that was actually quite different. My examiners were more psycho-dynamically oriented individuals, and they accepted the fact that a life-long medication strategy was not necessarily in the best interest of all patients.
So, the board certification process, itself, is extremely relative. I would expect to encounter the exact difficulties when I sit for the examination again and I will give the same answers, based on the same scientifically-based knowledge.
THE COURT: I'll accept this witness as an expert and weigh her testimony accordingly.
Q Dr. Jackson, did you prepare a report and sign an affidavit -- well -- excuse me, Your Honor.
THE COURT: That's okay. But could you get closer to the microphone?
Q Yes. Did you notarize a statement -- have notarized a statement in preparation for this hearing?
A Yes, I did.
THE COURT: Mr. Gottstein, I'm sorry to do this to you, but I just got the email that Dr. Mosher is on the

Page 169

phone. Do you want me to have him call back in 10 minutes, or what do you want to do?
MR. GOTTSTEIN: Grace, can you? Let's take Dr. Mosher.
THE COURT: That's your preference?
MR. GOTTSTEIN: Yes.
THE COURT: Ma'am, I'm very sorry to do this. We've been trying to get Dr. Mosher on the line, and the witnesses we typically go in order. And he was not available by phone. I've just received an email that he's called back in.
DR. JACKSON: That's absolutely fine.
THE COURT: All right. I appreciate it very much.
DR. JACKSON: Would you like me -- you'll call me back?
THE COURT: Yes.
DR. JACKSON: Okay. Thank you.
THE COURT: You bet. Dr. Mosher, can you hear me?
DR. MOSHER: Yes. Long distant, but I can hear you.
THE COURT: All right. I'll try to speak into the microphone more clearly. My name is Morgan Christen. I'm a superior court judge and I'm assigned to this case. I have you on a speaker phone on an overhead in the courtroom, sir. And Mr. Gottstein has asked that you testify. Are you able to do that at this time?

Page 170

DR. MOSHER: Well, I guess. I didn't prepare must, but anyway, I'll do my best.
THE COURT: All right. That's fine. I need to have the oath administered to you. Could you please raise your right hand?
DR. MOSHER: Okay.
THE CLERK: Do you swear or affirm that the information you are about to give in this matter before the court is the truth, the whole truth, and nothing but the truth?
DR. MOSHER: I do.
THE COURT: Sir, could you please state your full name and spell your last name?
DR. MOSHER: It's Loren Mosher, M-O-S-H-E-R-.
THE COURT: All right. Thank you. Mr. Gottstein, you may inquire.
DR. LOREN MOSHER
testified as follows on:
DIRECT EXAMINATION
BY MR. GOTTSTEIN:
Q Dr. Mosher, I can't express my appreciation enough for your willingness to testify after just getting back from Germany yesterday, and I just felt like I wanted to express that.
Your affidavit has just been admitted. And I

Page 171

represented that you would have it notarized and send it. Is that true?
A I just did that. It should be there tomorrow afternoon.
Q Thank you. Could you briefly -- because we've got a total of, I think 28 minutes left in this whole hearing, including to hear from Dr. Jackson -- discuss your credentials, please?
A I graduated from Stanford as an undergraduate, Harvard Medical School, Harvard psychiatric training, more training at the National Institute of Mental Health, post-doctoral fellowship in England, professor -- assistant professor of psychiatry at Yale -- I'm sort of going chronologically -- from '68 to '80 I was the chief for the Center for Studies of Schizophrenia, at the National Institute of Mental Health from 1980 to '88 I was professor of psychiatry at the Uniform Services University of the Health Sciences in Bethesda, Maryland. That's a full-time, tenured, academic position. '88 to '96 I was the chief medical director of the Montgomery County Maryland Public Mental Health System. That's a bedroom community to Washington, D.C. From '96 to '98 I was clinical director of the San Diego County Public Mental Health System. Since November of '98 I have been the director and principle in Satiria (ph) Associates, a

Page 172

private consulting firm that I formed, and I also hold clinical professorships at the University of California San Diego School of Medicine, and at the Uniform Services University of the Health Sciences in Bethesda, Maryland. So that's briefly my credentials.
Q Dr. Mosher, did you mention being head of schizophrenia research at the National Institute of Mental Health?
A Yeah, I said I was the head of the Center for Studies of Schizophrenia from 1968 until 1980.
Q Okay. I move to qualify Dr. Mosher as an expert psychiatrist, especially in schizophrenia.
MR. KILLIP: Your Honor, just a couple questions.
VOIR DIRE EXAMINATION
BY MR. KILLIP:
Q Dr. Mosher, Jeff Killip with the Alaska Attorney General's Office. I just want to ask you if you are currently board certified in psychiatry?
A I've been board certified since 1969.
Q Okay. And are you currently a member in good standing with the American Psychiatric Association?
A No, I am not. I resigned from the American Psychiatric Association.
Q And do you have a reason for that?
A Yes, I have a reason for it. I felt like they no

Page 173

longer represented my interested and the $1,000 a year that I was paying for them was just basically a waste of money, while they pursued their own interests to the detriment of what I consider to be the people they should be pursuing an interest for, and that's their patients. So anyway, I'm not a member. I resigned in December of 1998.
Q So, is it fair to say that you have a philosophical disagreement with their approach, presently?
A Well, yeah. I don't like how they do business.
Q When you say do business, you mean practice psychiatry in the United States?
A Well, we could take up the next half hour on that subject, but basically I feel that they have taken the person out of psychiatry and psychiatry has -- is now a dehumanizing, impersonal, non-individualized specialty that is interested purely in pharmical therapy now. That's big, broad brush strokes, but that's -- obviously that's not true of every single one, but that's my complaint about the organization.
Q Okay.
A There's a -- if you want to read my letter of resignation, you can look on my web site.
Q Okay, thank you.
THE COURT: Any objection?

Page 174

MR. KILLIP: No.
THE COURT: All right. This witness will be qualified
Q Thank you, Dr. Mosher. In the first sentence of the introduce of your affidavit on page two, you talk about the biomedical model. I was going to ask you what you mean by that. Have you already answered that, or would you like to expand on that?
A Well, you know, what I mean by that is the phrase is currently being used that, let's take, for example, schizophrenia is a brain disease. Well, that's a perfect example of the medical model -- of the biomedical model. When -- whereas, there is no evidence that schizophrenia is, in fact, a brain disease. And so a hypothesis that schizophrenia is a brain disease, has been converted into a biomedical fact. And I disagree with converting hypotheses into beliefs in the absence of supporting evidence.
Q Okay, thank you. Now, in your opinion, is medication the only viable treatment for schizophrenia paranoid type?
A Well, no, it's not the only viable treatment. It is one that will reduce the so-called positive symptoms, the symptoms that are expressed outwardly for those kinds of folks. And that way they may seem better, but in the long

Page 175

run, the drugs have so many problems, that in my view, if you have to use them, you should use them in as small a dose for as short a period of time as possible. And if you can supply some other form of social environmental treatment -- family therapy, psychotherapy, and a bunch of other things, then you can probably get along without using them at all, or, if at all, for a very brief period of time. But you have to be able to provide the other things. You know, it's like, if you don't have the other things, then your hand is forced.

MR. KILLIP: Excuse me, Your Honor. I just would renew our continuing objection about offering test on medical practice in the context of this hearing.

THE COURT: This hearing is going to last 20 more minutes, and I'm going to let Mr. Gottstein use the time.

Q Now, as a hypothetical question, if a woman who had managed -- who has over a 25 year experience with medications and has -- including navaine, paxil, risperdal and zyprexa -- and then has managed to not -- to wean herself from those for a year, would your recommendation be that she be placed back on them, particularly against her will?

A Well, I think she is an absolute saint if she was able to get off of those drugs. Those drugs are extraordinarily difficult to get off of, especially

Page 176

zyprexa, which is a thienobenzodiazepine derivative and the thienobenzodiazepine valium-type drugs are very addictive. And so, zyprexa, in particular, is difficult to get off. And if she got off herself -- got herself off of zyprexa, that's quite a remarkable feat in my clinical experience. So I would be loath to put her back onto, especially zyprexa. But, you know, the other -- risperdal is also problematic for getting off. Actually, they all are, it's just a matter of degree. And if she got off for a year, then I would certainly try to do whatever I can to avoid putting her back on. And if she doesn't want them, then that's even -- you know, if you can't negotiate some drug that she may calm down on, like, for example, if she if kind of agitated and anxious -- I don't know this woman. I've never seen her face-to-face, so I can't really speak to her particular problem without having seen her, but if she is, let's say, unhappy, agitated, and so forth, then sometimes short-term use of drugs like valium is quite helpful and it get's people through a crisis without getting them back onto the neuroleptics drugs, the anti-psychotic drugs.

Q Okay, thank you. Now, in your affidavit, you say involuntary treatment should be difficult to implement and used only in the direst of circumstances. Could you explain why you have that opinion?

Page 177

A Well, it's just, you know, the degree to which you have to force people to do anything.....

MR. KILLIP: Your Honor, I'm going to object.

A .....is the degree to which it's going to be very difficult to forge a good therapeutic relationship. And in the field of psychiatry, it is the therapeutic relationship which is the single most important thing. And if you have been a cop, you know, that is, some kind of a social controller and using force, then it becomes nearly impossible to change roles into the role -- the traditional role of the physician as healer advocate for his or her patient. And so I think that that -- we should stay out of the job of being police. That's why we have police. So they can do that job, and it's not our job.

Now, if because of some altered state of consciousness, somebody is about to do themselves grievous harm or someone else grievous harm, well then, I would stop them in whatever way I needed to. I would probably prefer to do it with the police, but if it came to it, I guess I would do it. In my career I have never committed anyone. It just is -- I make it my business to form the kind of relationship that the person will -- that we can establish a ongoing treatment plan that is acceptable to both of us. And that may you avoid getting into the fight around whatever. And, you know, our job is to be healers,

Page 178

not fighters.

THE COURT: There's an objection to that question. The objection was relevance?

MR. KILLIP: Yes.

THE COURT: Overruled.

Q Now, you say you've never committed anybody. But you've had a lot of experience with -- or, I should say, have you had a lot of experience with people with schizophrenia?

A Oh, dear. I probably am the person on the planet who has seen more acutely psychotic people off of medication, without any medications, than anyone else on the face of the planet today.

Q Thank you.

A Because of the Satiria Project that we did for 12 years where I would sit with people who were not on medications for hours on end. And I've seen them in my private practice, and I see them to this day in my now, very small, private practice. But --

THE COURT: Sir, I think I understand the answer.

A I find that people who are psychotic and not medicated are among the most interesting of all the customers one finds.

Q Thank you, Dr. Mosher.

THE COURT: That's a yes.

Page 179

Q Dr you know Dr. Grace Jackson?
A I do.
Q Do you have an opinion on her knowledge of psychopharmacology?
A I think she knows more about the mechanisms of actions of the various psychotropic agents than anyone who is a clinician, that I'm aware of. Now, there may be, you know, basic psychopharmacologists, you know, who do lab work who know more, but as far as a clinician, a practitioner, I don't know anyone who is better-versed in the mechanisms, the actions, the effects and the adverse effects of the various psychotropic drugs.
Q Thank you, Dr. Mosher. I have no questions, but perhaps the State will have some.
MR. KILLIP: Yes, thank you.

DR. LOREN MOSHER

testified as follows on:

CROSS-EXAMINATION

BY MR. KILLIP:

Q Dr. Mosher, is it not your understanding that the use of anti-psychotic medications is the standard of care for treatment of psychosis in the United States, presently?
A Yes, that's true.
Q Okay, so is it fair to say that your viewpoint --

Page 180

MR. GOTTSTEIN: Objection, relevance.
THE COURT: Overruled.
Q Would you say that your viewpoint presented today falls within the minority of the psychiatric community?
A Yes, but I would just like to say that my viewpoint is supported by research evidence. And so, that being the case, it's a matter of who judges the evidence as being stronger, or whatever. So, I'm not speaking just opinion, I'm speaking from a body of evidence.
Q Thank you, Dr. Mosher.
THE COURT: Nothing further?
MR. KILLIP: Nothing.
MR. GOTTSTEIN: No, Your Honor.
THE COURT: All right. Sir, I appreciate your testimony very much and want to thank you. It sounds like the lawyers are done with you, so you can hang up.
DR. MOSHER: Okay. Well, good luck and I hope -- what's her name, Ms. Myers?
THE COURT: Faith Myers.
DR. MOSHER: Gets out and without drugs. Thank you.
THE COURT: Thank you, sir. All right. Do you want to try to call Dr. Jackson back?
MR. GOTTSTEIN: Yes, Your Honor.
THE COURT: All right. Dr. Jackson?
DR. JACKSON: Yes?

Page 181

THE COURT: Great. We're back on record. This is Morgan Christen again. I have you back on the same overhead speaker.
DR. JACKSON: Yes, ma'am.
THE COURT: What I'm going to do, I think, to save time, is to just remind you that you remain under oath and allow Mr. Gottstein to ask his questions.
DR. JACKSON: Um-hmm. Yes, ma'am.

DR. GRACE JACKSON

testified as follows on:

DIRECT EXAMINATION (continued)

BY MR. GOTTSTEIN:

Q Thank you, Dr. Jackson. Obviously we're down to 10 minutes now, and I appreciate you waiting all day. And I'm going to have to be, obviously, a little bit -- or more than a little bit brief.
Did you -- we were just talking about an affidavit, I think, that you signed, or a report that you swore. Did you do so?
A Yes, that is correct. Yup.
Q And is it -- can I --?
THE COURT: Do I have this? Oh, you're just handing it to me now, okay.
MR. GOTTSTEIN: I was in the middle of that.
THE COURT: I see. I beg your pardon.

Page 182

MR. GOTTSTEIN: Exhibit D.
THE COURT: Thank you, sir.
Q What's the title of that?
A This is an analysis of the olanzapine that is zyprexa, the clinical trials, and I've called this A Dangerous Drug with Dubious Efficacy.
Q Okay.
MR. KILLIP: Excuse me, Your Honor. I just wanted to note for the record that we've got about 20+ pages, half of them are stapled upside down. We're probably not going to have a meaningful opportunity to look at this before cross-examination. I just want to make that record.
THE COURT: Yes, I have the same exhibit.
MR. KILLIP: Thank you.
MR. GOTTSTEIN: And I would note that I received nothing from them before anything.
Q I think what I -- does this accurately -- well, obviously it accurately describes the results of your research into the drug olanzapine. Is that correct?
A Yes, that's right.
Q Okay. Have you -- I'm going to try -- I'm trying to get some stuff into the record here, Your Honor. And so -- and then we'll get to more substantive.
Did you send me some information regarding the

Page 222

MR. GOTTSTEIN: .....if that's what our decision is.
THE COURT: If you could let me know, I'd sure appreciate it, because I'm --
MR. GOTTSTEIN: Absolutely, Your Honor. I included you in that.
THE COURT: Yeah, I appreciate it. Because, as I said, I'm -- I have a personal appointment out of the office that's actually a medical appointment I scheduled for some months and moved several times, myself, so I'd like to know as soon as I can, so that I can know how to handle that.
And I appreciate what you're both doing, which strikes me as you're both being very, very cooperative and trying your level best to get this done in a timely manner that jumps through all the hoops required by the statute and make sure that I have the information that I need to make the decision.
Is there anything further I can take up today, productively? No?
MR. KILLIP: I don't think so, Your Honor.
THE COURT: All right. Well then, I'll let you both ring off. It's after 5:00 and I've kept you. Thanks very much for your help. I'll have Hilary confirm tomorrow morning about that time, but that should be at least in pencil on your calendars. And I'll let you know if I need

Page 223

to speak to you sooner, after I get the report from the court-appointed visitor.
MR. KILLIP: Okay.
THE COURT: Thank you both very much.
MR. KILLIP: Thank you.
MR. GOTTSTEIN: Thank you.
THE COURT: Off record.
(Off record.)
5:03:47

Page 224

TRANSCRIBER'S CERTIFICATE

I, Joanne Kearse, hereby certify that the foregoing pages numbered 1 through 222 are a true, accurate, and complete transcript of the hearings that took place on March 5, 2003 and March 10, 2003, In the Matter of F.M., Superior Ct. No. 3AN-03-277 PR, transcribed by me from a copy of the electronic sound recording to the best of my knowledge and ability.

Dated this 7th day of April, 2003.

JOANNE KEARSE

IN THE TRIAL COURTS FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT

AT ANCHORAGE

In the Matter of the Necessity
for the Hospitalization of
W.S.B.,

Respondent.
_____/

No. 3AN-07-1064 PR

30-DAY COMMITMENT HEARING

PAGES 1 THROUGH 103

BEFORE THE HONORABLE ANDREW BROWN
MASTER

Anchorage, Alaska
September 5, 2007
9:14 a.m.

APPEARANCES:

FOR STATE OF ALASKA: Elizabeth Russo
Attorney General's Office
Human Services Division
1031 West 4th Avenue, Suite 200
Anchorage, Alaska 99501

FOR W.S.B.: James Gottstein
406 G Street, Suite 206
Anchorage, Alaska 99501

Also Present: W.S.B.

PROCEEDINGS

3AN2707-162

9:14:26

THE COURT: This is the matter of the case involving the hospitalization for William Bigley, file number 007-1064. This is the time set for the hearing concerning State's petition -- petition for court approval of administration of psychotropic medication. And Ms. Russo is here representing the State, and Mr. Gottstein is here representing Mr. Bigley.

So, any preliminary matters, Ms. Russo?

MS. RUSSO: Yes, Your Honor. Along -- I just filed a pre-hearing brief this morning. Part of my pre-hearing brief is a motion to strike all the attachments that had been attached to the respondent's pre-hearing brief, including the affidavits that were filed along with it.

At this point, just -- many of them, I don't believe, are relevant to the issues in this case. If the respondent wishes to introduce them as evidence later on, then we could take them up the, but I would ask the court to take that up.

THE COURT: Okay.

MS. RUSSO: And then I understand that there is a witness that Mr. Gottstein has subpoenaed and

wishes to testify this morning.

My only witness is Dr. Worrall, and there were staffing issues at the hospital, so he's not here yet. he will be here at 10 o'clock this morning.

I would object to Mr. Gottstein calling Ms. Porter. I don't know how she can provide relevant testimony in this case, and I think we should probably try and figure that out. I understand she is only available this morning, so we should probably figure out the issue of her testimony as quickly as possible so that she's not detained any longer than need by.

MR. GOTTSTEIN: But she's not under subpoena, Your Honor.

MS. RUSSO: Oh, she isn't? Okay.

THE COURT: Okay.

MR. GOTTSTEIN: But (indiscernible).

MS. RUSSO: Let me -- Ms. Russo, anything else before hear from Mr. Gottstein?

MS. RUSSO: Not at this time, Your Honor.

THE COURT: Okay.

Mr. Gottstein?

MR. GOTTSTEIN: Well, first off, of course, I think the petition should be dismissed so that there is no question that I've asked for it. I'm doing so now, and I think there is -- it may be a little unclear in

terms of the proper procedure, but whether you call it a motion or judgment on the pleadings -- for example, they have failed to allege facts sufficient to support their petition. And I brought this up on Friday, and suggested that, on due process grounds, that they -- you know, that I be notified. And I'm gonna re-raise that because there is something in their brief this morning that shows that they really should have done that, and I was entitled to it. But the basic thing is that they haven't -- the basic motion.

There are two real motions, you know, procedurally. A motion for judgment on the pleadings, based on their allegations and their responses, which is in the pre-trial hearing, which could be considered an answer. Especially that background section should be considered an answer.

And then, of course, there is evidence on all those. And I don't know that there is any authentication issue with respect to the court documents. And I had a subpoena out for Dr. Worrall, to bring the records, so that if there is any question about authentication -- so I think that's proper evidence. And, so, then, that would then be a summary judgment motion, basically. And, so, I think, technically, that needs to be addressed first.

And then, I really -- okay -- and then -- and then in terms of the notice -- of course, my brief says that they have to say -- they have to say, under Meyers, what drugs and what combinations they are proposing, in order for a proper analysis to be used. And on Friday I said that they should provide, you know, the information under Meyers. And, of course, Your Honor denied that. But that was a due process argument.

But now she comes in and complains that I've got information about a drug that they're not proposing. I don't even know what drugs they're proposing, which is what I asked for last Friday.

Again, sorry for getting worked up about that. But it really just seems, you know, like -- you know, come on, let's have notice and reasonable opportunity to respond and handle these things properly, as Meyers directed us to do. That these forced drugging petitions are not something -- that they're something that need to be done -- I'm not trying to delay, but they need to be done properly and well considered because of the important interest at stake.

Okay. And then looking through it -- ah, you know -- and we've got a huge amount of stuff that could be done before we can get through -- you know, all the

effects. How do you -- does his medical history indicate whether or not he's suffered any of the -- any side effects from the medication -- from Risperadone?

A Well, he has tardive dyskinesia, which is most likely from the years and years of getting drugs like Haldol, Prolixin -- because he's been getting medications for over 25 years, and those drugs have a 2% per year accumulative risk of tardive dyskinesia.

MR. GOTTSTEIN: Objection, Your Honor.

THE COURT: Okay. What's the nature of the objection?

MR. GOTTSTEIN: Well, the issue about scientific information, that -- I think he should produce the -- what he relies on for that. My understanding is, it's higher than that, as the reason. But -- so I object to that.

THE COURT: Okay. Ms. Russo?

MS. RUSSO: Your Honor, I think Dr. Worrall's testified about the amount of research and the continuing education and the lectures he does, and that's his understanding, as Mr. Bigley's treating physician, as to the amount of risk.

If Mr. Gottstein feel that Dr. Worrall's

testimony is inaccurate, he can counter that during his claims. Dr. Worrall isn't testifying that there is no risk. He's saying that there ins indeed a risk. If Mr. Gottstein has other experts that can counter that, he can present that evidence. I don't -- I think Dr. Worrall -- there's been a sufficient basis for Dr. Worrall's testimony.

MR. GOTTSTEIN: And...

THE COURT: Okay. Wait a minute. The doctor was testifying as to -- what I understood was his -- let me rephrase it. The doctor was testifying concerning, as I understood it -- his belief as to Mr. Bigley's tardive dyskinesia. And it seems like the doctor was relying on what he understood was Mr. Bigley's previous medical history, or administration of drugs to him. And, so, to me, it's just a matter of, t his is the doctor's professional opinion in trying to understand what Mr. Bigley's current situation is, based on what the doctor knows of his past. So I'm going to allow that to stand.

MR. GOTTSTEIN: Your Honor, if I may.

THE COURT: Yeah.

MR. GOTTSTEIN: This just illustrates -- I think the distinction that our court made in Marron or Mara -- I don't know how you say it, but I'll call it

"Marron." That clinical observations, you don't need to go through the Coon standards, but once you get into scientific evidence, that you do. And so I was objecting to the 2% figure, because I think that I'm entitled to have -- you know, to give me the basis for that.

THE COURT: Okay. Ms. Russo, do you want to add anything?

MS. RUSSO: I don't think that this is going into the Marron and Coon. I don't agree with Mr. Gottstein's analysis of this. And quite frankly, I don't know -- I mean, Dr. Worrall's testifying about the fact that Mr. Bigley has tardive dyskinesia from previous medications that he had been on for years. These are not the medications that Dr. Worrall wishes to prescribe for Mr. Bigley at this time. So we're talking about Mr. Bigley's past medical history here.

THE COURT: I'm going to let the testimony stand as is, based on my ruling -- previous ruling. Next question?

MS. RUSSO: Okay. Thank you.

Q And, Dr. Worrall, does the Risperadone have the -- have a side effect of tardive dyskinesia, as well? Can that...

A Yes, it does, but it's considerably less than

-- there is no antipsychotic that -- that has proven to be free of any risk of tardive dyskinesia. The training that psychiatrists traditionally get from any setting, whether it be an academic residency program or literature, is that the risk of the older typical antipsychotics is considerably higher than the newer atypicals. Clozapine being the safest of all, with respect to that risk.

And if I could clarify. I did say a 2% cumulative risk per year. So in 20 years, that's a 40% risk. It does add up to a high number over the years on the typical antipsychotics.

MR. GOTTSTEIN: Yes, Your Honor, and I understood that, and I think the rate is high.

Q Okay. And, Dr. Worrall, did you -- even knowing that there is this risk of tardive dyskinesia, is that something you weighed in your analysis?

A Yes. The risk of the tardive dyskinesia getting worse in a potential with psychotropic drug treatment, antipsychotics in particular. The risk is -- we don't have a number on that. There isn't good research on that. It really would be difficult to quantify. There is some

MR. BIGLEY: See him in person.
MR. GOTTSTEIN: I do -- I -- I'm trying to accommodate the -- I know the practicalities of everything, but it just seems like we're in the same town, that we ought to be able to do that. I notice that, you know, Dr. Worrall has a lot of papers, and I haven't had a chance to, you know, look and see what -- you know, what he's referring to. It's those sorts of things. We might -- I have a -- I -- I'm -- I'm pretty sure I'll have some questions on the chart and stuff, and it just seems more, ah...
THE COURT: Then he's here right now, we're going to have to proceed with him and Ms. Porter will have to wait, and she can...
MR. BIGLEY: Now, (indiscernible).
THE COURT: She could be telephonic Monday.
MR. GOTTSTEIN: I -- I -- wo -- then, in light of that, then I will withdraw my objection to a telephonic testimony.
MR. BIGLEY: (indiscernible) telephonic.
THE COURT: So, Doctor, you're excused for now and we will contact you some time Monday. You -- and, ah, Ms. Russo...
MR. BIGLEY: (Indiscernible).
THE COURT: ...will work out how we'll contact

you now. Thank you.
All right. So, now...
MR. GOTTSTEIN: Short break?
THE COURT: We don't really have time.
MR. GOTTSTEIN: Well, I gotta get...
THE COURT: Okay. Go -- yeah, we'll go off record.
MR. GOTTSTEIN: Okay.
(Off record - 11:18 a.m.
(On record - 11:30 a.m.)
THE COURT: You can be seated. This is a continuation of the Bigley matter. So, I guess, first we have to have Ms. Porter sworn in. So if you'll just stand there, we'll get you sworn in, please.

*

called as a witness in behalf of the respondent, being first duly sworn upon oath, testified as follows:
(Oath administered)
WITNESS: I do.
THE CLERK: And you can be seated.
MR. GOTTSTEIN: Thank you, Your Honor.
THE COURT: Wait a minute. The clerk has a couple questions she has to ask the witness.
MR. GOTTSTEIN: Oh, I'm sorry.
THE CLERK: Would you please state your full

name, spell your last name, and give a mailing address.
MR. GOTTSTEIN: Certainly. It's Sarah Frances Porter. The Porter is spelled P-O-R-T-E-R. And the mailing address would be 112 Manly Street. That's M-A-N-L-Y Street, Paraparaumu, which is, P-A-R-A-P-A-R-A-U-M-U, New Zealand. And the postal code is 5032.
THE CLERK: Thank you.
THE COURT: Yes?
MR. GOTTSTEIN: Your Honor, I have a quick administrative matter. I need to get a transcript of today's hearing prepared, and I was discussing with the clerk how to -- and there might be a delay to get a copy. I was wondering if we could make sure that we could expedite getting the CD over so that I can -- and then ask them to expedite getting a copy made for me.
THE COURT: Okay. So, like, tomorrow morning some time we can...
THE CLERK: (Indiscernible).
THE COURT: I guess -- so we would have to call your office when it's available for pickup.
MR. GOTTSTEIN: That's perfect, Your Honor.
THE COURT: Okay. And, of course, for Ms. Russo, too.

MS. RUSSO: Uh-huh (affirmative).
MR. GOTTSTEIN: Yeah.
THE COURT: Okay. So we'll -- as soon as my office can call tomorrow morning and say it's ready for pickup, we'll do that. Okay?
MR. GOTTSTEIN: Okay.
THE COURT: Thanks.
MR. GOTTSTEIN: Thank you.

DIRECT EXAMINATION

BY MR. GOTTSTEIN:

Q Thank you very much for agreeing to testify, Ms. Porter. We only have 25 minutes, so I'm gonna try and do this expeditiously. But it's important for the court to know your background, education, experience and history as it relates to treating or taking care of, and involvement with people diagnoses with serious mental illness. So if you could just go through that. But, pretty -- you know, kinda quickly, but, also, give a pretty full idea of your experience, please.

A Okay. I've worked in the mental health seat in New Zealand for the last 15 years in a variety of roles. I'm currently employed as a strategic advisor by the Capital and Coast District Health

Page 74

Board. I'm currently doing a course of study called the Advanced Leadership and Management in Mental Health Program in New Zealand. And, in fact, the reason I'm here is, I won a scholarship through that program to study innovative programs that are going on in other parts of the world so that I could bring some of that information back to New Zealand.

I also have personal experience of using mental health services which dates back to 1976 when I was a relatively young child.

What else would you like to know?

Q Well, a little bit more. Did you run a program in New Zealand?

A Yes. I set up and run a program in New Zealand which operates as an alternative to acute mental health services. It's called the KEYWA Program. That's spelled K-E-Y-W-A. Because it was developed and designed to operate as an alternative to the hospital program that currently is provided in New Zealand. That's been operating since December last year, so it's a relatively new program, but our outcomes to date have been outstanding, and the funding body that provided with the resources to do the

Page 75

program is extremely excited about the results that we've been able to achieve, with people receiving the service and helping us to assist and seating out more similar programs in New Zealand.

Q You're a member of the organization called INTAR, is that correct?

A I am a member of INTAR, which is the International Network of Treatment Alternatives for Recovery. And I'm also a member of the New Zealand Mental Health Foundation, which is an organization in New Zealand that's charged with the responsibility for promotion of mental health and prevention of mental disability in New Zealand.

Q Okay. Are there -- can you describe a little bit what INTAR is about?

A INTAR is an international network of people who are interested in promoting the knowledge about, and availability of access to alternatives to traditional and mainstream approaches to treating mental distress. And INTAR is really interested in identifying successful methods of working with people experiencing distress to promote mental well being, and, in particular,

Page 76

alternatives to the use of mainstream medical model or medication type treatments.

Q And are there people in INTAR that are actually running those kind of programs?

A There are. There's a wide variety of people doing that. And some of them are, also, themselves, interestingly, have backgrounds in psychiatry and psychology.

Q I won't go into that. Are there members of INTAR who are psychiatrists?

A There are. Indeed. Yes, indeed.

Q Do you know -- do you remember any of their names?

A Dr. Peter Stastny is a psychiatrist, Dr. Pat Brechan (ph), who manages the mental health services in West Cork, Ireland, and also in parts of England, as a psychiatrist.

MR. BIGLEY: He's a scientist?

A Yep.

Q Okay. Is it fair to say that all these people believe that there should be other methods of treating people who are diagnosed with mental illness than insisting on medication?

A Absolutely, there are. And that's quite a strong theme, in fact, for -- for that group, and

Page 77

I believe that it's based on the fact that there is now growing recognition that medication is not a satisfactory answer for a significant proportion of the people who experience mental distress, and that for some people...

MR. BIGLEY: That's the scientist.

A ...it creates more problems than solutions.

Q Now, I believe that you testified that you have experience dealing with those sorts of people as well, is that correct?

A I do.

Q And would that include someone who has been in the system for a long time, who is on and off drugs, and who might refuse them?

A Yes. Absolutely. We've worked with people in our services across the spectrum. People who have had long term experience of using services and others for whom it's their first presentation.

Q And when you say "long term use of services," does that include -- does that mean they need medication?

A Unfortunately, in New Zealand the primary form of treatment, until very recent times, has been medication, through the lack of alternatives.

MR. BIGLEY: (Indiscernible).
A And we're just now beginning to develop alternatives. They'd offer people real choice and options in terms of what is available instead of medication that might enable people to further address the issues which are raised by the concerns related to their mental state.
Q And I think I understood you to say that the program that you run along that line has had very good outcomes, is that correct?
A It has. The outcomes to date have been outstanding. The feedback from services users and from other people working with the services -- both, peoples families and the clinical personnel working with those people has supported the approach that we have taken.
Q And is -- and I think you said that, in fact, it's been so impressive that the government is looking at expanding that program with more funding?
A Indeed. And, in fact, right across New Zealand they are now looking at what can be done to create -- make resources available to set up...
MR. BIGLEY: (Indiscernible).

A ...more such services in New Zealand.
MR. BIGLEY: (Indiscernible).
Q Is there a philosophy that you might describe in terms of how -- that would go along with this kind of alternative approach?
A The way that I would describe that is that it's -- it's really about relationships. It's about building a good therapeutic relationship with the person in distress and supporting that person to recognize and come to terms with the issues that are going on in their life, in such a way that builds a therapeutic alliance and is based on negotiation, rather than the use of force or coercion, primarily...
MR. BIGLEY: (Indiscernible).
A ...because we recognize that the use of force and coercion actually undermines the therapeutic relationship and decreases the likelihood of compliance in the long term with whatever kinds of treatment or support has been implicated for the person. So we have created and set up our service along the lines of making relationship and negotiation the primary basis for working with the person and supporting the person to reflect on and reconsider what's going on to

create what might be defined as a crisis, and to devise strategies and plans for how the person might be with the issues and challenges that they face in their life.
MR. BIGLEY: (Indiscernible).
Q Now, you mentioned -- I think you said that coercion creates problems. Could you describe those kind of problems?
A Well, that's really about the fact that these growing recognition -- I think worldwide, but particularly in New Zealand, that coercion, itself, creates trauma and further distress for the person, and that that, in itself, actually undermines the benefits of the treatment that is being provided in a forced context. And so our aiming and teaching is to be able to support the person to resolve the issues without actually having to trample...
MR. BIGLEY: (Indiscernible).
A ...on the person's autonomy, or hound them physically or emotionally in doing so.
Q And I think you testified that would be -- include people who have been in the system for a long time, right?
A It does, indeed. Yes.

Q And would that include people who have been coerced for a long time?
A In many cases, yes.
MR. BIGLEY: She didn't (indiscernible).
Q And -- and have you seen success in that approach?
A We have. It's been phenomenal, actually. Jim, I've been -- personally, I -- I had high hopes that it would work, but I've...
MR. BIGLEY: (Indiscernible).
Q ...been really impressed how well, in fact, it has worked, and how receptive people had been to that approach.
MR. BIGLEY: (Indiscernible).
A Now, are there some -- I want to talk a little bit about other consequences of coercion. For example, can you describe some of the things that happen to people when they -- when they're forced?
MS. RUSSO: Your Honor, I'm objecting to this line of questioning. She hasn't -- she's being asked to offer an opinion, but she hasn't been offered as an expert yet. I don't know what Mr. Gottstein is hoping to offer Ms. Porter as an expert in, but, I -- I think we're getting ahead of ourselves in this.

MR. BIGLEY: (Indiscernible).
THE COURT: Okay. So, Mr. Gottstein, your response to Ms. Russo's...
MR. GOTTSTEIN: Well, I think we can do it now. I would offer Ms. Porter as an expert in the provision of alternative mental health...
MR. BIGLEY: (Indiscernible).
MR. GOTTSTEIN: ...treatment as an alternative to the mainstream standard of care.
MR. BIGLEY: (Indiscernible).
A If I could add something.
THE COURT: Wait a minute. I have to deal with the attorneys first.
Ms. Russo?
MS. RUSSO: Can I voir dire Ms. Porter?
THE COURT: Yes. Go ahead.
MS. RUSSO: Thank you.

VOIR DIRE EXAMINATION

BY MS. RUSSO:
Q Ms. Porter, you said you were in Alaska to study other systems. You won a scholarship?
A Yes.
Q And what specifically were you -- how long have you been in Alaska?
A For a relatively short time. I arrived here

on Monday and I'm here until Saturday. So I've only got five days in this area.
MR. BIGLEY: Take me with you.
A But what I...
MR. BIGLEY: Take me with you. Take me with you.
A What I wanted to also mention is that the work that we had been doing in New Zealand, in terms of -- particularly with the...
MR. BIGLEY: (Indiscernible).
A ...specific (indiscernible) of reducing the use of force is based on some of the work that was done by SAMHSA, in terms of the reduction of seclusion and restraint, and the material that they produced about that.
MR. GOTTSTEIN: Your Honor, maybe she should say who SAMHSA is?
Q Yes. That was the next question.
A It's the Substance Abuse and Mental Health organization in America that's also done things like the new Freedom Commission. The director is Terry Kline, who, I understand is appointed by President Bush.
MR. BIGLEY: I know him, too (indiscernible).
A And he -- he actually came out to New Zealand

to visit our service four weeks ago and was very impressed with the work that we're doing here. And, in fact, there's talk...
MR. BIGLEY: (Indiscernible).
A ...about bringing us back to the United States to talk to people over here about the way that we're working and providing different kinds of services that are more supportive of peoples autonomy and requiring...
MR. BIGLEY: (Indiscernible).
A ...less use of force. And what they found in the research that they did about reducing restraint and seclusion was, not only did it increase the therapeutic outcomes for the clients, but it improved the work -- satisfaction for the staff working with people and reduced the cost of the services of...
MR. BIGLEY: (Indiscernible).
A ...time taken off because of injuries associated with people being hit while they're trying to seclude or manager people through the use of force, so.
Q And who have you met with since -- or, what is your, sort of, I guess, agenda for meeting with people while you're here?

A I've met with all kinds of different people. I actually attended a conference in Ottawa, which is called the International Initiative in Mental Health Leadership. And there was a number of different people there, including...
Q If I'm gonna -- just stop, since we are on limited time, and...
A Yeah.
Q ...we want to get as much of your testimony as possible. In -- in Alaska...
MR. GOTTSTEIN: Your Honor, can she be allowed to answer the question?
THE COURT: I'm going to allow Ms. Russo to continue.
Q I'm trying to direct you towards just specifically...
MR. GOTTSTEIN: I'm sorry.
Q ...in Alaska, in Anchorage.
MR. BIGLEY: Saved my life.
Q Who have you met with?
A Different people. Andrea, Jim...
Q Andrea who?
A Schmook.
Q Schmook. Okay.
A Yeah. You might know her. I believe she's

part of the organization...
Q Uh-huh (affirmative).
A ...that you work with.
Q Yep.
MR. BIGLEY: (Indiscernible).
A Eliza Ella and Tead Ella, and -- oh, I'm struggling to think of the names now. I feel on the spot.
MR. GOTTSTEIN: You got to meet Cathy Creighton (ph), right?
A Yep. That -- those people, as well. Also, while I've been in the United States and Canada, I have met with...
MR. BIGLEY: (Indiscernible).
A Some. Yep.
MR. BIGLEY: (Indiscernible).
A And met with Sherry Meade (ph), Kelly Slater, John Allen, who is the director of the Office of Recipient (indiscernible) in New York. Mat Mathai (ph), Amy Colsenta (ph), Isaac Brown, and Dan Fisher.
Q And have you had -- besides Ms. Schmook, have you talked with anybody from API, or...
A No, I haven't. But I'd be very interested to know if you've got thoughts on that, who I should

talk to.
Q Okay. And in your conversations, I guess, with Ms. Schmook, or with the other people in Anchorage -- have you been made aware of what treatment options are available for individuals with mental illness in Anchorage?
A Some, yes. I would say I -- I wouldn't proclaim that I've got a full and perfect picture, but I've certainly been made aware of some of the options that are available here in Alaska, and some of the -- the history of the state and the way mental health services have evolved in this area, which is very interesting, by the way.
Q Yeah. Probably. And, so...
MR. BIGLEY: (Indiscernible).
MS. RUSSO: Your Honor, I would object to Ms. Porter's qualifications as an expert in alternative mental health treatment, in regards as to how it specifically relates to this case. I don't know -- if she just stated she doesn't have the full picture. She's heard some of what's available in Alaska, but she doesn't have the full picture of what we're facing in Anchorage, dealing with this particular situation.
THE COURT: Okay. Mr. Gottstein, your

response?
MR. GOTTSTEIN: Well, I can ask a couple other questions, but I think -- I'm -- that might be an okay limitation. But I'd also like to ask:
DIRECT EXAMINATION CONTINUED
BY MR. GOTTSTEIN:
Q Are you familiar with an organization called CHOICES?
A Yes, I am.
Q Could you describe what you know about them?
A CHOICES does case management for people in the area -- supporting people to -- actually, it's different kinds of services. I know that Paul works at CHOICES, and that -- other parts of services that they -- and with API, and other kinds of housing and mental health providers here.
Q And would you say -- describe CHOICES philosophy as consistent with the INTAR approach?
A I think it probably is, yes. Because CHOICES stands for Consumers Having Ownership In the service...
Q Creating Effective...
A Yes. Creating Effective Services. So, yes. Absolutely.

Q Okay. Now, you said -- okay. Absolutely. Okay.
MR. GOTTSTEIN: So I think she certainly, at least, has knowledge of that option.
THE COURT: Ms. Russo, do you want to comment further?
MS. RUSSO: I rely on what I said earlier, Your Honor.
THE COURT: All right. I'm going to find that -- I really do not find that Ms. Porter can qualify as an expert witness in this case, at this time, because...
MR. BIGLEY: I'm murdered.
THE COURT: ...I'm not -- to be honest, certain exactly what she's being...
MR. BIGLEY: What...
THE COURT: ... -- other than her giving...
MR. BIGLEY: (Indiscernible)...
THE COURT: ...what I regard as a non-expert opinion as to what might be offered here, but not necessarily being very knowledgeable as to Mr. Bigley's situation.
MR. BIGLEY: (Indiscernible).
THE COURT: Ms. Porter's been here just a couple days, leaving in a couple days. I'm just not

convinced that I can regard her as an expert witness as to available alternative treatments in Anchorage, which I think...

MR. BIGLEY: (Indiscernible).

THE COURT: ...is the thrust of what she's being offered.

MR. GOTTSTEIN: No, Your Honor.

THE COURT: No?

MR. GOTTSTEIN: No. I think that she has testified some to that, but I believe that -- as I put it in my brief, that Mr. Bigley is entitled to alternatives that could be made available. And so she's really being offered as a witness as to that. As -- you know...

MR. BIGLEY: (Indiscernible).

MR. GOTTSTEIN: ...as well as what she knows about choices, but that's what she's being offered as.

MR. BIGLEY: You're killing me here.

THE COURT: Ms. Russo, any other comment?

MS. RUSSO: Your Honor, I -- with all due respect to Ms. Porter, and the work that she's done and is doing, I don't -- the -- the alternatives to which Mr. Bigley can present evidence as, have to be realistic in this state. And I don't know that, at this particular point in time, we're at a point --

we've got -- I'm sure Mr. Gottstein will be calling people from CHOICES to testify as to exactly what, in particular, they do in their relationship with Mr. Bigley. I'm just not sure her testimony will be relevant to the...

MR. BIGLEY: The president will find out.

MS. RUSSO: ...issue before the court.

MR. BIGLEY: President of the United States. Is there a problem?

MR. GOTTSTEIN: Your Honor, basically, if she's given her testimony -- I mean, that's the testimony that I'm offering.

MR. BIGLEY: (Indiscernible). They get on board right now. Th -- (indiscernible) called me and Bush called me. (Indiscernible).

MR. GOTTSTEIN: Sh-sh.

THE COURT: So it's not gonna be -- so, Mr. Gottstein, there's not gonna be any further examination by you?

MR. GOTTSTEIN: I -- I think at this point -- I mean, we're four minutes from when we have to leave. I do have a couple more questions, yes. But, ah -- but she's already described by the efficacy of other approaches with people that are in Mr. Bigley's type of situation. And I could re-ask her those questions, but

I don't see any need to.

MR. BIGLEY: (Indiscernible).

THE COURT: Okay. Well, I guess -- I'm looking at the Rules of Evidence 702, Testimony by Experts. It says, "If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence, or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise."

So, actually, I think that -- giving, maybe a broad reading of this rule,...

MR. BIGLEY: I can see if...

THE COURT: ...I'll allow Ms. Porter to testify as an expert in the area of alternative treatments, but, not necessarily...

MR. BIGLEY: (Indiscernible).

THE COURT: ...in Alaska, but, what may be -- what her -- what may be available in other places, just -- just -- just that, and then, we'll see where we head with other witnesses.

So, I guess, Mr. Gottstein -- and I'm using the computer clock on the bench. It has 11:54. That's a little quick. So we have a little more time.

MR. GOTTSTEIN: Okay. Thank you. Thank you,

Your Honor. So, I think most of the testimony I was gonna elicit has already come in on voir dire.

Q But I did want to talk about some of the effects of coercion. Could you describe that. And I could prompt you some, but that may be -- let's do it without that, first.

MR. BIGLEY: (Indiscernible).

A I think generally speaking, coercion is unhelpful and counterproductive in terms of fooling a therapeutic relationship with somebody in need of care. And that, actually, often the effects of coercion can, themselves, be detrimental and compound the problems faced by a person with experience of serious mental illness, which is why I think there is growing moves internationally to find other ways of working with people to address the kinds of issues and challenges that people face.

Q Does coercion, in your opinion, create reactions that are then regarded as symptoms?

A Oftentimes that's the case, Jim. Particularly, we are -- like, in the case of people being required to take medication that they might feel is not helpful or even worse, possibly a harmful to themselves, sometimes that

can be regarded as symptomatic. Like, I've certainly witnessed a number of cases where people have formed the view that they are being poisoned by medication. But when they express t his fear, that that, itself, has been regarded as a symptom of illness, and (indiscernible) the justification for treatment, which becomes a very vicious circle and a bit of a Catch 22 from service user's perspective.

Q Are there other symptoms, you think - or, reactions that you think are caused by coercion?

A Ah...

Q Let me -- let me -- is it common for people who are coerced to be labelled "paranoid"?

A Yes. Often. Because people can think that things are being done to them, which, it would appear from that person's perspective, to be the case, but often that could be misinterpreted as "paranoid" by service, and then, again, used as further justification for requiring the person to accept treatment.

Q Can you give an example?

A Well, for instance, if a person believed that services wanted to take, say, a blood sample to check whether or not the person had the

therapeutic levels of medication in their blood stream, the person might think that the blood test was being required as a way for the services to get them, or trick them into taking more medication. And that can happen and is reasonably common. Certainly, in New Zealand, I would imagine it would be the same in other parts.

Q And would that -- then, would that reaction be -- would that often be labelled "paranoia"?

A It would, because -- but I think that's, again -- it's a product of different (indiscernible), where services would say some things as -- you know, potentially being a benefit to the service user, where the service user might say that it's to their detriment. So that's, again, different perspectives of the same thing. But from the service users perspective, it's a difficult issue and it might well be perceived as paranoia on the part of the person. Which, again, gets labelled as a symptom and treated as such, so it becomes, again, a self fulfilling situation.

MR. GOTTSTEIN: I could ask some more questions, but I think I'll let Ms. Russo use the rest of the time for cross examination.

THE COURT: Ms. Russo.

MS. RUSSO: Thank you.

CROSS EXAMINATION

BY MS. RUSSO:

Q Just a couple questions. Mr. Porter, before today, had you met Mr. Bigley?

A No, I had not met Mr. Bigley before today.

Q And have you had a chance to spend any time with Mr. Bigley today?

A I haven't.

Q And you're whole approach -- does the -- does the recipient of the -- does the service user -- do they have to be willing to accept the services, in order for your approach to work?

A It's certainly helpful for that approach to work. If the person is unwilling for the approach to work, then it's least likely to succeed.

Q Okay. and so what happens when the person is not willing to work with the people who want to work with him?

A We'd need to negotiate around options and consequences and that's generally the approach that we take.

Q And you had said at the very beginning or your

testimony that, I think, your approach -- let me see if I can refer to my notes. Is that -- that -- your approach, you didn't believe that forced medication -- and correct me if I'm giving your testimony wrong, but that it was -- that it wouldn't work for a significant portion of the population. Did you mean all of the population, or did you mean that...

A That forcing people to take medication would not work for most people.

Q Most people. But there may be outliers?

A I would say in rare and exceptional cases, there might well be. Because, again, these -- in my view, there's no absolutes. It's like saying -- and the same way as you can't say, medication is a good answer for everybody. There are some people for whom medication is helpful. But I think that generally speaking, I'm not certain what your legislation requires here, but in New Zealand, the requirement is that even people subjected to compulsory treatment, it is only able to be and provided without the consent of the person for the first 28 days. And the rational for that is that it's expected that after 28 days of use of medication, that the

person themselves would be able to recognize the benefit of it and then voluntarily agree to continue taking it. And so that's certainly a safeguard that's built into the New Zealand legislation. I would imagine you would have something similar here, and that would actually -- might provision for the person to be able to make an informed choice, and presumably after 28 days of using a medication, or be it by force, the person themselves would be able to recognize the benefit. But if there isn't a benefit that's able to be perceived by the person, then I would hope that service providers would be able to actually acknowledge that, and work with the person to find some other means of addressing the issues and concerns that are least distressing to the person. Because the unfortunate truth of the matter is that as medication really doesn't work for all people, there are a few people for whom it is a good answer, and it's helpful. But they are a large number for whom it's problematic and uncomfortable and distressing.

Q And are there -- is basically the whole thrust of your work sort of designed to -- to make sure that people are able to live to the best of their

abilities in a community, and to have as full of a life as possible outside of institutionalized treatment?

A Absolutely. And, in fact, the definition of recovery that we use in New Zealand is, recovery means the person being able to live well with or without symptoms of mental illness.

Q Okay. Thank you. Those are all my questions.

THE COURT: Any redirect?

MR. GOTTSTEIN: Yes. Just very briefly.

REDIRECT EXAMINATION

BY MR. GOTTSTEIN:

Q What would be your response to the idea that someone who has been -- you know, coerced into taking -- forced to take medication, isn't competent to decide whether or not it should be continued.

MS. RUSSO: Objection, your Honor. I don't know that there is a basis for giving an opinion on somebody's competency. Maybe I didn't fully understand the question.

THE COURT: Yeah. Mr. Gottstein?

MR. GOTTSTEIN: Well, the idea is that often, when patients complain about medications not working and all these terrible side effects, they're saying,

"Oh, well, they're crazy, so they don't know that it's good for them." And that's basically what is -- if Ms. Porter might have a response to that.

THE COURT: I'm going to allow her to answer.

A Well, to be honest, I'm uncomfortable with what the use of force meant. It's probably been fairly evident from what I've said so far. And I think that the issue of persons capacity to consent, I think is, in fact, progressively moving towards allowing more people to be recognized as being able to consent, and, in fact, they (indiscernible) on the rights of people with disabilities has changed the wording around the peoples capacity to consent, which means that people always had the right to be able to consent or not to treatment, and that a person needs support to be able to make those decisions, that such support be made available through advocacy. But that there is an increasing move to respect the autonomy and the personal choice of the person at the center of treatment, more of the time.

Q So does that mean that even -- that even someone who is psychotic knows what's happening to themselves?

A I believe that people do, Jim, to be honest. I believe that even people who are (indiscernible) have a degree of clarity about what's going on with themselves, particularly in terms of the physical well being, and that the peoples capacity to be able to recognize and make decisions about their own physical and mental self needs to be honored and respected as much as possible, and that in so doing, peoples capacity and competence increases.

MR. GOTTSTEIN: I have no further questions.

THE COURT: Ms. Russo?

MS. RUSSO: None.

THE COURT: All right. Ms. Porter, you're free to go. Have a good flight back.

A I will. Thank you very much.

THE COURT: Thank you.

Okay. So this case is going to be in recess until 1:30 Monday, September 10th, right here. And we can go off record.

END

That the foregoing transcript is a transcription of testimony of said proceedings to the best of my ability, prepared from tapes recorded by someone other than Pacific Rim Reporting, therefore "indiscernible" portions may appear in the transcript;

I am not a relative, or employee, or attorney, or counsel of any of the parties, nor am I financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal this 7th day of September, 2007.

Notary Public in and for Alaska
My commission expires: 10/05/2007

Curriculum Vitae

Grace E. Jackson, MD

1201 Clipper Lane
Wilmington, NC 28405
(910) 208 3278

Email Address:
grace.e.jackson@att.net

Education:

University of Colorado Health Sciences Center - School of Medicine, M.D.
Graduated 5/96.

California Lutheran University, B.S. Major: Biology. Summa cum laude.
Graduated 5/92.

California Lutheran University, MPA. Major: Public Administration. GPA: 4.00
Graduated 8/87.

California Lutheran University, B.A. Major: Political Science. Summa cum laude.
Graduated 5/86.

Current and Past Certifications:

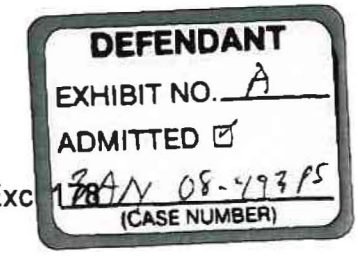
Board Certified Psychiatrist (Diplomate, American Board of Psychiatry and Neurology), 2004 – 2014.

Basic Life Support: expires 4/2008.

Past Certifications: Advanced Cardiac Life Support, Advanced Trauma Life Support, Pediatric Advanced Cardiac Life Support.

Honors and Awards:

Esprit de Corps Award (awarded by fellow residents - 6/00). Hippocrates Award (5/96). Richard C. Hardin Award (5/95). Honors in Surgery, Family Practice, Psychiatry clinical rotations (UCHSC School of Medicine). Scholastic Honor Society (CLU equivalent of Phi Beta Kappa). Alpha Mu Gamma (foreign language honor society). Kwan Fong Institute Scholarship in East Asian Studies. Most Inspirational Runner, Cross Country.



Medical Training:
Psychiatry Residency, National Capital Area Consortium - Malcolm Grow Medical Center, National Naval Medical Center, Walter Reed Army Medical Center - JUL 1997 - JUN 2000. Graduated 6/00.

Psychiatry Internship, Naval Medical Center San Diego, San Diego, CA
JUN 1996 - JUL 1997
Including Combat Casualty Care Course and ATLS, San Antonio TX (February 1997).

Psychiatric Experience: Clinical, Forensic, and Research

Clinical and Forensic Consultant – 1201 Clipper Lane – Wilmington, NC 28450
February 2008 through present
Contract consultant for clinicians, patients, and attorneys specializing in review of records, preparation of treatment plans, neurotoxicology research, lecturing, and writing.

Private practice – 1213 Culberth Drive – Ste. 139, Wilmington, NC 28405
May 2007 through January 2008
Clinical psychiatrist specializing in forensic consultation, psychotherapy, medication management (detox/neurorehabilitation), neurotoxicology, lecturing, and writing.

Forensic Consultant – 4021 Brookstone Drive – Winterville, NC 28450
October 2006 through April 2007
Contract consultant for forensic cases involving psychiatric rights, medical negligence, product liability, and neurotoxicology.

Veterans Administration Mental Health Clinic – Locum Tenens Psychiatrist, Eugene OR
July 2006 – September 2006
Clinical psychiatrist assigned to outpatient psychiatric clinic. Responsible for psychiatric evaluations, medication management, medical workups, and monitoring. Updated metabolic profiles in accordance with Veterans Administration IG guidelines. Ordered and read EKGs where indicated. Close collaboration with social workers, nursing staff, and community caregivers in the case management of patients with severe and chronic mental illness. Assignment required adjustment of complex polypharmacy regimens in order to minimize metabolic and neurobehavioral toxicities of previous and continuing treatments. Caseload: 200+ patients ranging in age from 20s to 80s.

Forensic Consultant - 4021 Brookstone Drive – Winterville, NC 28450
March 2004 through June 2006
Contract consultant for forensic cases involving psychiatric rights, medical negligence, product liability, and neurotoxicology.

NC Department of Corrections – Locum Tenens Psychiatrist, Eastern NC
August 2003 – March 2004
Clinical psychiatrist assigned to misdemeanor in-processing camp, low custody camp (outpatient), and long term residential facility (housing chronically mentally ill prisoners). Responsible for evaluations, medication management, psychotherapy, discharge summaries, and treatment planning with multidisciplinary team.

Independent forensic consultant, researcher, author, lecturer –
4003 Gaston Court - New Bern NC 28562
April 2002 – June 2003
Expert witness with Law Project for Psychiatric Rights. Initial stages of background research preparatory for writing of first book (*Rethinking Psychiatric Drugs: A Guide for Informed Consent*) published in July 2005.

Staff Psychiatrist, National Naval Medical Center, Bethesda, MD
July 2000 - March 2002
Assigned to adult outpatient clinic at Bethesda Naval Hospital and US Naval Academy. Evaluated and treated active duty military members, dependents, and retirees. Responsible for thorough medical workups and consultation with all relevant specialty clinics. Prepared variety of administrative documents, including medical boards, TDRL (Temporary Disability Retirement List) reports, memoranda for administrative separations, letters for insurers or employers. Devised and delivered comprehensive treatment plans, incorporating supportive, cognitive / behavioral, and psychodynamic psychotherapy; pharmacotherapy; and referrals to outside providers (nutritional, exercise, relaxation, energy-based, music, and/or art therapies). Supervised residents as attending physician on-call, assisting with emergency room assessments and dispositions, adolescent admissions, and surgical/medical ward consultations. Supervised psychiatry interns during their weekly continuity clinic, including pre-clinic viewing and discussion of pertinent films (humanities/literature). Back-filled for staff psychiatrist / department head in Corpus Christi, TX, performing leadership role as only staff psychiatrist on site (October 2000). Assisted Bethesda Chief of Clinical Staff in preparation of Command Provider Morale Survey (August 2001).

Internship and Residency Rotations - 1996 - 2000:

PGY-1 rotating internship, including two months of inpatient psychiatry; two months of neurology; one month each of C/L psychiatry, emergency medicine, family practice, pediatrics, ambulatory care, OB/GYN, general surgery, CCU, internal medicine.

PGY-2 Seven months inpatient adult psychiatry at Walter Reed Army medical center (54 bed locked psych/med ward), 1 month inpatient addictions (Malcolm Grow), 1 month adult Partial Psychiatric Hospitalization program (Walter Reed), 1 month inpatient child/adolescent psychiatry, 1 month emergency psychiatry / night float, 1 month NOVA (Northern Virginia State Hospital) chronically mentally ill

PGY-3 dedicated year of outpatient psychiatry, including long-term and short-term psychotherapy: two long-term psychodynamic cases, two CBT cases, one short-term psychodynamic case, two family therapy cases, one marital psychotherapy case, one short-term psychotherapy group, one long-term psychotherapy group, > 100 active medication management cases (active duty members, dependents, retirees)

PGY-4 Two months inpatient adult psychiatry as subattending (Walter Reed Army Medical Center), two months intensive outpatient treatment (Partial Hospitalization Program - Walter Reed), 4 months electives (neurology consult, child /adolescent outpatient, research, outpatient addictions), 3 months emergency/consult-liaison psychiatry (Walter Reed), 1 month community psychiatry (including forensic psychiatry at Clifton T. Perkins maximum security hospital in Jessup, MD and care of indigent at Montgomery County Crisis Center, Rockville, MD)

Personal Training Psychotherapy:

Psychodynamic/Psychoanalytic training therapy: 3 1/2 yrs. with Dr. Ann-Louise Silver, a former analysand of Harold Searles. Intermittent psychotherapy with Dr. Alexander Lowen, founder of Bioenergetic Analysis. Additional experience with energy modalities, music therapy, deep tissue massage, and Jungian / trance work.

Governmental Testimony:

Florida State Legislature in support of H.B. 1213 and S.B. 2286,
Informed Consent in Education (12 April 2006) – written testimony

Food and Drug Administration, Psychopharmacologic Drug Advisory Committee,
Open Public Hearing, Gaithersburg, MD (23 March 2006) – oral testimony

Food and Drug Administration, Pediatric Advisory Committee,
Open Public Hearing, Gaithersburg, MD (22 March 2006) – oral testimony

Lecturing Experience:

"The Role of Psychiatric Drugs in the Treatment of Addiction," presented at the 58th Annual Conference of the National Catholic Council on Alcoholism and other related drug problems (NCCA), New Orleans, LA (23 January 2008)

"Chemo Brain: A psychiatric drug phenomenon," presented at the 10th Annual Conference of the International Center for the Study of Psychiatry and Psychology, Arlington, VA (13 October 2007)

"Parens Patriae, Parens Inscius: Beware the Dangers of the Incompetent State," presented at the 9th Annual Conference of the International Center for the Study of Psychiatry and Psychology, Bethesda, MD (09 October 2006)

"Addiction and Stimulants," presented at ICSPP Press Conference, Gaithersburg, MD (22 March 2006)

"Ritalin vs. Jiminy Cricket: The Suppression of Human Intention (Are Psychiatrists Medicating Can't or Won't?)," presented at the 5th Annual Conference of the New Jersey Institute for Training in Psychoanalysis, Inc., Teaneck, NJ (12 March 2006)
"Risk Assessment and the Challenge of Neurotechnologies: When Do Treatments Become Toxins to the Self ?" presented before the Novel Tech Ethics Research Team of Dalhousie University, Halifax, Nova Scotia (06 February 2006)

'Rethinking Psychiatric Drugs," presented before the Committee for Public Counsel Services / Continuing Legal Education for attorneys, Boston MA (14 November 2005)

"*Parens patriae*, *Parens inscius*: The Problem of the Incompetent State," presented at the 7th Annual Conference of ISPS-US (International Society for the Psychosocial Treatments of Schizophrenia and Other Psychoses), Boston MA (12 November 2005)

"Allostatic Load: How Psychiatric Drugs Stress the Brain and Body," presented at the 8th Annual Conference of the International Center for the Study of Psychiatry and Psychology, New York City (09 October 2005)

"Rethinking Psychiatric Drugs," presented at META Services, Phoenix, AZ (18 May 2005)

"What Doctors May Not Tell You About Psychiatric Drugs," presented at University of Central England, Birmingham, UK (09 June 2004)

"Psychiatric Drugs: What We All Need to Know," presented to community health centers in Shropshire County UK (07 and 08 June 2004)

"Cybernetic Children," presented for the British Psychological Society/Psychotherapy Section at the Tavistock Clinic, London UK (05 June 2004)

"SOS: The Current Crisis in Psychiatric Drugs," presented for Global Opportunities, Inc. and Children's Development Council. Palm Beach, FL (17 April 2004)

"Gulf War Syndrome: Then and Now," presented for the New Bern Coalition for Peace and Justice New Bern, NC (20 May 2003)

"Be Careful What You Fish For: An Introduction to Pre-Psychosis Screening Programs," presented at the Columbia Academy of Psychodynamics, Columbia, MD (19 March 2003)

"The Limitations of Biological Psychiatry," and "Recognizing the Drug-Induced Crisis," plenary lecture and individual workshop presented at the annual conference of ICSPP (International Center for the Study of Psychiatry and Psychology), Newark, NJ (11-13 OCT 2002)

"A Plea for Psyche," and "Postmodern Psychiatry," presented at Mental Health in the 21st Century Conference, Teesside University, Middlesbrough UK (06 and 13 SEP 2002)

"The Promise of Biotechnology: Unintended Consequences in the Posthuman Era," presented at 7th annual Women in Technology International Conference, Santa Clara, CA (20 JUN 2002)

"The Meaning of ADD/ADHD," presented at 1st Steven Baldwin Memorial Conference, Teesside University, Middlesbrough UK (28 FEB 2002)

"Beyond Reductionism - One Resident's Search for Mind," Chief Resident Research Project, presented at Walter Reed Army Medical Center (14 JUN 2000)

Teaching Experience:

Expert panelist/contributor to "A Critical Skills Curriculum on Psychiatric Medications for Mental Health Professionals" (Florida International University, Miami, FL - 2007).

Chief Resident in Psychiatry (Walter Reed Army Medical Center - 1999 - 2000):
Supervised junior residents, interns, and medical students on various rotations, including inpatient, partial hospitalization program, addictions medicine, and consult-liaison service. Organized and led morning report on inpatient ward, selecting daily case presentations as subattending. Delivered lectures on case formulation, psychotherapies, psychiatric history, and biopsychosocial model of illness. Assisted consult-liaison service chief with hypnotherapy interventions in pain and rehab/physiatry clinics.

Instructor, Political Science (California Lutheran University, Thousand Oaks, CA – 1986 - 1988):
Prepared and delivered original curriculum in American government. Advised, tested, and evaluated students. Assisted students with career development planning. Prepared grant proposals for tenured faculty members and Dean for International Affairs. Completed advanced degree in Public Administration, including community service project (library site selection assessment) for city of Thousand Oaks.

Forensic Experience:

Expert Witness
in re: Thomsen vs. Thomsen
Morristown, NJ (April – May 2008)

Professional Consultant:
Vickery, Waldner, & Mallia
(November 2006 through February 2008)

Expert Witness
in re: Rogers vs. Ulmer's Drug
Homer, AK (April – May 2007)

Expert Witness
in re: L. Welch
Nampa, ID (March – April 2007)

Expert Witness
in re: J. Freeman
Springfield, Massachusetts (June 2006)

Expert Witness
in re: G. Daniels
Melbourne Australia (December 2005 – present)

Expert Witness in guardianship case
in re: A. Braman
Columbia Circuit Court, OR (July 15, 2005)

Expert Witness in foster care case
Witness for Attorney Ad Litem – Pasco County FL
Juvenile Dependency Division Case No. 96-01158DPAES (August 4, 2004)

Forensic consultant re:
State of Utah vs. Leon Gall (April 30, 2004)

Expert Witness and Professional Consultant - Law Project for Psychiatric Rights
March 2003 - Present
Ad hoc forensic assistant for Alaska attorney specializing in rights of mentally ill. Activities have included professional testimony and affidavits, retrieval and analysis of medical research, and assistance with development of publicly accessible computer database.

Creighton in re: Office of Hearings and Appeals (August 26, 2004)
Bavilla vs. Department of Corrections (April 4, 2004)
Myers vs. Alaska Psychiatric Institute (February 2003)

Other Employment:

Rapid City Regional Hospital – Family Practice Residency Rapid City, SD
June 2003 - July 2003
First year resident in family practice, responsible for inpatient treatment of medical patients, consultations, and outpatient clinic (children and adults). Responsibilities included EKG stress tests, Intensive Care Unit / Cardiac Care Unit (patient management). Left residency in good standing to resume work as mental health specialist due to concerns about continuing crisis in "evidence based medicine" and drug safety.

Secretary / Receptionist , Kamiya Biomedical Company
June 1992 - August 1992
Temporary assistant for independent biomedical firm in Westlake Village, CA. Responsible for preparing all shipping documents, updating mail and invoice computer database, processing incoming orders, and interacting with large domestic and international customer network, correspondence, phones.

Administrative Assistant, Pepperdine University
June 1991 - August 1991
Temporary assistant in Insurance and Risk Management Department. Adjusted student athletic claims, property floater, employee and student insurance database.

Treasury Analyst, Pepperdine University
April 1989 - August 1989
Administered living trusts. Fulfilled debt compliance and daily cash management requirements for University. Executed wire transfers, foreign currency transactions, and various custodial duties for University accounts and securities. Generated financial reports, correspondence. Systematized procedures of this position prior to transition back to school for premedical studies.

Administrative Assistant, Pepperdine University
January 1989 - April 1989
Assistant to VP for Finance, overseeing payments of taxes and expenses for University-managed property. Maintained investment and real estate files. Regulated access to off-site safekeeping vault. Generated correspondence and reports. Supervised student workers. Ordered department supplies, routed mail, scheduled appointments, and screened incoming calls for office personnel.

Administrative Assistant, Pepperdine University
November 1988 - January 1989
Temporary assistant in Insurance and Risk Management Department. Adjusted student athletic claims, updated University property floater and driver records, edited and prepared University Safety Manual, supervised athletic policy changeover.

Publications:

"A Critical Analysis of the Neurogenesis Theory of Antidepressant Efficacy," (April 2008) – under peer review.

"Chemo Brain: A Psychiatric Drug Phenomenon ?" *Medical Hypotheses* 70:3 (2008): 572-577.

"The Case Against Stimulants," contributed chapter, in S. Timimi and J. Leo, *Rethinking ADHD* (Hampshire, UK: Palgrave Macmillan, expected 2008).

"Mental Health Screening in Schools: Essentials of Informed Consent." *Ethical Human Psychology and Psychiatry* 8 (2006): 217-225.

"A Curious Consensus: Brain Scans Prove Disease?" *Ethical Human Psychology and Psychiatry* 8 (2006): 55-60.

Rethinking Psychiatric Drugs – A Guide for Informed Consent (Bloomington, IN: Author House, 2005).

"Cybernetic Children," contributed chapter, in C. Newnes and N. Radcliffe, *Making and Breaking Children's Lives* (Ross on Wye: PCCS Books, 2005).

Contributor to "The Myth of the Magic Pill" in B. Duncan, S. Miller, and J. Sparks. *The Heroic Client*, 2nd ed. (San Francisco: Jossey Bass, 2004).

"A Plea for Psyche." *Review of Existential Psychology & Psychiatry* XXVI (2003): 97-100.

"The Dilemma of Early Intervention: Some Problems with Mental Health Screening and Labeling." *Ethical Human Sciences and Services* 5 (2003): 35-40.

"Rethinking the Finnish Adoption Studies: A Challenge to the Doctrine of Genetic Determinism." *Journal of Critical Psychology, Counselling, and Psychotherapy* 3 (2003): 129-138.

Other Independent Research:

"Aerospace Medicine: A Review of Major Responses to Space Flight" - Aerospace Medicine Clerkship at Johnson Space Center, Houston TX (spring 1996)

"Psychobiology: Mind/Body Communication in the Manifestation and Mitigation of Illness" (spring 1992)

Volunteer Activities:

Member, Board of Directors - ICSPP January 2001- present
As active member of International Center for the Study of Psychiatry and Psychology, have participated in lectures, research, and communiques with fellow health care professionals, policy makers, and public. Contributed to position paper on ADHD as part of Task Force on Child/Adolescent Mental Health Care. Frequent consultant on risks associated with use of mind-altering drugs and alternatives to same.

US Navy June 1996 - March 2002
As psychiatry intern, prepared and distributed intern directory; assisted with annual beach picnic, and coordinated purchase and distribution of discount lab coats. As resident: facilitated small group discussions of Uniformed Services 2nd yr. medical student course in psychiatry; instructor at Operational Medicine Course (Bushmaster) at Camp Bullis, TX (November 1988). Member of Call Committee, responsible for preparation and distribution of call schedule for over 40 interns and residents covering three separate emergency rooms / hospitals. Pioneered night float system for PGY2s.

University of Colorado School of Medicine 1992 - 1996
Class Secretary / Treasurer (1992 - 1996). Responsible for student administered accounts, fundraising activities, and minutes of all class government meetings. Student Council Secretary (1992-1993). Co-President, AMSA (American Medical Student Association) - University of Colorado Chapter (1993-1994): donated medical books to Romania, oversaw fundraising efforts, supervised Medicine Wheel alternative medicine lecture series. Course Representative, Microbiology and Immunology (1993 - 1994). Co-editor, Medical Examiner, medical school newspaper (1993-1994). National Editor, AMSA Medical Education Task Force Quarterly Newsletter (1993 - 1994). Sports: class softball and soccer teams (1993 - 1994). Senior Class Co-President (1995-1996). Coordinated Match Day celebration, co-wrote Senior Skit, recruited and hosted Graduation speaker.

Professional Memberships:

International Center for the Study of Psychiatry and Psychology (member, Board of Directors), International Society for the Psychosocial Treatment of Schizophrenia and Other Psychoses.

Personal Facts:

Facile writer and speaker. Well travelled (East Asia, Europe, USA). Hobbies include medical research, movies, poetry, music, physical fitness, time in nature, foreign languages, literature.

Appendix A

Evidence for the Neurotoxicity of Antipsychotic Drugs

The History of Neuroleptics

The modern history of psychiatric drugs dates back to the early 1950s, when derivatives of the synthetic dye and rocket fuel industries were found to have medicinal properties. Following World War II, a wide variety of compounds came to be tested in humans. The antihistamine known as chlorpromazine (Thorazine) is generally regarded as the first "anti-psychotic" drug, responsible for igniting the psychopharmacology revolution. As Thorazine grew in popularity, medications replaced neurosurgery and shock therapies as the favored treatments for the institutionalized mentally ill. (For three excellent reviews on this subject, see Cohen, Healy, and Valenstein).[1-3]

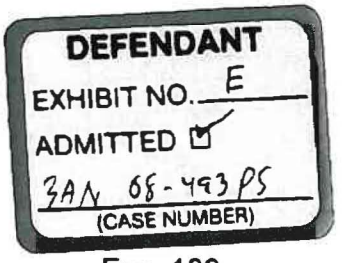
When, in 1955, Drs. Jean Delay and Pierre Deniker coined the term "neuroleptic" to describe Thorazine, they identified five defining properties of this prototype: the gradual reduction of psychotic symptoms, the induction of psychic indifference, sedation, movement abnormalities (parkinsonism), and predominant subcortical effects.[4] At its inception, Thorazine was celebrated as a *chemical lobotomizer* due to behavioral effects which paralleled those associated with the removal of brain tissue.[5] As the concept of lobotomy fell into disfavor, the alleged antipsychotic features of the neuroleptics came to be emphasized. Ultimately, the two terms became synonymous.

Ignorant of the historical definition of neuroleptics as ***chemical lobotomizers***, members of the psychiatric profession have only rarely acknowledged the fact that these dopamine blocking compounds have been, and continue to be, a major cause of brain injury and dementia. Nevertheless, the emergence of improved technologies and epidemiological investigations have made it possible to demonstrate why these medications should be characterized as neurotoxins, rather than neurotherapies.

Evidence for Neuroleptic (Antipsychotic) Induced Brain Injury

Proof of neuroleptic toxicity can be drawn from five major lines of evidence:

1) postmortem studies of human brain tissue
2) neuroimaging studies of living humans
3) postmortem studies of lab animal brain tissue
4) biological markers of cell damage in living humans
5) lab studies of cell cultures/chemical systems following drug exposure



Line of Evidence #1: Postmortem Studies in Humans

In 1977, Jellinger published his findings of neuropathological changes in the brain tissue of twenty-eight patients who had been exposed to neuroleptics for an average of four to five years.[6] In most cases, the periods of drug treatment had been intermittent. At autopsy, 46% of the subjects were found to have significant tissue damage in the movement centers (basal ganglia) of the brain, including swelling of the large neurons in the caudate nucleus, proliferation of astrocytes and other glial cells, and occasional degeneration of neurons. Three patients exposed to chronic neuroleptic therapy also demonstrated inflammation of the cerebral veins (phlebitis). An example of the abnormalities is shown below:

This photo demonstrates reactive gliosis (black dots represent scar tissue) in the caudate of a patient who had received neuroleptic therapy. Patients in this study had received the following drug treatments: chlorpromazine (Thorazine), reserpine, haloperidol (Haldol), trifluoperazine (Stelazine), chlorprothixen (Taractan), thioridazine (Mellaril), tricyclic antidepressants, and/or minor tranquilizers.

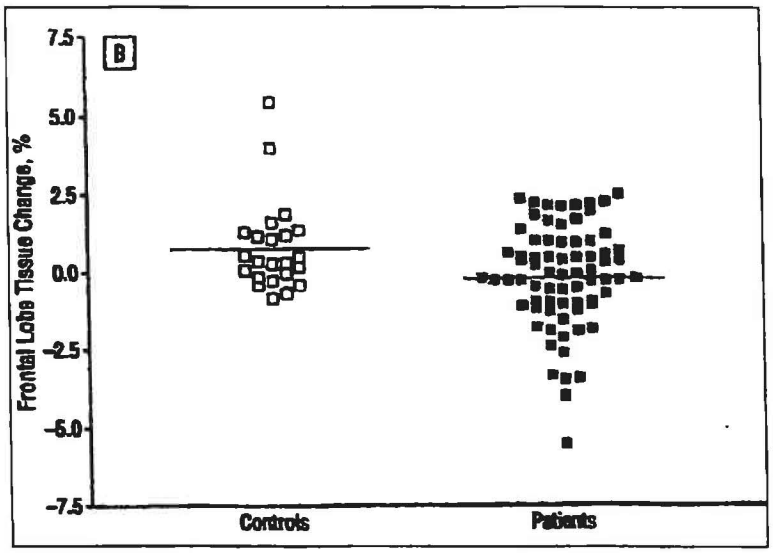
The Jellinger study is historically important because it included two comparison or control groups, allowing for the determination of treatment-related vs. illness-related changes. Damage to the basal ganglia was seen in only 4% of an age-matched group of psychotic patients who had *avoided* long-term therapy with neuroleptics; and in only 2% of a group of patients with routine neurological disease. Based upon the anatomic evidence, Jellinger referred to the abnormal findings as ***human neuroleptic encephalopathy*** (meaning: a drug-induced, degenerative brain process).

Line of Evidence #2: Neuroimaging Studies of Living Human Subjects

Several groups of researchers have documented a progressive reduction of frontal lobe tissue in patients treated with neuroleptics. Madsen et al. performed serial C.T. scans on thirty-one previously unmedicated psychotic patients and nine healthy controls. Imaging was performed at baseline and again after five years.[7-8] During this time, the patients received neuroleptic therapy in the form of traditional antipsychotics (such as Thorazine) and/or clozapine. Findings were remarkable for a significant progression of frontal lobe atrophy in all of the patients, relative to the controls. ***The researchers detected a dose-dependent link to brain shrinkage, estimating the risk of frontal degeneration to be 6% for every 10 grams of cumulative Thorazine (or equivalent) exposure.***

Similar findings have been documented with newer technologies, such as magnetic resonance imaging (MRI). In 1998, Gur et al. published the results of a study which followed forty psychotic patients prospectively for 2 ½ years.[9] At entry, half of these individuals had received previous treatment with neuroleptics, and half were neuroleptic naïve. All patients subsequently received treatment with antipsychotic medications. ***At the end of thirty months, the patients displayed a significant loss of brain volume (4 to 9%) in the frontal and temporal lobes.*** For both patient groups, this volume loss was associated with unimpressive changes in target symptoms (e.g., the inability to experience pleasure, restricted affect, and limited speech) and ***with significant deteriorations in cognitive functioning*** (such as attention, verbal memory, and abstract thought).

Researchers at the University of Iowa began a longitudinal investigation of psychotic patients between 1991 and 2001.[10] Enrolling 23 healthy controls, and 73 patients recently diagnosed with schizophrenia, the study design called for a series of MRI exams to be conducted at various intervals (planned for 2, 5, 9, and 12 years). In 2003, the research team published the results from the first interval. Head scans and neuropsychological testing were repeated on all patients after a period of three years of neuroleptic treatment. Several findings were remarkable. ***First, patients demonstrated statistically significant reductions in frontal lobe volume (0.2% decrease per year) compared to the healthy controls***:



These changes were associated with more severe negative symptoms of schizophrenia (alogia, anhedonia, avolition, affective flattening), and with impairments in executive functioning (e.g., planning, organizing, switching). ***Second, almost 40% of the patients failed to experience a remission***, defined by the investigators as eight consecutive weeks with nothing more than mild positive symptoms (delusions, hallucinations, bizarre behavior, inappropriate affect, formal thought disorder). In other words, *almost half of the patients remained floridly psychotic*. ***Third, these poor outcomes occurred despite the fact that the patients had been maintained on neuroleptics*** for 84% of the inter-MRI duration, and ***despite the fact that the newest therapies had been favored***: atypical antipsychotics had been given for 62% of the treatment period. Reflecting upon these disappointing results, the research team conceded:

> "...the medications currently used cannot modify an injurious process occurring in the brain, which is the underlying basis of symptoms...We found that progressive volumetric brain changes were occurring despite ongoing antipsychotic drug treatment." [11]

In 2005, Lieberman et al. published the results of their international study involving serial MRI scans of 58 healthy controls and 161 patients experiencing a first episode of psychosis.[12] Most patients (67-77%) had received prior treatment with antipsychotics for a cumulative duration of at least four months. Throughout the two-year period of follow-up, patients were randomized to double-blind treatment with olanzapine (5 to 20 mg per day) or haloperidol (2 to 20 mg per day). The study protocol permitted the use of concomitant medications, such as minor tranquilizers (up to 21 days of cumulative therapy). Mood stabilizers and antidepressants other than Prozac (which could be used at any time) were allowed only after the first three months of the study. The primary outcome analysis involved a comparison of MRI changes from baseline, focusing upon seven regions of interest: whole brain, whole brain gray matter, whole brain white matter, lateral ventricles, 3rd ventricle, and caudate. ***Haloperidol recipients experienced persistent gray matter reductions throughout the brain.*** These abnormalities emerged as early as twelve weeks. ***For olanzapine recipients, significant brain atrophy (loss of gray matter) was detected in the frontal, parietal, and occipital lobes following one year of drug exposure***:

Average change in tissue volume (cubic centimeter) by week 52

	olanzapine	haloperidol	controls
frontal gray	- 3.16	- 7.56	+ 0.54
parietal gray	- 0.86	- 1.71	+ 0.70
occipital gray	- 1.49	- 1.50	+ 0.99
whole brain gray	- 3.70	- 11.69	+ 4.12

In addition to these changes, both groups of patients experienced enlargements in whole brain fluid and lateral ventricle volumes. These disturbances in brain morphology (structure) were associated with retarded improvement in symptoms and neurocognitive functioning.

Line of Evidence #3: Postmortem Animal Studies

Acknowledging the longstanding problem in medicine of distinguishing the effects of treatment from underlying disease processes, scientists at the University of Pittsburgh have advocated the use of animal research involving monkeys (non-human primates). In one such study, the researchers attempted to identify the effects of lab procedures upon brain samples prepared for biochemical and microscopic analyses.[13] Eighteen adult male macaques (aged 4.5 to 5.3 years) were divided into three groups and were trained to self-administer drug treatments. *Monkeys received oral doses of haloperidol, placebo (sham pellets), or olanzapine for a period of 17 to 27 months*. During this time, blood samples were taken periodically and drug doses were adjusted in order to achieve plasma levels identical to those which occur in clinical practice (1 to 1.5 ng/mL for haloperidol; 10-25 ng/mL for olanzapine). At the end of the treatment period, the animals were euthanized. Brains were removed, and brain size was quantified using two different experimental procedures.

A variety of behavioral and anatomical effects were noted. ***First, all animals appeared to develop an aversion to the taste and/or subjective effects of the medications***. This required creative changes in the methods which were used to administer the drug treatments. ***Second, a significant number of monkeys became aggressive during the period of study*** (four of the six monkeys exposed to olanzapine; two of the six monkeys exposed to haloperidol). One monkey, originally placed in the sham treatment group, engaged in self-mutilatory behaviors. A switch to olanzapine resulted in no improvement. However, when the animal was provided with increasing human contact, a doubling of cage space, a decrease in environmental stimuli, and enhanced enrichment, his behavior stabilized. ***Third, the chronic exposure to neuroleptics resulted in significant reductions in total brain weight compared to controls (8% lower weight for haloperidol, 10% lower weight for olanzapine)***. Regional changes in weight and volume were also significant, with the largest changes identified in the frontal and parietal lobes:

	volume reduction in brain weight (relative to sham controls)	
	olanzapine	haloperidol
frontal lobe	10.4%	10.1%
parietal lobe	13.6%	11.2%

Based upon these results, the researchers concluded that the progressive reductions in brain volume which have been reported in many studies on schizophrenia may reflect the effects of drug treatment. They proposed that further studies be undertaken to characterize the mechanisms responsible for these changes and to identify the precise targets (neurons, glia) of these effects.

Line of Evidence #4: Biological Markers of Cell Damage

Researchers in Austria have been interested in identifying a biological marker which can be used to diagnose Alzheimer's dementia or other forms of degenerative disease prior to death. In 2005, Bonelli et al. published the results of an investigation which involved the retrospective analysis of the cerebrospinal fluid (CSF) from 84 patients who had been hospitalized for the treatment of neurological conditions.[14] Hospital diagnoses included two forms of dementia (33 cases of Alzheimer's dementia, 18 cases of vascular dementia), low back pain (9 patients), headache (5 patients), and neuropathy (4 patients). Researchers evaluated the fluid samples for tTG (tissue transglutaminase), an enzyme which is activated during the process of apoptosis or programmed cell death. Medical histories were also reviewed in order to identify pharmaceuticals consumed within 24 hours of the fluid collection via lumbar puncture.

Findings were remarkable for significant relationships between treatment with neuroleptics and elevations in tTG, particularly for females and patients with Alzheimer's dementia. When specific medications were reviewed, five antipsychotics (***including three of the so-called atypicals: melperone, olanzapine and zotepine***) were associated with above average levels of tTG:

tTG levels for patients receiving antipsychotic medications	
melperone	14.95 ng/dL
zotepine	8.78 ng/dL
olanzapine	8.50 ng/dL
flupentixol	7.86 ng/dL
haloperidol	7.30 ng/dL
average tTG for entire patient group:	4.78 ng/dL

Based upon these results, the research team drew the following conclusions:

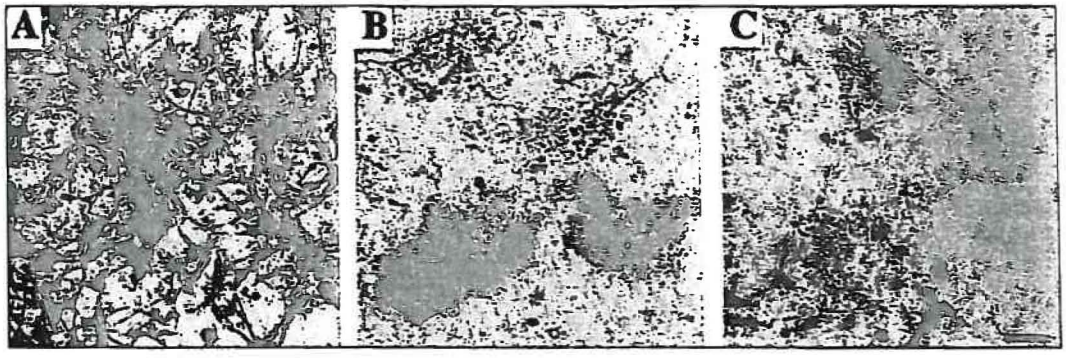
> "...our study failed to show a difference in neurotoxicity between atypical and typical neuroleptics, and we should be careful when using neuroleptics as first-line drugs in Alzheimer's dementia patients...Because the level of cerebral apoptosis of non-demented patients on antipsychotics appears to be indistinguishable to [sic] Alzheimer's dementia patients without this medication, the question might arise as to whether neuroleptics actually induce some degenerative process...In conclusion, we suggest that typical and atypical neuroleptics should be strictly limited in all elderly patients, especially in females and all patients with Alzheimer's dementia." [15]

While there were limitations to the Austrian study, it remains the only existing investigation of cell death in living subjects – none of whom received neuroleptics for mental illness. Furthermore, although the study failed to address possible relationships between apoptosis and antipsychotic exposure in terms of *dose* and *duration of treatment*, the implications extend far beyond the geriatric population. In fact, the finding that neuroleptic medications (and other psychiatric drugs) induce the process of apoptosis has inspired the oncology community to research these chemicals as adjuvant treatments for cancer. In other words, many psychiatric drugs are lethal to rapidly proliferating cells. To the extent that these chemotherapies are lethal to normal as well as cancerous tissues, there exists an urgent need for medical professionals and regulatory authorities to properly characterize the full effects of these toxins.

Line of Evidence #5: Lab Studies of Isolated Cells or Tissues

In vitro studies refer to research conducted upon tissue samples or isolated chemical systems obtained from lab animals or humans. In one such project, researchers in Germany exposed cell cultures to varying concentrations of haloperidol (Haldol).[16] The experiment involved the removal of hippocampal neurons from embryonic rats. Some of these neurons were then incubated with the neuroleptic and or its active metabolite (reduced haloperidol), while a control group of neurons remained drug free. Following a twenty-four hour period of incubation, neurons exhibited a dose-related reduction in viability, relative to the control:

drug concentration	Haldol	Reduced Haldol (drug metabolite)
1 uM	27% cell death	13% cell death
10 uM	35% cell death	29% cell death
100 uM	96% cell death	95% cell death



Examples of neuronal cell loss (death) following incubation with Haldol

A: normal neurons (dark) from unmedicated hippocampal brain tissue
B: 100 uM of Haldol: severe loss of cell bodies and neuron extensions.
Note: Dark patches at bottom of slide represent abnormal cells which have rounded up and detached from the culture dish.
C: 10 uM of Haldol: moderate loss of neurons and neuronal extensions.

Although this particular investigation involved a non-human species (rats), its results were medically concerning. First, the study employed Haldol concentrations which are clinically relevant to humans. In common medical practice, psychiatric patients are exposed to doses of Haldol which produce blood levels of 4 to 26 ng/mL. Brain levels are five to forty times higher. This means that psychiatric patients are indeed exposed to Haldol concentrations (1.4 to 2.8 uM) identical to the low levels that were tested in the German study. Second, the potential toxicity of Haldol in humans may be far greater than that revealed here, based upon the fact that this experiment was time limited (24 hour incubation only). Third, the neurons sampled in this experiment were taken from the key brain structure (hippocampus) associated with learning and memory. The possibility that Haldol kills neurons in this area (even if limited to 30%) provides a mechanism of action which accounts for the cognitive deterioration that is frequently observed in patients who receive this neuroleptic.

Dementia

Several teams of investigators have documented the problems associated with the use of neuroleptics in patients with pre-existing dementia. In a study which enrolled 179 individuals diagnosed with probable Alzheimer's disease, subjects were followed prospectively for an average of four years (range: 0.2 to 14 years).[17] Symptoms were evaluated on an annual basis, and changes in medication were carefully observed. Over the course of the investigation, 41% of the subjected progressed to severe dementia, and 56% of the patients died. Using a statistical procedure called proportional hazards modeling, the ***researchers documented a statistically significant relationship between exposure to neuroleptics and a two-fold higher likelihood of severe neurobehavioral decline.***

In England, a longitudinal investigation followed 71 demented patients (mean age: 72.6 years) over the course of two years.[18] Interviews were conducted at four-month intervals, and autopsy analyses of brain tissue were performed on 42 patients who expired. Main outcomes in this study were changes in cognitive functioning, behavioral difficulties, and (where applicable) postmortem neuropathology. ***The research team discovered that the initiation of neuroleptic therapy was associated with a doubling of the speed of cognitive decline.*** This relationship was independent of the degree of dementia or the severity of behavioral symptoms for which the medications may have been prescribed.

While the methodology could not definitively prove that the drugs were the cause of mental deterioration, the study clearly demonstrated their inability to prevent it. The researchers concluded that:

> "an appropriate response at present would be to undertake regular review of the need for patients to continue taking neuroleptic drugs, pursuing trials without medication where possible. This study highlights the importance of understanding the neurological basis of behavioural changes in dementia so that less toxic drugs can be developed for their treatment." [19]

In 2005, an United Kingdom team of investigators performed autopsies on forty patients who had suffered from dementia (mean duration: four years) and Parkinsonian symptoms (mean duration: three years) prior to death.[20] Based upon a postmortem tissue analysis of the brain, exposure to neuroleptics (***old and new***) was associated with a four-fold increase in neurofibrillary tangles, and a 30% increase in amyloid plaques in the cortex of the frontal lobes. Due to the fact that the prevalence of symptoms did not vary between patients who received neuroleptics and those who remained neuroleptic free, the abnormalities detected appeared to be a result of the pharmaceutical agents, rather than a pre-existing disease. Most importantly, the findings suggest that all of the antipsychotics (***old and new***) are capable of inducing or accelerating the pathological changes (plaques and tangles) which are the defining features of Alzheimer's disease.

To review:

Evidence from postmortem human analyses reveals that older neuroleptics create scarring and neuronal loss in the movement centers of the brain. These changes are an example of *subcortical* dementia, such as Parkinson's or Huntington's disease.

Evidence from neuroimaging studies reveals that ***old and new*** neuroleptics contribute to the progressive shrinkage and/or loss of brain tissue. Atrophy is especially prominent in the frontal lobes which control decision making, intention, and judgment. These changes are consistent with *cortical* dementia, such as Niemann-Pick's or Alzheimer's disease.

Evidence from postmortem analyses in lab animals reveals that ***old and new*** neuroleptics induce a significant reduction in total brain weight and volume, with prominent changes in the frontal and parietal lobes.

Evidence from biological measurements suggests that ***old and new*** neuroleptics increase the concentrations of tTG (a marker of programmed cell death) in the central nervous system of living humans.

Evidence from *in vitro* studies reveals that haloperidol reduces the viability of hippocampal neurons when cells are exposed to clinically relevant concentrations. (Other experiments have documented similar findings with the second-generation antipsychotics.)

Shortly after their introduction, neuroleptic drugs were identified as chemical lobotomizers. Although this terminology was originally metaphorical, subsequent technologies have demonstrated the scientific reality behind this designation. Neuroleptics are associated with the destruction of brain tissue in humans, in animals, and in tissue cultures. Not surprisingly, this damage has been found to contribute to the induction or worsening of psychiatric symptoms, and to the acceleration of cognitive and neurobehavioral decline.

Appendix B

Successful Alternatives to Antipsychotic Drug Therapy [21-22]

In a paper entitled "The Tragedy of Schizophrenia," psychologist and psychotherapist, Dr. Bert Karon, challenges the prevailing notion that psychosis remains a largely incurable brain disease which is best modified by pharmacotherapy. Mindful of the fact that "there has never been a lack of treatments which do more harm than good," Karon explicitly contends that humane psychotherapy remains the treatment of choice for schizophrenia, and he understands why this has always been so.

Karon reminds his readers that history provides important lessons for contemporary practitioners. The Moral Treatment Movement in the late 18th century emphasized four essential elements in the care of the mentally ill:

- respect for the patient (no humiliation or cruelty)
- the encouragement of work and social relations
- the collection of accurate life histories
- the attempt to understand each person as an individual

When these imperatives were applied in the asylums of America and Europe, the rates of discharge reached 60-80%. This was far better than the 30% recovery rate which occurred about a century later, in the era of pharmacotherapy.

Although the Moral Treatment Movement was replaced by the tenets of biological psychiatry in the late 1800s, its elements were incorporated in the theory and practice of various psychosocial therapies. For reasons which were largely political and economic, however, the consensus in American psychiatry came to denigrate the use of these Moral Treatment offshoots – particularly, in the treatment of psychosis.

Academic opinion leaders in the field of psychiatry now contend that there is insufficient evidence to support the use of psychotherapy as a major or independent intervention for psychosis. This perspective is contradicted by a rich (but suppressed) history in the published literature, and by the success of many ongoing programs, some of which are summarized below.

The Bockoven Study

This study compared the prognoses of 100 patients who were treated at Boston Psychopathic Hospital between 1947 and 1952; and 100 patients who were treated at the Solomon Mental Health Center between 1967 and 1972. Patients were similar in the severity of their symptoms, but the earlier cohort received treatment that was limited to psychosocial therapies. In contrast, the 1967 cohort received medication, including neuroleptics. Five-year outcomes were superior for the earlier cohort: 76% return to community and a 44% relapse in terms of re-hospitalization. In comparison, the 1967 cohort experienced an 87% return to the community, but a 66% rate of rehospitalization. The investigators concluded that medications were associated with higher numbers of relapsing patients, and a higher number of relapses per patient.

The Vermont Longitudinal Study of Persons With Severe Mental Illness

In 1955, a multidisciplinary team of mental health care professionals developed a program of comprehensive rehabilitation and community placement for 269 severely disabled, back wards patients at the Vermont State Hospital. When none of these patients improve sufficiently through two or more years of neuroleptic therapy, they were offered a revised plan of treatment. The intensive rehabilitation program was offered between 1955 and 1960. Subsequently, patients were released to the community as they became eligible for discharge, receiving a variety of services that emphasized continuity of care. At a long-term follow-up performed between 1980 and 1982, 68% of patients exhibited no signs of schizophrenia, and 45% displayed no psychiatric symptoms at all. Most patients had stopped using medication (16% not receiving, 34% not using, and 25% using only sporadically). A subsequent analysis revealed that all of the patients with full recoveries had stopped pharmacotherapy completely. (In other words, compliance with antipsychotic drug treatment was neither necessary, nor sufficient, for recovery.)

The Michigan State Psychotherapy Project

Between 1966 and 1981, Drs. Bert Karon and Gary VandenBos supervised the Michigan State Psychotherapy Project in Lansing, Michigan. Patients were randomly assigned to receive about 70 sessions of psychoanalytically informed psychotherapy, medication, or both over a period of 20 months. By the end of treatment, the psychotherapy group had experienced earlier hospital discharge, fewer readmissions (30-50% fewer days of hospitalization), and superior improvement in the quality of symptoms and overall functioning. The poorest outcomes occurred among the chronically medicated, even when drugs were combined with psychotherapy.

The Colorado Experiment

In 1970, Drs. Arthur Deikman and Leighton Whitaker presided over an innovative treatment ward at the University of Colorado. Occurring just 20 years after the advent of the neuroleptics, the Colorado experiment attached a priority to psychosocial interventions during the inpatient care of 51 patients diagnosed with severe mental illness. Individual and group psychotherapies were delivered in the spirit of the Moral Treatment Movement, motivated by a spirit of collaboration, respect, and a desire to understand behaviors as expressive of meaning. Furthermore, psychotherapies were used with the goal of restoring pre-psychotic abilities and independent functioning, rather than with the more limited goal of blunting symptoms in order to justify rapid discharge. *Medications were used as interventions of last resort.* After ten months of experimentation, the researchers made the following discovery: compared to "treatment as usual" (neuroleptics and supportive therapy), the recipients of intensive psychotherapy experienced lower recidivism (fewer readmissions after discharge) and lower mortality.

The Soteria Project

Between 1973 and 1981, Dr. Loren Mosher (then Director of Schizophrenia Research at the National Institute of Mental Health) presided over an investigational program in Northern California. Over the course of nine years, the Soteria project involved the treatment of 179 young psychotic subjects, newly diagnosed with schizophrenia or schizophrenia-like conditions. A control group consisted of consecutive patients arriving at a conventional medical facility, who were assigned to receive care at a nearby psychiatric hospital. Soteria was distinguished by an attitude of hopefulness; a treatment philosophy which de-emphasized biology and medicalization; a care setting marked by involvement and spontaneity; and a therapeutic component which placed a priority upon human relationship. Most significantly, Soteria involved the minimal use of neuroleptics or other drug therapies. Two-year outcomes demonstrated superior efficacy for the Soteria approach. Although 76% of the Soteria patients remained free of antipsychotics in the early stages of treatment; and although 42% remained free of antipsychotics throughout the entire two-year period, the Soteria cohort outperformed the hospital control group (94% of whom received continuous neuroleptic therapy) by achieving superior outcomes in terms of residual symptoms, the need for rehospitalization, and the ability to return to work.

The Agnews State Hospital Experiment

In 1978, Rappoport et al. summarized the clinical outcomes of 80 young males (aged 16-40) who had been hospitalized in San Jose at Agnews State Hospital for the treatment of early schizophrenia. Following acceptance into a double-blind, randomized controlled study, subjects were assigned to receive placebo or neuroleptic therapy (chlorpromazine). Treatment effectiveness was evaluated using various rating scales for as long as 36 months after hospital discharge. The best outcomes, in terms of severity of illness, were found among the patients who avoided neuroleptic therapy both during and after hospitalization. Patients who received placebo during hospitalization, with little or no antipsychotic exposure afterward, experienced the greatest symptomatic improvement; the lowest number of hospital readmissions (8% vs. 16-53% for the other treatment groups); and the fewest overall functional disturbances.

Finland – Acute Psychosis Integrated Treatment (Needs Adapted Approach)

In 1992, clinicians in Finland launched a multi-center research project using Acute Psychosis Integrated (API) Treatment. Keenly aware of the problems associated with antipsychotic drug therapy, the research team adopted a model of care which emphasized four features: family collaboration, teamwork, a basic therapeutic attitude, and adaptation to the specific needs of each patient. The initial phase of the project enrolled 135 subjects (aged 25-34) experiencing a first episode of psychosis. All were neuroleptic naïve, and all had limited or no previous exposure to psychotherapy. Three of the six participating treatment facilities agreed to use antipsychotic medications sparingly. The experimental protocol assigned patients to two groups with 84 receiving the Needs Adapted Approach, and 51 receiving treatment as usual. Two-year outcomes favored the experimental treatment group: fewer days of hospitalization, more patients without psychosis, and more patients with higher functioning. These outcomes occurred despite the fact that the Needs Adapted group consisted of more patients with severe illness (diagnosed schizophrenia) and longer durations of untreated psychosis, and despite the fact that 43% of the Needs Adapted subjects avoided antipsychotics altogether (vs. 6% of the controls).

Subsequent refinements to the Needs Adapted Approach have expanded upon these initial successes.[23-25] In a series of papers describing outcomes for what has evolved to be known as the Open Dialogue Approach, the Finnish clinicians have achieved the following five-year outcomes for first-episode, non-affective psychosis:

82% rate of full remission of psychotic symptoms
86% rate of return to studies of full-time employment
14% rate of disability (based upon need for disability allowance)

The results of the Finnish experiment stand in stark contrast to the results of the prevailing American standard of care, which currently features a 33% rate of lasting symptom reduction or remission; and, at most, a 40% rate of social or vocational recovery.[26]

Pre-Therapy: A Client-Centered Approach [27]

It has been suggested by many professionals that it is not possible to conduct meaningful psychotherapy with any individual who is deep in the throes of a psychotic process. Pre-Therapy refers to a client-centered form of psychotherapy which reaches through psychosis and/or other difficulties (such as cognitive limitations, autism, and dementia) in order to make contact with the pre-verbal or pre-expressive Self. Drawing upon the principles of the late Carl Rogers and developed by American psychologist, Dr. Garry Prouty, Pre-Therapy emphasizes the following treatment philosophy and techniques:

unconditional positive regard for the client:
"the warm acceptance of each aspect of the client's world"

empathy: "sensing the client's private world as if it were your own"

congruence: "within the relationship, the therapist is freely and deeply himself or herself"

non-directiveness: "a surrendering of the therapist to the client's own intent, directionality, and process"

psychological contact: exemplified by the therapist's use of contact reflections, an understanding of the client's psychological or contact functions, and the interpretation of the client's contact behaviors

Although Pre-Therapy has not been promoted or publicized within the United States, it has been used successfully around the world to assist regressed or language-impaired individuals in regaining or improving their capacity for verbal expression. (It has even been used to resolve catatonia successfully, without the use of drug therapy.) [28]

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Respectfully Submitted,

Grace E. Jackson, MD	14 May 2008 Date of Submission

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
AT ANCHORAGE

In the Matter of the Necessity for the Hospitalization of: WILLIAM BIGLEY, Respondent.	Case No. 3AN-08-00493 P/R FINDINGS AND ORDER CONCERNING COURT-ORDERED ADMINISTRATION OF MEDICATION

FINDINGS AND ORDER

A petition for the court approval of administration of psychotropic medication was filed on April 28, 2008.

Respondent was committed on May 5, 2008 for a period of time not to exceed 30 days in an order signed by Judge Rindner on that date.

Hearings were held on May 12, May 14 and May 15, 2008, to inquire into respondent's capacity to give or withhold informed consent to the use of psychotropic medication, and to determine whether administration of psychotropic medication is in the respondent's best interested considered in light of any available less intrusive treatments. *See Myers v. API*, 138 P.3d 238, 252 (Alaska 2006).

Having considered the allegations of the petition, the evidence presented and the arguments of counsel, the court finds:

1. The evidence is clear and convincing evidence that the respondent is not competent to provide informed consent concerning the administration of psychotropic medication. The evidence presented was clear and convincing that Mr. Bigley lacks the

capacity to assimilate relevant facts about his current mental health condition. This finding is supported not only by the testimony of the health care professionals from API, the court visitor, and Mr. Cornils, but by Mr. Bigley's own demeanor during the course of the court proceedings. Mr. Bigley's demeanor in the courtroom was indicative of some limited understanding by him that the court proceedings were to address API's request for an order to administer psychotropic medication without his consent. But he was quite agitated and maintained a running monologue throughout most of the court proceedings. The evidence was clear and convincing, particularly the testimony of Dr. Maile, that Mr. Bigley denies the existence of a mental illness and is unwilling to confer with either the court visitor or API staff in an effort to assimilate relevant facts about his mental health. The evidence was also clear and convincing that Mr. Bigley is unwilling to participate in treatment decisions at all because he is unwilling to communicate or cooperate at all with API staff or with the court visitor regarding any such proposed treatment. The court visitor attempted to assess Mr. Bigley's capacity to give or withhold informed consent, but was unable to do so because of Mr. Bigley's complete refusal to cooperate with her. Mr. Bigley has indicated that he believes the hospital staff is poisoning him, both as to the food and drink he was provided as well as any medication. Counsel for Mr. Bigley asserted that Mr. Bigley's belief that the medication could poison him was a reasonable objection to the medication, given the medication's side effects. But the evidence was clear and convincing that Mr. Bigley's concern of being poisoned is not due to any potential side effect of the proposed medication; rather, it constitutes a delusional belief that API would attempt to administer a substance that is poison in the strictest sense of that term --rather than an antipsychotic medication with potentially significant side effects. The evidence is clear and convincing that Mr. Bigley does not have the capacity to participate in treatment decisions by means of a rational thought process, and is not able to articulate reasonable objections to using the proposed medication.

2. The evidence is clear and convincing that Mr. Bigley has never previously made a statement while competent that reliably expressed a desire to refuse future treatment with psychotropic medication. The court visitor testified she was unaware of any such statement. Mr. Bigley did not introduce any evidence of such a statement. Through his counsel, Mr. Bigley asserted that the fact that Mr. Bigley promptly ceased taking antipsychotic medication after his prior releases from API is demonstrative of such a statement to refuse future treatment. But this court finds that the fact that Mr. Bigley has ceased taking antipsychotic medication in the past does not, in itself, reliably express a desire to refuse such medication in the future.

3. The evidence is clear and convincing that the proposed course of treatment is in Mr. Bigley's best interest. API has proposed to administer one medication to Mr. Bigley at this time - risperadone. The proposed dosage is up to 50 mgs. every two weeks. API presented clear and convincing evidence that the administration of this medication to Mr. Bigley meets the standard of medical care in Alaska for individuals with Mr. Bigley's medical condition. The evidence is clear and convincing that Mr. Bigley is unable at the present time to obtain any housing or mental health services outside of API because of his current aggressive and angry behavior. He is not welcome at the Brother Francis Shelter or in any assisted living home at the present time. The option that Mr. Bigley simply be permitted to come and go from API as he chooses is not a realistic alternative for two reasons - first, it is inconsistent with API's role as an acute care facility for individuals throughout the state that are in need of acute mental health care, and second, the evidence is clear and convincing that Mr. Bigley would not avail himself of this option even if it were available to him. As such, it is not a less intrusive treatment at all. When medication has been administered in the past to Mr. Bigley, his behavior has improved to such an extent that he has been able to successfully reside in the community, albeit for short periods of time. Without the administration of medication at this time, the evidence is clear and convincing that there will not be any improvement in Mr.

Bigley's mental functioning. And this particular medication has not caused severe side effects to Mr. Bigley in the past. Evidence was introduced that Mr. Bigley has had tardive dyskinesia as a result of the long term administration of antipsychotic medication to him over a period of many years, but the risk of that condition is considerable less with risperadone that with some other medications. [See Transcript of 2003 proceedings at 42-45; 3AN-02-00277 CI] Although CHOICES has provided valuable assistance to Mr. Bigley in the recent past that has enabled Mr. Bigley to function outside of API, the testimony of Paul Cornils constitutes clear and convincing evidence that that entity is not able to provide assistance to Mr. Bigley to enable him to live in the community at the present time because Mr. Bigley is not following treatment advice to receive medication. Although Mr. Bigley presented evidence as to the potential side effects of risperadone, both long term and short term, he presented no viable alternative to such treatment at the present time. In short, the evidence is clear and convincing that in order for Mr. Bigley to be most likely to achieve a less restrictive alternative than his current placement at API, the involuntary administration of risperadone is needed. In reaching this conclusion, this court has considered that the involuntary administration of risperadone to Mr. Bigley by injection is highly intrusive, and that there is a certain degree of pain associated with the receipt of an injection, particularly if it is to be administered to a patient that is strongly opposed to its administration. And the court has considered the adverse side effects of risperadone that were presented in court, and the fact that Mr. Bigley has not experienced some of those side effects, such as diabetes or undesirable weight gain when the drug has been administered to him in the past. The drug has been in use since the early 1990's, and, as noted above, falls within the standard of care in Alaska at the present time. The risk to Mr. Bigley of nontreatment is very high- the evidence is clear and convincing that Mr. Bigley will continue to be unable to function in the community unless he receives this treatment - the only form of treatment that is available to him at the current time. As such, although highly

intrusive to Mr. Bigley in the short term, this court finds that the proposed treatment is the least intrusive means of protecting Mr. Bigley's constitutional right to individual choice in his mental health treatment over the long term.

ORDER

For the foregoing reasons, API's petition for the administration of psychotropic medication is GRANTED, solely with respect to the use of risperadone in an amount not to exceed 50 mg per two weeks during the respondent's period of commitment. If API seeks to use additional or other medication during the period of commitment, it may file a motion to amend this order. If API seeks to continue the use of psychotropic medication without the patient's consent during a period of commitment that occurs after the period in which the court's approval was obtained, the facility shall file a request to continue the medication when it files the petition to continue the patient's commitment.

Pursuant to Mr. Bigley's request at the close of the evidence in this proceeding, this decision is STAYED for a period of 48 hours so as to permit Mr. Bigley to seek a stay of this order from the Alaska Supreme Court.

5-19-08
DATE
12:30 p.m.

Sharon Gleason
SHARON L. GLEASON
Judge of the Superior Court

I certify that on 5/19/08
a copy of this order was sent to:

respondent's attorney
attorney general
treatment facility
court visitor
guardian

Clerk: A. Stanley