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IN THE SUPREME COURT FOR THE STATE OF ALASKA

WILLIAM BIGLEY, Appellant, vs. ALASKA PSYCHIATRIC INSTITUTE Appellee.	) Supreme Court No. S-13116
	) Trial Court Case No. 3AN 08-493 P/R

OPPOSITION TO MOTION FOR RECONSIDERATION OF ORDER ON EMERGENCY MOTION FOR STAY PENDING APPEAL

For the reasons that follow, Appellant, William Bigley, respondent below, by and through counsel, hereby opposes the motion by Appellee, Alaska Psychiatric Institute (API) for reconsideration (Motion for Reconsideration) of this Court's May 23, 2008 Order granting a stay pending appeal (Stay Order) of the Superior Court's May 19, 2008 order granting API's petition for forced medication of Appellant (Forced Drugging Order).[1]

In its Motion for Reconsideration, notwithstanding Appellant having shown he faces a danger of irreparable harm, and API failing to show it is not adequately protected, API asks this Court to reject the balance of hardships standard it adopted in the Stay

Order in favor of probable success on the merits. As set forth below, this Court's original determinations that the balance of hardships approach applies is correct, and Appellant meets the standard for obtaining a stay thereunder. Appellant also establishes that even under the probable success on the merits standard, Appellant demonstrates probable success. Because of Appellant's discharge on or around June 5, 2008, however, Appellant first addresses whether or not such discharge renders the Stay Order and the Motion for Reconsideration Order moot.

I. Appellant's Discharge and Mootness

In the Stay Order, this Court noted that it is highly likely the present commitment order will have expired before this Court can rule on the merits of the appeal and that the possibility of technical mootness is substantial, and directed the parties to discuss in their briefing whether the Court should nonetheless reach the merits of the Forced Drugging Order.[2] Appellant was discharged on June 4 or 5, 2008, which raises the same issue with respect to the Stay Order, itself. In other words, has the Stay Order become technically moot, thus also mooting the motion for reconsideration, and if so, should the Court nonetheless reach the merits of the Motion for Reconsideration?

API's Motion for Reconsideration suggests the Motion for Reconsideration has not been rendered moot by Appellant's discharge, when at page 2, it states the Stay Order "effectively precludes API from administering medication for Mr. Bigley during this, or any future, commitment periods." It is unclear, however, whether this statement was

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[1] Exhibit A, is the AS 47.30.839 petition (Forced Drugging Petition), and Exhibit B the Superior Court's Forced Drugging Order.

meant to include only extensions of the then existing commitment under the same case number, as distinct from future commitments in which a new 30-day petition might be filed under a different case number. What is clear is that unless Appellant is provided the sort of community support he seeks as a less intrusive alternative,[3] he is almost certainly going to continue to have the sorts of problems in the community that have been bringing him to API[4] and involved with the criminal justice system.[5]

In *Myers*, this Court invoked the public interest exception to the mootness rule,[6] noting, however, that the United States Supreme Court in *Washington v. Harper*,[7] held such an issue was not moot because the controversy could recur.

Here, as this Court acknowledges in its Stay Order[8] and API in its Motion for Reconsideration,[9] the controversy is at least likely to recur. Appellant suggests it is almost certain to recur. It is also clear that the issue is capable of evading review unless

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[2] §4 of Stay Order.
[3] Whether or not, having invoked the civil commitment and forced drugging statutes to psychiatrically confine and administer psychiatric drugs against Appellant's will, API may evade its constitutional obligation under *Myers v. Alaska Psychiatric Institute*, 138 P.3d 238, 254 (Alaska 2006), to provide a less intrusive alternative to the forced drugging by discharging Appellant is the main issue on appeal in S-13015. As a practical matter, the same situation has now occurred here as a result of Appellant's post appeal discharge.
[4] Without the requested community supports, it is almost certain Appellant will continue to experience these difficulties in the community even if he is psychiatrically drugged against his wishes .
[5] Appellant is consistently determined to be incompetent to stand trial without the prospect of becoming competent to stand trial and is then released from criminal custody, often to API for possible civil commitment.
[6] 138 P.3d at 245.
[7] 494 U.S. 210, 218-19, 110 S.Ct. 1028, 108 L.Ed.2d 178 (1990).
[8] Page 3.
[9] Page 2.

decided, and it is suggested here it raises a matter of grave public concern, which are the criteria for invoking the public exception to the mootness doctrine.[10]

With respect to the grave public concern criteria, unless appellants who make a sufficient showing to obtain a stay of forced drugging orders under AS 47.30.839 are able to do so, the fundamental right to decline psychiatric medication recognized in *Myers* will not have an effective manner of being vindicated on appeal.

It is also respectfully suggested here that under *Washington v. Harper*, the issue is not technically moot, at least with respect to Appellant's rights under the Due Process Clause of the United States Constitution. Appellant respectfully suggests the same should also be true under the Alaska Constitution.

Should this Court hold that the Stay Order and/or the Motion for Reconsideration are moot, the status of the stay in any subsequent forced drugging proceeding during the pendency of this appeal will be unclear unless the order holding the Motion for Reconsideration moot addresses the issue.

II. The Balance of Hardships Standard Applies

Raising the specter that applying the balance of hardships standard in this case means that every person subjected to a forced drugging order under AS 47.30.839 only has to make a "*de minimus* showing that he or she possesses some sort of colorable argument on appeal, "[11] in its Motion for Reconsideration, API asks this Court to hold that the "probable success on the merits" standard should be employed, rather than the

[10] *Myers*, 138 P.3d at 244.
[11] Page 2.

"balance of hardships" standard.[12] API's argument is flawed. In order to invoke the "balance of hardships" standard an appellant has to raise substantial and serious questions going to the merits, as well as demonstrate both a danger of irreparable harm and that API can be adequately protected.[13]

A. The Evidence of Irreparable Harm Is Compelling and Unrebutted

API has been presented with testimony of irreparable harm and the availability of a less intrusive alternative in defense of forced drugging proceedings against Appellant while represented by PsychRights,[14] at least four times since September of 2007, and has never contested it, including in this case.[15] In order to have the probable success on the

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[12] Pages 1-2.

[13] *State, Div. of Elections v. Metcalfe,* 110 P.3d 976, 978 (Alaska 2005) as made applicable by *Powell v. City of Anchorage*, 536 P.2d 1228, 1229 (Alaska 1975).

[14] PsychRights has limited its representation of Appellant under Civil Rule 81(d) to the forced drugging petitions. *See*, Exhibit C, pages 1 & 3, and Exhibit M. A limited entry of appearance was also filed in 3AN 07-1064 PR.

[15] The written testimony of Robert Whitaker (Exhibit G), Ronald Bassman (Exhibit I), Paul Cornils (Exhibit J) and the live testimony of Sarah Porter (Exhibit F, pp 12-20), regarding the lack of efficacy, decreased recovery rates and great harm from the drugs as well as the availability of a less intrusive alternative, was originally submitted in 3AN 07-1064 PR. Rather than contest this and also face Appellant's requests for a less intrusive alternative, API discharged Appellant "against medical advice" after he had been involuntarily committed rather than face being ordered to provide the available less intrusive alternative sought there (Exhibit K). *See* also Exhibit C, pp 11-12. This same testimony was presented in 3AN 08-247 PR (Exhibits C, pages 4-57, Exhibits G, I & J. In that case, API lost the commitment petition and was discharged and the forced drugging petition filed in that case was not heard. Exhibit L, page 15 (March 14, 2008, Tr. Page 55, lines 18-20). This same testimony was also presented in 3AN 08-416 PR, Exhibits C, pages 4-57, G, I, J & M. API also lost that commitment petition and Appellant was discharged and the forced drugging petition in that case was not heard. Exhibit N. The fourth time this testimony was presented is in the extant proceeding. It was augmented by the written testimony of Grace E. Jackson, MD and the live testimony of Dr. Jackson and Paul Cornils. Exhibit D is Dr. Jackson's Curriculum Vitae and Exhibit D is the written testimony Dr. Jackson submitted below.

merits standard apply, all API has to do in future cases is present sufficient evidence to rebut the evidence that Appellant faces the danger of irreparable harm. If it can.

Even though API has the option of attempting to rebut irreparable harm in future cases, it failed to do so in this case. The testimony in this case regarding irreparable harm is compelling and unrebutted. This consists of the written and oral testimony of Grace E. Jackson, MD,[16] who was qualified as an expert in psychiatry and psychopharmacology,[17] and the written testimony of Robert Whitaker,[18] which Dr. Jackson testified is "a very accurate and very clear presentation of the information as I understand it myself."[19] It also includes the prior testimony of Loren Mosher, MD, the former Chief for the Center for Studies of Schizophrenia at the National Institute of Mental Health under Evidence Rule 804(b)(1),[20] who testified that Dr. Jackson knows more about the mechanisms of actions of the various psychotropic agents than any clinician of whom he was aware.[21]

In Dr. Jackson's written testimony,[22] she summarizes the brain damage caused by the drug authorized to be forcibly injected in Appellant here[23] as follows:

> 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,

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[16] Exhibits E & H and Tr. 107-165 (May 14, 2008).
[17] Tr. 111 (May 14, 2008).
[18] Exhibit G.
[19] Tr. 111-112 (May 14, 2008).
[20] Exhibit F, page 5 (page 171 of transcript, lines 14-16).
[21] Exhibit F, page 7 (page 179 of transcript, lines 3-7).
[22] Exhibit E.
[23] Risperdal, also known as risperidone, is one of the "new neuroleptics." Dr. Jackson specifically testified at the hearing that her testimony pertaining to this class of drugs applied to Risperdal. Tr. 137, 138, 139, 140. There was also a tremendous amount of specific testimony regarding Risperdal throughout Dr. Jackson's testimony. Tr. 107-165.

> 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.
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> Neuroleptics are associated with the destruction of brain tissue in humans, in animals, and in tissue cultures. Not surprisingly, <u>this damage has been found to contribute to the induction or worsening of psychiatric symptoms, and to the acceleration of cognitive and neurobehavioral decline</u>.

(boldfacing in original, underlining added)

Dr. Jackson amplified on this in her live testimony, making it clear that Risperdal, as with all the drugs in this class, causes dementia, and other serious health problems, and the types of worsening behavioral symptoms described of Appellant.[24] Dr. Jackson also testified that very few clinicians are aware of the lack of effectiveness and extreme harm caused by the drugs, including Risperdal, because of the ability of the pharmaceutical industry to control the information to which clinicians are exposed.[25] Dr. Jackson further testified that the "improvement" described by clinicians are the lobotomizing effects of

[24] Tr. 107-65.

the drugs.[26]

Finally, in support of the emergency motion for stay here, largely summarizing her testimony, a further affidavit of Dr. Jackson was presented regarding the irreparable harm to Appellant should API be allowed to drug him against his will pending this appeal:[27]

> Mr. Bigley's initial dose of Haldol guaranteed the induction of Parkinsonian symptoms by day #3 of treatment (4/17/80). Furthermore, the continued administration of Haldol -- a chemical which replicates the mitochondrial effects of rat poison and insecticide -- guaranteed the rapid deterioration of his condition. (p.5) . . .
>
> [T]he materials which I have reviewed (see Section III, #3 above) demonstrate a persistent and continuing failure of API clinicians to consider the most likely diagnosis in the case at hand. In all probability, Mr. Bigley now suffers from a chemical brain injury (CBI). This development should preclude the attachment of any and all psychiatric labels at this time. It should also trigger the legal and medical systems to prioritize the delivery of interventions which promote neuro-rehabilitation, rather than neurodegeneration. (p.5) . . .
>
> 4) risperidone (Consta or oral forms) will potentially kill Mr. Bigley while offering no significant prospect of improvement, and zero probability of recovery . . .
>
> [Risperidone] possesses some features which make it particularly undesirable, even among drug enthusiasts.
>
> First, risperidone is unique among the newer "antipsychotic" drugs in terms of its potential to elevate prolactin. In some studies, hyperprolactinemia has occurred in as many as 90% of the risperidone patients. This is more than a trifling occurrence, due to the fact that hyperprolactinemia has been repeatedly linked to cardiac disease (e.g., via platelet aggregation, cardiomegaly, and heart failure).

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[25] Tr. 115-133..
[26]Tr. 141.
[27] Exhibit H. In this testimony Dr. Jackson discusses the failure of API to conduct needed tests, including for diabetes and other metabolic problems. While Dr. Hopson testified that tests for diabetes and other blood sugar problems were done, based on the records provided by API, this appears to be untrue.

> Second, even at typical or "ordinary" doses (D2 blockade of 60-80%), risperidone induces Parkinsonian side effects at a rate which equals or surpasses the so-called traditional or conventional neuroleptics (e.g., in 30-50% of the patients).
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> Third, the real-world risk of tardive dyskinesia due to risperidone is significant and far more prominent than API's spokesmen have presumably opined. In Jose de Leon's recent study of patients who began treatment with the newer therapies (65% receiving risperidone), more than 60% of the subjects with treatment histories similar to Mr. Bigley's developed tardive dyskinesia despite the use of these "safer" drugs.
>
> Fourth, given Mr. Bigley's advancing age (55 considered "elderly" in at least one published study); the early onset of Parkinsonian side effects (BPS at age 27); and a pre-existing organic brain syndrome (i.e., chemical brain injury), he is at high risk for tardive dyskinesia. In light of the fact that tardive dyskinesia (TD) reflects extensive damage to the brain - including impairments of judgment and insight, as much as impairment of movement - it is essential to avoid the use of any chemical intervention which might accelerate the emergence of this condition.
>
> Fifth, commensurate with the affidavits, exhibits, and testimony on behalf of the respondent, it is extremely improbable that risperidone will do anything but aggravate the effects of the dysmentia (chemical brain injury) from which Mr. Bigley continues to suffer. To the contrary, risperidone will compound that condition with real and substantial risks of sudden death from stroke, heart attack, pulmonary embolism, diabetes, falls, accidents, pneumonia, NMS, and - ultimately - dementia.
>
> For the aforementioned reasons, a Failure to Grant a Stay of the Superior Court's Order will result in irreparable harm. (pp. 7-8)

The testimony in this case makes clear that Appellant faces the danger of irreparable harm should API be allowed to restart drugging him.

B. <u>API Is Adequately Protected</u>

The Stay Order for which full court reconsideration is sought by API held that API was adequately protected because the evidence presented does not establish that medication is necessary to protect appellant, and API did not identify any need to protect

others from Appellant.[28] While protesting that the Stay Order "gave minimal analysis" to how API's interests are protected,[29] API fails to articulate any way in which its interests are not protected.[30] Thus, it does not appear API disputes that it is adequately protected.

III. Appellant Has Not Only Raised Serious and Substantial Questions Going to the Merits But Also Demonstrates Probable Success on the Merits

Even though it has not presented any evidence rebutting Appellant's evidence that he faces irreparable harm if the stay is not maintained, and even though it has failed to articulate any way in which it is not adequately protected, API argues the probable success on the merits standard should apply. It is hard to understand how the probable success on the merits standard can apply in these circumstances, but Appellant nevertheless demonstrates probable success on the merits.

In order to demonstrate probable success on the merits, a discussion of the legal criteria for granting a forced drugging petition under AS 47.30.839 is necessary. This Court's decision in *Myers v. Alaska Psychiatric Institute* is controlling, with its core holding being:

> [I]n future non-emergency cases 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.[31]

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[28] Stay Order, p. 3.
[29] Motion for Reconsideration, page 1.
[30] It does assert at page 2 that the stay prevents it from drugging Appellant in the way it believes it should, but of course, this is the purpose of the stay.
[31] 138 P.3d. 238, 254 (Alaska 2006).

The Superior Court in *Myers*, after listening to the same testimony from Loren Mosher, MD, the former Chief for the Center for Studies of Schizophrenia at the National Institute of Mental Health as submitted herein,[32] and written and oral testimony from Dr. Jackson, who, as set forth above, Dr. Mosher described as knowing more about the mechanisms of actions of the various psychotropic agents than any clinician of whom he was aware,[33] found,

> [T]here is a real and viable debate among qualified experts in the psychiatric community regarding whether the standard of care for treating schizophrenic patients should be the administration of anti-psychotic medication.
>
> * * *
>
> [T]here is a viable debate in the psychiatric community regarding whether administration of this type of medication might actually cause damage to her or ultimately worsen her condition.[34]

The Superior Court in Myers, however, believed AS 47.30.839 unambiguously limited its role "to deciding whether Ms. Myers has sufficient capacity to give informed consent," and felt constrained to adhere to its literal meaning.[35] *Myers's* core holding swept away the statutory limitation on constitutional grounds and in so doing stated:

> [T]he ultimate responsibility for providing adequate protection of [the right to refuse psychotropic medication] rests with the courts; and . . . adequate protection of that right can only be ensured by an *independent judicial determination of the patient's best interests* considered in light of any available less intrusive treatments.[36]

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[32] Exhibit F, page 5 (page 171 of transcript, lines 14-16).
[33] Exhibit F, page 7 (page 179 of transcript, lines 3-7).
[34] *See*, Exc. 299, 304 in S-11021.
[35] *Myers*, 138 P.3d at 240.
[36] 138 P.3d at 251-252, emphasis added.

This Court then required the trial court, in making its *independent* determination of best interests to, at a minimum, consider the information AS 47.30.837(d)(2) directs the treatment facility to give to its patients in order ensure the patient's ability to make an informed choice.[37] This includes:

> (A) an explanation of the patient's diagnosis and prognosis, or their predominant symptoms, with and without the medication;
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> (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;
>
> (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; and
>
> (E) information about alternative treatments and their risks, side effects, and benefits, including the risks of nontreatment[.][38]

This Court then found helpful and sensible the Supreme Court of Minnesota's holding that in order to determine the "necessity and reasonableness" of a treatment, "courts should balance [a] patient's need for treatment against the intrusiveness of the prescribed treatment," and also citing with approval the following "[f]actors that the Minnesota court believed should be considered included:"[39]

> (1) the extent and duration of changes in behavior patterns and mental activity effected by the treatment;
>
> (2) the risks of adverse side effects;

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[37] 138 P.3d at 252.
[38] 138 P.3d n.92.
[39] 138 P.3d 252, citing to *Price v. Sheppard*, 239 N.W.2d 905, 239 (Minnesota 1976).

(3) the experimental nature of the treatment;

(4) its acceptance by the medical community of the state; and

(5) the extent of intrusion into the patient's body and the pain connected with the treatment.[40]

A. Appellant Has Demonstrated Probable Success on the Merits on the Myers Factors

The Superior Court's decision, as does API's defense of that decision in its Motion for Reconsideration, essentially rests entirely upon API's psychiatrists' testimony that what they proposed is the standard of care, i.e., "acceptance by the medical community of the state." However, acceptance by the medical community of the state," is only one of many factors this Court held should, *at a minimum*, be considered by the Superior Court (Myers Factors). As Dr. Hopson, API's Medical Director, admitted there have been many medical standard of care disasters, in which the standard of care has been subsequently found to be very harmful to patients.[41]

The compelling and unrebutted evidence as to the other Myers Factors required to be analyzed by this Court in *Myers* is not addressed by either the Superior Court in its Forced Drugging Order, nor API in its Motion for Reconsideration. Appellant shall address them now.

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[40] *Id.*

[41] The Superior Court, cut off Appellant's questioning of Dr. Hopson about standard of care disasters, specifically stating it understood Appellant's point that the standard of care in the past has often been found to be harmful. Tr. 236, lines 10-15 (May 15, 2008). Tr. 234-237 (May 15, 2008).

(1) <u>An Explanation Of The Patient's Diagnosis And Prognosis, Or Their Predominant Symptoms, With And Without The Medication;</u>

(a) <u>Prognosis With Medication</u>

Dr. Khari testified that even when on medication Appellant maintains his delusional thought content.[42] Dr. Maile testified that Appellant's condition has been declining over time,[43] which is under the 28 year forced drugging regime imposed on him by API. Dr. Jackson testified that Appellant is an example of someone in whom the drugs has caused dementia[44] or dysmentia,[45] and reiterated to this Court that allowing API to administer Risperdal to Appellant will compound that condition with real and substantial risks of sudden death from stroke, heart attack, pulmonary embolism, dieabetes, falls, accidents, psymonia, Neuroleptic Malignant Syndrome, and dementia.[46] Dr. Jackson also testified that allowing API to administer Risperdal will cause further cognitive and behavioral decline in which Appellant will have increasing problems modulating self-control, anger and emotional expression.[47]

(b) <u>Prognosis Without the Medication</u>

Dr. Jackson testified regarding prognosis without the medication that Appellant had a better prognosis off the medication than on it, and because the withdrawal effects

[42] Tr. 47 (May 12, 2008).
[43] Tr. 22 (May 12, 2008).
[44] Tr. 135, Exhibit H, page 9.
[45] Exhibit H, page 9.
[46] Exhibit H, page 9.
[47] Tr. 136 (May 14, 2008).

manifest themselves as a worsening of psychiatric symptoms over some length of time, Appellant needs to be given a relatively extended period of time off the drugs.[48]

(2) 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;

(a) Possible Side Effects

A tremendous amount of evidence is presented elsewhere regarding the possible side effects and is not repeated here.

(b) Possible Benefits

Particularly instructive regarding the possible benefits of the proposed treatment, or more accurately, the lack of such benefit for many if not most of the people taking these drugs, is Robert Whitaker's written testimony, Exhibit G. Dr. Maile testified that Appellant is "a pleasant man" while drugged as opposed to when he is not[49] and it was his wish that he be forced to take the drugs so he would be a friendly, pleasant guy, easy to be around.[50] Dr. Hopson testified he is much calmer and affable when drugged.[51]

Appellant suggests being made more tolerable to others is not cognizable as a benefit to Appellant under the *Myers* best interests requirement.

(3) A Review Of The Patient's History, Including Medication History And Previous Side Effects From Medication;

Dr. Khari testified that based on past experience, she expects Appellant to quit

[48] Tr. 144-145 (May 14, 2008).
[49] Tr. 24 (May 12, 2008).
[50] Tr. 38. May 12, 2008).
[51] Tr 230 (May 15, 2008).

taking the drug as soon as he is discharged from the hospital.[52] Dr. Hopson testified that is Appellant's history.[53] Paul Cornils testified his experience with Appellant is he discontinues the medication as soon as he is released from the hospital[54] and then:

> That in no way in my personal opinion or experience is beneficial to Mr. Bigley, so my opinion is that unless Mr. Bigley agrees with the course of treatment and would voluntarily continue with it, it's futile.[55]

Mr. Cornils, who spent a considerable amount of time working with Appellant, also testified with respect to Appellant's being on or off drugs as follows:

> Q Did you observe any differences in Mr. Bigley's behavior?
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> A Beyond the sedative effects, no. His -- his delusions are as strong. His anger and aggression is still present, he just does not express them as strongly. He is less disturbing most of the time. I don't know if that makes sense to you or not. But if you spend a lot of time with him, like I have, he -- I have not noticed much difference except to say that his behavior is more socially acceptable when he's on medication.[56]

Dr. Maile erroneously testified that Appellant has not been diagnosed with Tardive Dyskenesia.[57] In fact, Appellant has been diagnosed with Tardive Dyskenesia.[58] Dr. Khari erroneously testified that Appellant did not show any side effects on Risperdal.[59] For example, Dr. Maile testified that Appellant complains about weight gain and being

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[52] Tr. 63 (May 12, 2008).
[53] Tr. 210 (May 15, 2008).
[54] Tr. 241, 243 (May 15, 2008).
[55] Tr. 243 (May 15, 2008).
[56] Tr. 241-242 (May 15, 2008).
[57] Tr. 39 (May 12, 2008).
[58] *See* page 42 of transcript of September 5, 2007, hearing in 3AN 07-1064 PR, which is part of the record in S-13015 (Dr. Worrall, his treating physician there, testifying "Well, he has tardive dyskinesia, which is most likely from the years and years of getting drugs like Haldol, Prolixin").
[59] Tr. 42 (May 12, 2008).

sleepy (ie, sedated)[60] as did the Court Visitor.[61] Another example is that Appellant has suffered sexual dysfunction as a side effect.[62]

(4) An Explanation Of Interactions With Other Drugs, Including Over-The-Counter Drugs, Street Drugs, And Alcohol; And

API presented a little testimony regarding interactions with other drugs, including over-the-counter, street drugs and alcohol,[63] however, Appellant doesn't have a history of using street drugs or alcohol in any problematic way.[64]

(5) Information About Alternative Treatments And Their Risks, Side Effects, And Benefits, Including The Risks Of Nontreatment[.]

Information about alternative treatments and their risks, side effects and benefits is covered extensively below in §III.(B). Without the less intrusive alternative requested by Appellant he is almost certain to continue to have serious problems in the community resulting in future admissions to API and involvement with the criminal justice system as a result of bothering people (e.g., violating property owners' directions to leave their premises and not return). A key component of the less intrusive alternative requested is to effectively address this problem.

(6) The Extent And Duration Of Changes In Behavior Patterns And Mental Activity Effected By The Treatment;

Dr. Khari testified that even when on medication he maintains his delusional thought content.[65] Dr. Maile testified that Appellant's condition has been declining over

[60] Tr. 38-39 (May 12, 2008).
[61] Tr. 80 (May 12, 2008).
[62] Tr. 80 (May 12, 2008).
[63] Tr. 52-53 (May 12, 2008)
[64] Tr. 81 (May 12, 2008).

time,[66] which is under the 28 year forced drugging regime imposed on him by API. As set forth above, Dr. Jackson testified this is likely due to the brain damage inflicted by the drugs, which she calls Chemical Brain Injury (CBI).[67] As set forth in §III.A.(3), above, it is unanimous that Appellant uniformly quits taking the drugs when they are not forced upon him.

(7) The Risks Of Adverse Side Effects;

The risks of adverse side effects was one of the factors set forth by the Minnesota Supreme Court in *Price* this Court cited with approval. This factor parallels one of the AS 47.30.837(d)(2)(B) factors, which has been extensively set forth elsewhere herein.

(8) The Experimental Nature Of The Treatment.

Dr. Khari testified the proposed treatment is not experimental.[68] The experimental nature of the treatment has not been made an issue in this case.

(9) Acceptance Of The Proposed Treatment By The Medical Community Of The State.

Both Dr. Khari,[69] and Dr. Hopson[70] testified the proposed treatment conformed to the standard of care in Alaska. Appellant agrees the proposed treatment is generally accepted by the psychiatric community of the state. However, it is respectfully suggested that in light of Dr. Jackson's, Dr. Mosher's and Mr. Whitaker's unrebutted testimony

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[65] Tr. 47 (May 12, 2008).
[66] Tr. 22 (May 12, 2008).
[67] *See*, above written testimony of Dr. Jackson and TR. 135 (May 14, 2008).
[68] Tr. 53 (May 12, 2008).
[69] Tr. 53 (May 12, 2008).
[70] Tr. 234 (May 15, 2008).

regarding how uninformed that acceptance is, and the harm it is causing,[71] as well as the many standard of care disasters, this factor should be downgraded if not eliminated. It is not logically relevant to the "independent judicial determination of the patient's best interests" required under *Myers*.[72]

(10) The Extent Of Intrusion Into The Patient's Body And The Pain Connected With The Treatment.

This Court has noted forced drugging has been equated with the intrusiveness of electroshock and lobotomy.[73] Dr. Hopson testified that if API was authorized to administer the Risperdal as it has requested and Appellant refused, he would be held down and injected.[74]

Appellant has demonstrated probable success on the merits with respect to best interests. Next he does so with respect to a less restrictive alternative.

B. There Is A Less Intrusive Alternative Available

One of the core holdings of *Myers* is the State may not forcibly drug someone with psychotropic medication(s) against his wishes unless "no less intrusive alternative treatment is available."[75] API may not avoid its obligation to provide a less intrusive alternative by choosing to not provide funds. *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 F.2d 1305, 1315 (5th Cir. 1974)(state legislature is not free to

[71] Tr. 112, et seq. (May 14, 2008) and Exhibits E, F, pp 2-8, & G.
[72] 138 P.3d at 252.
[73] *Myers*, 138 P.3d at 242; *Wetherhorn* 156 P.3d at 382.
[74] Tr. 185 (May 14, 2008). He also testified that in his experience patients will quite frequently submit when faced with that prospect. *Id*.

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, Appellant's constitutional right to a less intrusive alternative has sprung into being under *Myers*. *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 in a way that denies Appellant's right to a less intrusive alternative.

In *Hootch v. Alaska State-Operated School System*, in considering an equal protection claim regarding the right to state funding of local schools, this Court held that resolution of the complex problems pertaining to the location and quality of secondary education are best determined by the legislative process, but went on to state, "We shall not, however, hesitate to intervene if a violation of the constitutional rights to equal treatment under either the Alaska or United States Constitutions is established."[76] Here, it seems probable this Court would also not hesitate to order the provision of an available less intrusive alternative to satisfy the constitutional due process right to a less intrusive alternative it required in *Myers*. There would likely be some limitation on the State's obligation to provide less intrusive alternatives, such as extreme cost, but if the State

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[75] Myers v. Alaska Psychiatric Inst., 138 P.3d 238, 239 (Alaska 2006).
[76] *Hootch v. Alaska State-Operated School System*, 536 P.2d 793, 808–09 (Alaska 1975).

could reasonably provide a less intrusive alternative, it may not constitutionally forcibly drug the person instead.[77]

(1) <u>Appellant Presented Scientific and Expert Opinion Evidence That Outcomes Are Far Better For People Given Choices Other Than the Drugs</u>

Dr. Jackson, Dr. Bassman and Robert Whitaker submitted written testimony as to the overwhelming scientific evidence that many people given a chance to decline the neuroleptics will recover, or at least do far better, including those that have been on them for a long time.[78] In addition transcripts of the prior testimony of Loren Mosher, MD, and Sarah Porter was submitted under Evidence Rule 804(b)(1).[79]

Both Jackson and Whitaker presented numerous scientific studies demonstrating the superiority of non-drug approaches for many.[80] Dr. Bassman's written testimony is to similar effect, and he also notes, "when it is clear that medications are not effective, it is necessary and only humane to offer other options for the individual to choose."[81]

Sarah Porter was qualified as an expert in the area of alternative treatments[82] and testified through Evidence Rule 804(b)(1) to the following:[83]

> A. I've . . . set up and run a program in New Zealand which operates as an alternative to acute mental health services. . . . [O]ur outcomes to date have been outstanding, and the funding body that provided . . . the resources to

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[77] The less intrusive alternative sought by Appellant is not costly when compared to the current costs of the revolving-door incarcerations of Appellant in API and jail.
[78] Exhibits E, G & I, respectively.
[79] Exhibit F.
[80] Exhibit E, pp 12-16. and Exhibit G, pp 6-8, respectively.
[81] Exhibit I, p. 2.
[82] Exhibit F, p.17, (transcript p. 92, September 5, 2007, in 3AN 07-1064 PR).
[83] Exhibit F, pp 12-14 (transcript pp 73-81, September 5, 2007, in 3AN 07-1064 PR).

do the program is extremely excited about the results . . . and [starting] out more similar programs in New Zealand. . . .

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.

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

A Unfortunately, in New Zealand the primary form of treatment, until very recent times, has been medication. . . .

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

A . . . [C]oercion, 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 -- and have you seen success in that approach?

A We have. It's been phenomenal, actually. . . . I had high hopes that it would work, but I've . . . been really impressed how well, in fact, it has worked . . . .[84]

[84] Exhibit F, pp 12-19.

Dr. Mosher's testimony included the following:

> Q . . . 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 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.[85]

(2) <u>Appellant Presented a Well-Thought Out Available Less Intrusive Alternative</u>

Mr. Cornils's written testimony describes in some detail the rationale, prospects and availability of a less intrusive alternative designed specifically for Appellant.[86] Mr. Cornils was also cross-examined with respect to this written testimony and gave redirect testimony at the May 15, 2008, hearing.[87] In this live testimony, Mr. Cornils testified that if Appellant initially had someone with him for up to 24 hours a day and other needed resources, especially housing, he would likely improve to the point where he didn't need someone to be with him as much and could live successfully in the

[85] Exhibit F, pp 5-6.
[86] Exhibit J. This written testimony was originally submitted September 12, 2007, in 3AN 07-1064 PR, and was resubmitted in the two intervening force drugging proceedings in which Appellant was represented by PsychRights, but was not committed, and then resubmitted again in this case.
[87] Tr. 239-262 (May 15, 2008).

community without psychiatric medication.[88]

Mr. Cornils testimony was equivocal with respect to whether CHOICES would take Appellant as a client if he didn't have a psychiatrist willing to work with him without drugs,[89] but was very clear CHOICES would do so if there was such a psychiatrist.[90] Thus, it appears if API was ordered to provide a less intrusive alternative that did not involve medication, and sufficient resources were made available, CHOICES would be available to work with Appellant.[91] Dr. Jackson testified that the less intrusive alternative to which Mr. Cornils testified to was exceedingly thorough, of which she was envious, and was a very solid and a reasonable proposal as a first step.[92]

However, whether or not CHOICES is available or could become available, it is absolutely clear that API, itself, could provide these types of services and supports.

Dr. Hopson admitted it is Appellant's loss of housing that causes a problem with him being in the community.[93] Dr. Hopson also testified that if Appellant were provided intensive case management, which is the type of services requested by Appellant and described by Mr. Cornils, Appellant might very well never come back to the hospital.[94]

(3) <u>API Refuses to Provide Available Less Intrusive Alternatives</u>

The foregoing makes clear that a much more effective and beneficial less intrusive alternative is available if only API would provide it. It is just as clear API heretofor

[88] Tr. 245-247 (May 15, 2008).
[89] Tr. 250-252 (May 15, 2008).
[90] Tr. 251 (May 15, 2008).
[91] Tr. 251 (May 15, 2008).
[92] Tr. 150 (May 14, 2008).
[93] Tr. 182 (May 14, 2008).

refuses to do so. Dr. Hopson, API's Medical Director, testified API was unwilling to implement Appellant's proposed less intrusive alternative because it is not its mission.[95] Dr. Hopson further testified that API refuses to do so because "it sets a precedence for us to be providing a different level of care than we're accustomed to doing."[96] These are not permissible bases for providing unconstitutional services. *See*, the *Wyatt v. Stickney*[97] and *Wyatt v. Anderholt*,[98] analysis at §III.B., above.

In sum, just as with respect to best interests, Appellant has shown probable success on the merits with respect to the availability of a less intrusive alternative.

Even if the probable success on the merits standard is held to apply, Appellant only needs to prevail on either best interests or less intrusive alternative, and he has demonstrated probable success on the merits with respect to both.

IV. CONCLUSION

For the foregoing reason, this Court should sustain its May 23, 2008, Order granting a stay of the Forced Drugging Order pending appeal.

Dated this 2nd day of June, 2008, at Anchorage, Alaska.

LAW PROJECT FOR PSYCHIATRIC RIGHTS

By: _____
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[94] Tr. 183 (May 14, 2008).
[95] Tr. 181 & Tr. 183 (May 14, 2008). Tr. 215 (May 15, 2008).
[96] Tr. 215 (May 15, 2008). However, Dr. Hopson admitted API had made an exception in the past for Appellant, by providing outpatient services it doesn't normally provide when it involved drugging. Tr. 233 (May 15, 2008).
[97] 344 F.Supp. at 392.
[98] 503 F.2d at 1315.

Exhibits

A. Petition for Court Approval of Administration of Psychotropic Medication (Forced Drugging Petition).

B. Findings and Order Concerning Court-Ordered Administration of Medication, dated May 19, 2008 (Forced drugging Order).

C. Limited Entry of Appearance with selected attachments thereto.

D. Grace E. Jackson Curriculum Vitae.

E. Report of Grace E. Jackson, MD (Jackson Report).

F. Evidence Rule 804(b)(1) testimony of Loren R. Mosher, MD, in 3AN 07-277 CI (Mosher Testimony) and Sarah Porter in 3AN 07-1064 PR.

G. Affidavit of Robert Whitaker (Whitaker Affidavit).

H. Affidavit of Grace E. Jackson, MD (Dr. Jackson Affidavit).

I. Affidavit of Ronald Bassman, PhD.

J. Affidavit of Paul Cornils.

K. Notice Re: Discharge

L. Transcript of March 14, 2008, 30-Day Involuntary Commitment hearing in 3AN 08-416 PR.

M. Conditional Limited Entry of Appearance in 3AN 08-00416 PR.

N. Order of Dismissal of Petition for Commitment in 3AN 08-416 P/S