

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

**COPY**  
Original Received  
Probate Division

APR 30 2008

Clerk of the Trial Court

**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<sup>1</sup> 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

<sup>1</sup> 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.

MAR 10 2008

Clerk of the Trial Court

Law Project for Psychiatric Rights  
406 G Street, Suite 206  
Anchorage, AK 99501  
907-274-7686 phone  
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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*,<sup>1</sup> and moves for an order requiring API to provide the following less intrusive alternative:<sup>2</sup>

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.<sup>3</sup> API shall first attempt to negotiate an acceptable abode, and failing that procure it and make it available to Mr. Bigley.

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<sup>1</sup> 138 P.3d 238 (Alaska 2006).

<sup>2</sup> 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.

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 Cornils, Affidavit of Ronald Bassman, PhD., and Affidavit of Robert Whitaker, all filed March 6, 2008.

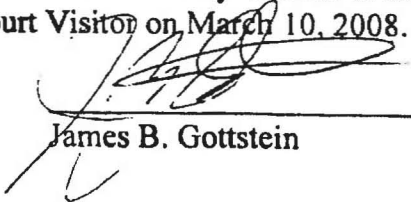
DATED: March 10, 2008.

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

<sup>3</sup> API may seek to obtain a housing subsidy from another source, but such source may not be his Social Security Disability income.

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**COPY**  
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MAR 06 2008

Attorney for Respondent

Clerk of the Trial Court

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.<sup>1</sup> A key component of this strategic campaign is to rectify that judges ordering people to take these

<sup>1</sup> Forced electroshock is not administered in Alaska to my knowledge.



drugs are being misled about them.<sup>2</sup> 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,<sup>3</sup> 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.<sup>4</sup>

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

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<sup>2</sup> 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.

<sup>3</sup> 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.

<sup>4</sup> This will be discussed below.

<sup>5</sup> 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.<sup>6</sup> 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.<sup>7</sup>

## **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.<sup>8</sup>

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<sup>6</sup> 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.

<sup>7</sup> Mr. Bigley, of course, is entitled to the lawyer of his choice, if he can obtain such representation.

<sup>8</sup> 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).<sup>9</sup>

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

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."<sup>12</sup>

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.<sup>13</sup>

This pattern was set by his third admission to API as described in the Discharge Summary 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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<sup>9</sup> Appendix 1.

<sup>10</sup> Appendix 1.

<sup>11</sup> Appendix 5.

<sup>12</sup> Appendix 8.

<sup>13</sup> 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)."<sup>14</sup> 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.<sup>15</sup>

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."<sup>16</sup>

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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<sup>14</sup> 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.

<sup>15</sup> Appendix 11.

<sup>16</sup> 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." <sup>17</sup> 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. <sup>18</sup>

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. <sup>19</sup>

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<sup>17</sup> Appendix 15.

<sup>18</sup> 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.

<sup>19</sup> Tr. 4/3/07:216 *et. seq.* (3AN 07-247 PR).

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.<sup>20</sup>

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

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.<sup>23</sup>

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*.<sup>24</sup>

#### **(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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<sup>20</sup> *Id.*

<sup>21</sup> *Id.*

<sup>22</sup> Tr. 4/3/07:208. (3AN 07-247 PR).

<sup>23</sup> See, e.g., Tr. 4/3/07:202 (3AN 07-247 PR).

<sup>24</sup> Appendix 19.

commitment for not taking Depakote as prescribed.<sup>25</sup> 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.<sup>26</sup>

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

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<sup>25</sup> 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.

<sup>26</sup> Appendix 25-26.

<sup>27</sup> 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.<sup>28</sup>

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<sup>28</sup> ¶B of Paul Cornils Affidavit.



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.<sup>29</sup>

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.<sup>30</sup>

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.<sup>31</sup>

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.<sup>32</sup>

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.<sup>33</sup>

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<sup>29</sup> ¶C of Paul Cornils Affidavit.

<sup>30</sup> ¶D of Paul Cornils Affidavit.

<sup>31</sup> ¶E of Paul Cornils Affidavit.

<sup>32</sup> ¶F of Paul Cornils Affidavit.

<sup>33</sup> ¶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*,<sup>34</sup> 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.<sup>35</sup>

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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<sup>34</sup> MDL 1596, United States District Court for the Eastern District of New York.

<sup>35</sup> 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 Zyprexa 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."

- (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.<sup>36</sup>
- 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,

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

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*.<sup>37</sup>

#### (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.<sup>38</sup>

### 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

<sup>37</sup> 38 P.3d at 254, emphasis added.

<sup>38</sup> 3AN 08-1064PR

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."<sup>39</sup>

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).<sup>40</sup>

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

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.

<sup>39</sup> Deniker, P. "The neuroleptics: a historical survey." *Acta Psychiatrica Scandinavica* 82, supplement 358 (1990):83-87.

<sup>40</sup> Cole, J, et al. "Phenothiazine treatment in acute schizophrenia." *Archives of General Psychiatry* 10 (1964):246-61.

<sup>41</sup> 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.<sup>42</sup>

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.<sup>43, 44, 45</sup> 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

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

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

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

<sup>45</sup> 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.

a patient who had developed such a supersensitivity is determined by more than just the normal course of the illness.<sup>46</sup>

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.<sup>47, 48, 49</sup> 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.<sup>50</sup>

#### **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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<sup>46</sup> 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.

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

<sup>48</sup> 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.

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

<sup>50</sup> 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.<sup>51, 52, 53</sup>

- 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.<sup>54, 55, 56, 57</sup> 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.<sup>58</sup>
- 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

<sup>51</sup> Harding, C. "The Vermont longitudinal study of persons with severe mental illness," *American Journal of Psychiatry* 144 (1987):727-34.

<sup>52</sup> Harding, C. "Empirical correction of seven myths about schizophrenia with implications for treatment." *Acta Psychiatrica Scandinavica* 90, suppl. 384 (1994):140-6.

<sup>53</sup> McGuire, P. "New hope for people with schizophrenia," *APA Monitor* 31 (February 2000).

<sup>54</sup> Ciompi, L, et al. "The pilot project Soteria Berne." *British Journal of Psychiatry* 161, supplement 18 (1992):145-53.

<sup>55</sup> 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.

<sup>56</sup> Cullberg J. "One-year outcome in first episode psychosis patients in the Swedish Parachute Project. *Acta Psychiatrica Scandinavica* 106 (2002):276-85.

<sup>57</sup> Lehtinen V, et al. "Two-year outcome in first-episode psychosis according to an integrated model. *European Psychiatry* 15 (2000):312-320.

<sup>58</sup> Seikkula J, et al. Five-year experience of first-episode nonaffective psychosis in open-dialogue approach. *Psychotherapy Research* 16/2 (2006): 214-228.



15-year followup exams, versus five percent of the medicated patients.<sup>59</sup>

## 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."<sup>60</sup> 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.<sup>61, 62, 63, 64, 65</sup>

<sup>59</sup> 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.

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

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

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

<sup>63</sup> Van Putten, T. "The many faces of akathisia," *Comprehensive Psychiatry* 16 (1975):43-46.

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

<sup>65</sup> Galyner, I. "Akathisia as violence." *Journal of Clinical Psychiatry* 58 (1997):16-24.

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.”<sup>66</sup> The quality of life on conventional neuroleptics, researchers agreed, is “very poor.”<sup>67</sup>

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.”<sup>68</sup>

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.<sup>69, 70, 71</sup> Schizophrenia patients now commit suicide at 20 times the rate they did prior to the use of neuroleptics.<sup>72</sup>

<sup>66</sup> Van Putten, T. “The board and care home.” *Hospital and Community Psychiatry* 30 (1979):461-464.

<sup>67</sup> Weiden P. “Atypical antipsychotic drugs and long-term outcome in schizophrenia.” *Journal of Clinical Psychiatry* 57, supplement 11 (1996):53-60.

<sup>68</sup> Keefe, R. “Do novel antipsychotics improve cognition?” *Psychiatric Annals* 29 (1999):623-629.

<sup>69</sup> Arana, G. “An overview of side effects caused by typical antipsychotics.” *Journal of Clinical Psychiatry* 61, supplement 8 (2000):5-13.

<sup>70</sup> Waddington, J. “Mortality in schizophrenia.” *British Journal of Psychiatry* 173 (1998):325-329.

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

<sup>72</sup> Healy, D et al. “Lifetime suicide rates in treated schizophrenia.” *British Journal of Psychiatry* 188 (2006):223-228.

## 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."<sup>73</sup>

18. After Risperdal (risperidone) was approved, physicians who weren't funded by Janssen 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.<sup>74, 75, 76, 77, 78</sup> Jeffrey Mattes, director of the Psychopharmacology Research Association, concluded in 1997: "It is possible, based on the available studies, that risperidone is not

<sup>73</sup> FDA approval letter from Robert Temple to Janssen Research Foundation, December 21, 1993.

<sup>74</sup> Rosebush, P. "Neurologic side effects in neuroleptic-naïve patients treated with haloperidol or risperidone." *Neurology* 52 (1999):782-785.

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

<sup>76</sup> Sweeney, J. "Adverse effects of risperidone on eye movement activity." *Neuropsychopharmacology* 16 (1997):217-228.

<sup>77</sup> Carter, C. "Risperidone use in a teaching hospital during its first year after market approval." *Psychopharmacology Bulletin* 31 (1995):719-725.

<sup>78</sup> 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.”<sup>79</sup> 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.<sup>80</sup>

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.”<sup>81</sup>

<sup>79</sup> Mattes, J. “Risperidone: How good is the evidence for efficacy?” *Schizophrenia Bulletin* 23 (1997):155-161.

<sup>80</sup> See Whitaker, R. *Mad in America*. New York: Perseus Press (2002):279-281.

<sup>81</sup> 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 there 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.<sup>82</sup>

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.<sup>83</sup> 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.<sup>84</sup>

## 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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<sup>82</sup> Lieberman, J, et al. "Effectiveness of antipsychotic drugs in patients with schizophrenia." *New England Journal of Medicine* 353 (2005):1209-1233.

<sup>83</sup> Davies, L, et al. "Cost-effectiveness of first- v. second-generation antipsychotic drugs." *The British Journal of Psychiatry* 191 (2007):14-22.

<sup>84</sup> 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)



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

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,

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<sup>85</sup> Tr. 9/5/2007:73-81.

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.



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

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 Cornils, 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 Cornils 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

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

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.

Probate Rule 2(b)(3)(D) impermissibly dispenses with statutory protections as well as the constitutional protections *Wetherhorn* requires.<sup>86</sup> 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,<sup>87</sup> 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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<sup>86</sup> 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*.

<sup>87</sup> 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.<sup>88</sup>

**(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:<sup>89</sup>

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*,<sup>90</sup>:

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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<sup>88</sup> 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.

<sup>89</sup> 138 P.2d 238, 242-3 (Alaska 2006), emphasis added.

<sup>90</sup> 156 P.3d 371, 382 (Alaska 2007), footnotes omitted.

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;<sup>91</sup>

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.<sup>92</sup> 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;

<sup>91</sup> 156 P.3d at 382, emphasis added.

<sup>92</sup> 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; . . . <sup>93</sup>

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. <sup>94</sup>

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."). <sup>95</sup>

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<sup>93</sup> 138 P.3d 252, emphasis added.

<sup>94</sup> *Id.*

<sup>95</sup> 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.



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

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,     )  
\_\_\_\_\_     )  
Case No. 3AN 08-00247 PR

**APPENDIX TO SUBMISSION FOR REPRESENTATION HEARING**

ALASKA PSYCHIATRIC INSTITUTE

HOSPITAL RECORD

SOCIAL HISTORY

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

Date: 4/18/80

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.

Appendix, p 1

ALASKA PSYCHIATRIC INSTITUTE

HOSPITAL RECORD

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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.

ALASKA PSYCHIATRIC INSTITUTE

HOSPITAL RECORD

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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

*This information is provided for  
your information only. It is not to be  
used for legal purposes. It is to be  
used for informational purposes only.  
It is not to be used for legal purposes.  
It is to be used for informational purposes only.  
It is not to be used for legal purposes.  
It is to be used for informational purposes only.*

ALASKA PSYCHIATRIC INSTITUTE

HOSPITAL RECORD

SAU	
Randy Gager, NA III	ADMISSION DATA BASE
4/15/80	
<i>[Signature]</i>	
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



ALASKA PSYCHIATRIC INSTITUTE

HOSPITAL RECORD

SAU  
Randy Gager, NA III  
4/30/80

DISCHARGE ASSESSMENT NOTE

*Randy Gager NA III*  
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

Appendix, p 5

Exhibit C, page 43 of 57

ALASKA PSYCHIATRIC INSTITUTE

HOSPITAL RECORD

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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

ALASKA PSYCHIATRIC INSTITUTE

HOSPITAL RECORD

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.

ALASKA PSYCHIATRIC INSTITUTE

HOSPITAL RECORD

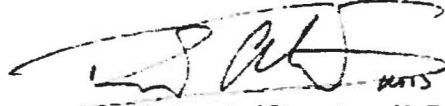
PATIENT: BIGLEY, William  
CASE #: 00-56-65

Discharge Summary - con't.  
Page 2

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

Information is provided and  
not to be used for anything  
other than medical purposes  
without the patient's  
written consent.

ALASKA PSYCHIATRIC INSTITUTE  
HOSPITAL RECORD

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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.

ALASKA PSYCHIATRIC INSTITUTE  
HOSPITAL RECORD

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Patient: BIGLEY, William Stanley  
Case # : 00-56-65  
Discharge Summary/Page 2

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.



ALASKA PSYCHIATRIC INSTITUTE  
HOSPITAL RECORD

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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 arrangements were made for discharge.

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

ALASKA PSYCHIATRIC INSTITUTE  
HOSPITAL RECORD

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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.

RM/sjb

*Robert Marshall*

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 68<sup>th</sup> 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

Information is provided and  
your facility's use (according  
guardian's authorization). Any  
information to other parties without  
the consent of patient/guardian  
is a breach of confidentiality

### DISCHARGE SUMMARY (ER)

PATIENT: BIGLEY, William

CASE #: 00-56-65

ADMITTING UNIT: KATMAI

ADMISSION DATE: 02/22/07

DISCHARGE DATE: 03/14/07

PAGE 1 of 4

Appendix, p 13

Exhibit C, page 51 of 57

# ALASKA PSYCHIATRIC INSTITUTE HOSPITAL RECORD

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

## DISCHARGE SUMMARY (ER)

PATIENT: BIGLEY, William  
CASE #: 00-56-65  
ADMITTING UNIT: KATMAI

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ADMISSION DATE: 02/22/07  
DISCHARGE DATE: 03/14/07  
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# ALASKA PSYCHIATRIC INSTITUTE

## HOSPITAL RECORD

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### 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.

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### DISCHARGE SUMMARY (ER)

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CASE #: 00-56-65  
ADMITTING UNIT: KATMAI

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ADMISSION DATE: 02/22/07  
DISCHARGE DATE: 03/14/07  
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# ALASKA PSYCHIATRIC INSTITUTE HOSPITAL RECORD

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## 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)  
dr/ft. 03/23/07

Information is provided and  
to your facility's use (according  
guardian's authorization). An  
to other parties without  
consent of patient/guardian  
a breach of confidentiality

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## DISCHARGE SUMMARY (ER)

PATIENT: BIGLEY, William  
CASE #: 00-56-65  
ADMITTING UNIT: KATMAI

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ADMISSION DATE: 02/22/07  
DISCHARGE DATE: 03/14/07  
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## ALASKA PSYCHIATRIC INSTITUTE HOSPITAL RECORD

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**IDENTIFYING DATA:** This is the 68<sup>th</sup> 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

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### ADMISSION DATA BASE

PATIENT: BIGLEY, William

ADMISSION DATE: 02/22/07

CASE #: 00-56-65

ADMITTING UNIT: KATMAI

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**ALASKA PSYCHIATRIC INSTITUTE  
HOSPITAL RECORD**

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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.

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**ALASKA PSYCHIATRIC INSTITUTE  
HOSPITAL RECORD**

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**ADMITTING DIAGNOSIS:**

Axis I: Schizoaffective Disorder. Bipolar Type.

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Axis III: Gastroesophageal reflux disease.

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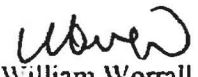
Axis IV: Stressors: Other psychosocial and environmental problems.

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)  
dr/ft. 03/02/07

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**ADMISSION DATA BASE**

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