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

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

LIMITED ENTRY OF APPEARANCE

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

DATED: April 29, 2008.

Law Project for Psychiatric Rights

By: _____
James B. Gottstein
ABA # 7811100

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

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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*,[1] and moves for an order requiring API to provide the following less intrusive alternative:[2]

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

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

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

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

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

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

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

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

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

Tim Twomey (907) 269-5168 direct

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

Hi Ron,

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

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

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

Hi Tim, Elizabeth, Linda, Beth and Kelly,

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

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

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

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

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

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

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

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

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

--

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

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USA
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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 PR

SUBMISSION FOR REPRESENTATION HEARING

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

I. Background

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

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

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

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

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

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

[4] This will be discussed below.

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

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

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

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

II. Mr. Bigley's History and Previous Proceedings

(A) Respondent's History

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

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

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

[8] Appendix 1-8.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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[17] Appendix 15.

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

[19] Tr. 4/3/07:216 *et. seq.* (3AN 07-247 PR).

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

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

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

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

(B)2007 Involuntary Commitment and Forced Drugging Proceedings

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

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

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

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

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

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

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

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

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

[26] Appendix 25-26.

[27] 3AN 07-1064PR.

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

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

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

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

[28] ¶B of Paul Cornils Affidavit.

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

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

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

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

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

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

(D) 2006/2007 Guardianship Proceedings

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

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

(1) Terminate the Guardianship.

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

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

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

---

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

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

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

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

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

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

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

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

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

III. Substantive and Procedural Matters

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

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

(A) Best Interests

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

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

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

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

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

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

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

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

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

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

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

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

[41] Gilbert, P, et al. "Neuroleptic withdrawal in schizophrenic patients." *Archives of General Psychiatry* 52 (1995):173-188.

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III. Evidence Revealing Increased Chronicity of Psychotic Symptoms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

V. Harmful Side Effects from Antipsychotic Medications

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

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

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

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

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

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

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

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

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

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

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

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

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

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[66] Van Putten, T. "The board and care home." *Hospital and Community Psychiatry* 30 (1979):461-464.
[67] Weiden P. "Atypical antipsychotic drugs and long-term outcome in schizophrenia." *Journal of Clinical Psychiatry* 57, supplement 11 (1996):53-60.
[68] Keefe, R. "Do novel antipsychotics improve cognition?" *Psychiatric Annals* 29 (1999):623-629.
[69] Arana, G. "An overview of side effects caused by typical antipsychotics." *Journal of Clinical Psychiatry* 61, supplement 8 (2000):5-13.
[70] Waddington, J. "Mortality in schizophrenia." *British Journal of Psychiatry* 173 (1998):325-329.
[71] Joukamaa, M, et al. Schizophrenia, neuroleptic medication and mortality. *British Journal of Psychiatry* 188 (2006):122-127.
[72] Healy, D et al. "Lifetime suicide rates in treated schizophrenia." *British Journal of Psychiatry* 188 (2006):223-228.

VI. The Research Literature on Atypical Antipsychotics

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

VII. Conclusion

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

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

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

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

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

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

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

(B)There is a Less Intrusive Alternative Available

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

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

(citations omitted, italics in original, underlining added)

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

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

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

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

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

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

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

A There are. Indeed. Yes, indeed.

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

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

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

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

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

A I do.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A It does, indeed. Yes.

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

A In many cases, yes. . . .

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

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

The affidavit of Paul 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

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

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

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

IV. Procedural Issues

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

(A) Objection to Referral to the Probate Master.

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

(1) Objections to an Unfavorable Recommendation Will Be Filed

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

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

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

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

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

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

(emphasis added).

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

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

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

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

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

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

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

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

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

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

(B)The Forced Drugging Petition is Premature

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

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

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

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

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

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

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

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

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

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

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

---

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

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

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

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

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

(2) the risks of adverse side effects;

. . . ; and

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

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

Sell v. United States, 539 U.S. 166, 123 S.Ct. 2174 (2003), a forced drugging to make one competent to stand trial case, based on the requirements of the United States Constitution, also requires a drug by drug analysis ("The specific kinds of drugs at issue may matter here as elsewhere. Different kinds of antipsychotic drugs may produce different side effects and enjoy different levels of success."). [95]

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[93] 138 P.3d 252, emphasis added.
[94] *Id.*
[95] While *Sell* is a competence to stand trial case, the U.S. Supreme Court used the same sort of standard constitutional law compelling state interest, further state interest and least intrusive alternative analysis the Alaska Supreme Court employed in *Myers* and is fully applicable here with respect to this issue.

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

V. Motion for Settlement Conference

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

DATED: March 6, 2008.

Law Project for Psychiatric Rights

By: _____
James B. Gottstein, Esq.
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IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
THIRD JUDICIAL DISTRICT, AT ANCHORAGE

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

Case No. 3AN 08-00247 PR

APPENDIX TO SUBMISSION FOR REPRESENTATION HEARING

ALASKA PSYCHIATRIC INSTITUTE

HOSPITAL RECORD

SOCIAL HISTORY

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

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

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

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

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

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

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

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

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

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

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

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

Patient's religious preference is Nazarene.

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

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

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

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

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

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

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

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

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

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

Severity: 4, moderate.

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

Annie Bowen

Annie Bowen, MSW

AB:dh

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

SAU
Randy Gager, NA III
4/15/80

ADMISSION DATA BASE

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

RG/sjb

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

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

SAU
Randy Gager, NA III
4/30/80

DISCHARGE ASSESSMENT NOTE

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

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

(DISCHARGE) WHAT PATIENT VERBALIZES AS FOLLOW-UP CARE

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

RG/sjb

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

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.

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

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

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

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

RA/ojb

Robert Alberts, M.D.
Staff Psychiatrist

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

ALASKA PSYCHIATRIC INSTITUTE

HOSPITAL RECORD

DISCHARGE SUMMARY

PATIENT: BIGLEY, William Stanley ADMISSION DATE: 2/27/81
CASE # : 00-56-65 DISCHARGE DATE: 5/04/81

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

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

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

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

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

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

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

No psychological studies were secured during this hospitalization.

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

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 Ludiomil was discontinued. Haldol was once again increased to 20 mg. t.i.d., on 4/3/81. Efforts to decrease or discontinue Cogentin were unsuccessful, so that he required relief of EPS with regular use of Cogentin. On 4/27/81 the Haldol was discontinued in favor of what was hoped to be the less sedative Navane 40 mg. h.s. He required intravenous Cogentin on the day after Navane was started, but thereafter, responded well to Navane with less sluggishness and waxy, bodily movements. His spirits improved, that he was able to be quietly pleasant in his interactions with unit staff members for the first time. He had reached maximum benefit from hospitalization, and arrangments were made for discharge.

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

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

FINAL DIAGNOSIS:

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

Axis II: Diagnosis confined to Axis I.

Axis III: No significant diagnosis.

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

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

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

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

Robert Marshall

RM/sjb

Robert Marshall, M.D.
Staff Psychiatrist

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

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

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

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

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

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

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

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

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

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

See what well means on page 2.

Contradicted by page 2

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

Where is documentation of necessity. Myers and/or

ADMITTING DIAGNOSIS:

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

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

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

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

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

FINAL DIAGNOSIS:

Axis I: Schizoaffective Disorder, Bipolar Type.

Caffeine Abuse.

Nicotine Dependence.

Axis II: Paranoid Personality Traits.

Axis III: Gastroesophageal reflux disease, by history.

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

Axis V: GAF: 35.

PROGNOSIS: Poor.

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

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

William A. Worrall, MD
Staff Psychiatrist

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ADMITTING DIAGNOSIS:

Axis I: Schizoaffective Disorder. Bipolar Type.

Caffeine Intoxication.

Nicotine Dependence.

Axis II: No diagnosis.

Axis III: Gastroesophageal reflux disease.

History of anorexia.

Axis IV: Stressors: Other psychosocial and environmental problems.

Axis V: GAF: 20.

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

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

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

William Worrall, MD
Staff Psychiatrist

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

Anchorage Community Mental Health Services

Medical Progress Note

Medication Compliance:	suspected poor
Medication Response:	poor
Change in Allergies:	none
Side Affects:	none identified
Review of Tests:	none
Assessment:	Bill presents grossly disorganized. Medication adherence is suspected to be poor. Early Release expires 3/25, and if depakote level indicates nonadherence, we will proceed with application to have Early Release revoked.
Plan:	Will check depakote level today. If level is now subtherapeutic, will proceed with application for revocation of Early Release.
Next Appointment:	Other - to be arranged

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

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
AT _____

In the Matter of the Necessity for the Hospitalization of:

William Bigler,
Respondent.

Case No. 3AN-07-247PR

NOTICE TO OUTPATIENT TO RETURN TO TREATMENT FACILITY WHERE COMMITTED

To: William Bigler
1555 Nechinost #7
Anchorage, AK 99501

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

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

3-19-07
Date

Signature of Provider of Outpatient Care

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

Scott A. Rasset
Printed Name

Utilization Review Associate
Title

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

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

By: _____
Outpatient Care Provider

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

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

AS 47.30.795(c)

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
AT ANCHORAGE

In the Matter of the Necessity for the Hospitalization of:	)	
WILLIAM BIGLEY, Respondent.	)	Case No. 3AN-07-0247 PR

Order

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

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

3/20/07
Date

Superior Court Judge
MICHAEL L. WOLVERTON

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

Clerk:

Recommended for approval on a
March 20, 2007

Probate Master

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA AT _____

In the Matter of the Necessity for the Hospitalization of:

William Eagler, Respondent.

Case No. 3AN-07-247PR

State Trooper Directions for Service

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

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

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

To Serve: RESPONDENT NAMED ABOVE

Address where respondent is at this time 1555 Arlington Dr. #7

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

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

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

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

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

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

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

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

RETURN OF SERVICE

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

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

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

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

Return Date _____

Commissioner of Public Safety

By _____

Printed Name _____

Title _____

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

ALASKA PSYCHIATRIC HOSPITAL

Report Contact

AT

William S

Reguarding: BIGLEY ,BILL

Date: 03/19/2007

Time: 15:42

Patient Type: Prior Patient

APH No.: 00 56 65

Adult

Person Making Referral:

SCOTT

Agency:

ACMHS

Phone # of Agency:

City/State:

Seeking: Information Only

Contact Type: Telephone Contact

Legal:

Still Pending

Brief Statement of Problem or Situtation

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

RdN
3/20/07

DISTRIBUTION

ORIGINAL: Medical Record Services
COPIES TO:

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

Time Spent on Contact:

Recorded By:
LLS_LAUREL_L_SILBERSCHMIDT, LCSW
BIGLEY ,BILL

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

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

SPECIAL VERDICT FORM
(Commitment)

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

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

6 (Number of jurors answering yes)

_____ (Number of jurors answering no)

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

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

_____ (Number of jurors answering yes)

6 (Number of jurors answering no)

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

_____ (Number of jurors answering yes)

_____6_____ (Number of jurors answering no)

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

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

_____ (Number of jurors answering yes)

_____ (Number of jurors answering no)

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

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

_____ (Number of jurors answering yes)

_____ (Number of jurors answering no)

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

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

_____ (Number of jurors answering yes)

_____ (Number of jurors answering no)

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

If at least five jurors answered yes to:

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

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

Verdict: Verdict for the Respondent, William Bigley

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

DATED: 6/26/07

Printed name of foreperson Jane S. Keith

Signature of foreperson Jane S. Keith

[redacted]

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

ALASKA PSYCHIATRIC INSTITUTE

DATE	TIME	ORDER	NURSE SIGNATURE
3-21-07	1134	Pt from court ordered meds 90 Day TDO/med petition renewal Risperidone Consta 50 mg IM q 2 wks Starting 3/22/07 Quetiapine 300 mg po BID Divalproex ER 500 mg po BID	Filed
		request Depakote Level Monday if compliant if refuses scheduled BID meds give ziprasidone 20 mg IM up to BID 2x/24 hrs	(Cmy)
		Oral PRN: olanzapine zydis 10 mg po q 1 hr prn agitated state NTE 3x 24 hrs	
		If refuses oral PRN: olanzapine IM 10 mg q 1 hr NTE 3x/24 hrs for ag. d/t/b state for safety of self/others	
3/21/07	1105	Olanzapine 10 mg + lorazepam 2 mg IM Now for BOR Warrall/Stanford 3-22-07 10:00	
3-22-07	1010	Pt to go to court at 330 downtown for 90 day hearing Stand at UNLESS case is continued	330

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

Please write or print legibly.
Please use ball point pen.

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

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

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

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

AFFIDAVIT OF ROBERT WHITAKER

STATE OF MASSACHUSETTS)
) ss.
SUFFOLK COUNTY)

By Robert Whitaker

I. Personal Background

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

III. Evidence Revealing Increased Chronicity of Psychotic Symptoms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

V. Harmful Side Effects from Antipsychotic Medications

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

VI. The Research Literature on Atypical Antipsychotics

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

VII. Conclusion

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

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

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

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

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

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

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

Robert B. Whitaker

Robert Whitaker

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

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

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

State of Alaska)
)ss
Third Judicial District)

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

Dated: March 6, 2008

James B. Gottstein

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

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

Lisa E. Smith

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

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

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

AFFIDAVIT OF RONALD BASSMAN, PhD

STATE OF NEW YORK)
) ss.
ALBANY COUNTY)

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

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

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

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

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

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

- T.D. Survivor, Washington, DC

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

- T.D. Survivor, New York

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

- T.D. Survivor, Louisiana

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

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

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

*Recovery is the reawakening of hope after despair.

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

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

*Recovery is active coping rather than passive adjustment.

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

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

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

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

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

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

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

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

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

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

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

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

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[10] Onken S. et al. Mental Health Recovery: What Helps and What Hinders: A National Research Project for the development of Recovery Facilitating System Performance Indicators, Prepared for National Technical Assistance Center for State Mental Health Planning, National Association of State Mental Health Program Directors, 2002.

[11]Anthony W. Recovery from mental illness: The guiding vision of the mental health system in the 1990s, An Introduction to Psychiatric Rehabilitation, ed. The Publications Committee of IAPRS, Boston University, 1994.

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

[13] Harding C.M. Zahniser J.H. Empirical correction of seven myths about schizophrenia with implications for treatment. Acta Psychiatr Scand, 90 (suppl 384): 140-146, 1994.

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

Ronald Bassman, PhD

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

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

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

State of Alaska)
)ss
Third Judicial District)

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

Dated: March 6, 2008

James B. Gottstein

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

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

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

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

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

Case No. 3AN 07-1064 P/S

AFFIDAVIT OF PAUL A. CORNILS

STATE OF ALASKA)
) ss.
THIRD JUDICIAL DISTRICT)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FURTHER YOUR AFFIANT SAYETH NAUGHT.

DATED September 12, 2007.

By: Paul A. Cornils
Paul A. Cornils

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

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

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

State of Alaska)
)ss
Third Judicial District)

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

Dated: March 6, 2008

James B. Gottstein

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

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

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