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 08-1252PR

APPENDIX TO
RESPONDENT'S HISTORY

ALASKA PSYCHIATRIC INSTITUTE
HOSPITAL RECORD

SOCIAL HISTORY UPDATE

PATIENT: BIGLEY, William S.
CASE #: 00-56-65 DATE: 3/3/93

IDENTIFYING DATA: This is the tenth API admission for this 40-year-old, divorced, Aleut, Caucasian, unemployed male admitted on a 90-day commitment, transferred from Mt. Edgecumbe Hospital in Sitka where he has completed a 30-day commitment. Information for this history is obtained through review of the records, as well as contact with the case management staff at the Sitka Mental Health Center where Mr. Bigley receives case management services. There are currently no outstanding legal issues. Reliability of information obtained from the Mental Health Center is considered to be good. Mr. Bigley is very delusional, angry, paranoid, and hostile, and is unable to provide any information for this report.

PRESENTING PROBLEM & SUBJECTIVE SYMPTOMS: The reason for this admission is Mt. Edgecumbe's inability to hospitalize people who are on a 90-day commitment. Therefore, it was necessary to transfer Mr. Bigley to API. The precipitant of his hospitalization at Mt. Edgecumbe was his decompensation and experiencing of severe psychotic symptoms of delusional thought and paranoia. He became very agitated, threatening, and menacing. He made specific threats to kill other people. This is a reflection of worsening of his condition, as his threats are usually rather vague and general and somewhat magical in nature. In addition to the threatening behavior, Bill also was fearing that his food and medication were poisoned. As result of this, he was not eating and was losing a considerable amount of weight, thereby endangering his health.

PREVIOUS PSYCHIATRIC TREATMENT: Bill has been treated nine times previously at API. He receives outpatient follow-up services through Sitka Mental Health Center, where Dr. Read is his psychiatrist and Rae Baggon is his case manager. Phone number for the Mental Health Center is 747-8994. In addition to hospitalizations at API, Bill has been hospitalized several times at Mt. Edgecumbe Hospital. According to case management staff, several brief admissions occurred there between Bill's last discharge from API on 9/30/92 and his recent admission to Mt. Edgecumbe which occurred approximately a month ago.

MOST RECENT HISTORY: After his last discharge from API, Bill went to Sitka where he lives in an apartment supported by the Sitka Mental Health Center. He supports himself on Social Security and public assistance. According to case management, Bill almost immediately ceased taking his Clozaril, claiming that its unwanted side effects were too unpleasant to warrant his continuing taking it. His mental status began to deteriorate, and he exhibited the paranoia and delusional thought that is so characteristic of his decompensation. Several brief admissions to Mt. Edgecumbe Hospital occurred. Occasionally these were precipitated by Bill's experiencing and expressing suicidal impulses. After brief stays when he would become stabilized

on medication, he would request discharge, and no longer being suicidal, he would be released from Mt. Edgecumbe. According to the Mental Health Center staff, alcohol and street drugs do not figure into the difficulties that Bill has been experiencing recently.

As referred to earlier in this report, Bill began to make very specific and personalized threats toward others, particularly his wife whom he threatened to kill with a shotgun as the result of her interfering with his visitation of his two daughters. Mental Health Center staff indicates that this is a very different behavior for Bill, who usually does not get so specific in making his threats. It was felt to represent a deterioration from his normal baseline. Delusional beliefs about food and medication being poisoned caused Bill to be medication noncompliant. He also stopped eating. It was felt that the combination of all of these behaviors constituted grounds for commitment. While committed at Mt. Edgecumbe Hospital, he began to refuse to cooperate with medication, thereby causing his condition to remain essentially unchanged. He was also found to be gravely disabled and was committed for 90 days and then transferred to API. According to the Mental Health Center staff, Bill was extremely upset by the death of a friend of his daughter's by suicide, which occurred just prior to his commitment to Mt. Edgecumbe Hospital. His daughters were quite close to this girl, and Bill also is said to have known her rather well and been quite upset by her suicide and its impact on his daughters. Apparently, Bill's paranoia is also extending to the mental health community about whom he is expressing delusional beliefs.

POST-HOSPITAL RESOURCES: Upon discharge from API, Bill will return to live in his apartment in Sitka and will continue to receive follow-up services through Sitka Mental Health Center. His source of financial support will continue to be Social Security and public assistance. His emotional supports will also be the same. He has two teenage daughters that he sees regularly. He also has a number of friends with whom he socializes.

CLINICAL SOCIAL WORK ASSESSMENT: Reveals a 40-year-old, unemployed, divorced Aleut/Caucasian male admitted for his tenth API admission on a 90-day commitment. He experienced severe stress as a result of the suicide of a friend of his daughters'. This occurred at a time when Bill was noncompliant with medication and was also experiencing paranoid delusions that were causing him not to eat because he thought his food was poisoned. The combination resulted in his needing to be committed for psychiatric hospitalization. Medication noncompliance is an ongoing problem that has resulted in frequent decompensation and hospitalization for Mr. Bigley. Efforts to insure medication compliance are the primary requirement for enabling Bill to maintain himself successfully in the community. Clinical social work services will involve promoting the idea of medication being helpful to maintain his mental status.

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

Coordination of discharge planning with the Sitka Mental Health Center will also be a Social Work responsibility.

Michael Campbell M.S.W.

Michael Campbell, MSW
Clinical Social Worker

MC/bj/BJSH7 5007

d. 3/3/93
t. 3/9/93

dr./ft. 3/11/93

IDENTIFYING DATA: This is the 48th admission for Bill who is a 48-year-old, divorced, Aleut male who was referred by the court for a psychiatric examination.

PRESENTING PROBLEM: Bill was admitted for competency to proceed on a petition to revoke his probation.

SOCIAL HISTORY: Since the time of Bill's last discharge on 8/29/01, he has been continuously incarcerated at Cook Inlet Pretrial facility on Mike Mod. He had been compliant with medications of Prolixin IM and oral Prolixin. Bill appears to have lost weight since the time of his discharge in August. He reports that he has an upset stomach from his medication and requests a minor change in his medication. Bill continues to have an apartment in the community. He has a conservator, Kelly Bartholomew, at the Office of Public Advocacy. He maintains regular contact with his mother Rosalee here in town, and has outpatient services with Southcentral Counseling Center and ongoing probation with adult probation here in the Anchorage field office with Bill Burritt, 334-2322. No other changes at this time since the time of his last social history update.

Maesha Champion-Read LCSW

Maesha Champion-Read, LCSW
Clinical Social Worker

MCR/tb/SH/1135E
d. 11/26/01
t. 11/29/01
dr/ft. 12/06/01

IDENTIFYING DATA: This is the 50th Alaska Psychiatric Institute admission for Bill, who is a 49-year-old, divorced, Aleut male who belongs to the Sealaska Corporation.

PRESENTING PROBLEM AND SUBJECTIVE SYMPTOMS: Bill was admitted on 5/31/02 on a Return From Early Release outpatient commitment to the Denali Unit. He was later transferred to Katmai Unit for noncompliance with conditions of his Early Release.

MOST RECENT PSYCHOSOCIAL HISTORY UPDATE: Since the time of his last Social History Update, which was in November of 2001, Bill remained hospitalized until April 30th when he was discharged on an Early Release. He returned on May 12th to the Denali Unit for a brief stay of two days, and was discharged once again on Early Release, to be returned 17 days later on Return From Early Release secondary to noncompliance with his conditions. Bill has continued follow-up with Southcentral Counseling Center's IDP team with poor results. He has multiple complaints about the services he is provided. His complaints include concerns that various people bring him medication. Some of these people he does not know or recognize. He also is not happy with having to wait for up to an hour and a half in the morning and then another hour and a half in the evening to get his prescribed medications. Since the time of Bill's last admission, his clinician and case manager have both changed, and Bill will be working with new staff who have been hired onto the IDP team. He vacillates between wanting to arrange his own follow-up between ANMC and Southcentral Counseling Center. He has a conservator, Kelly Bartholomew at the Office of Public Advocacy, who manages his finances. There is no further current information available at this time.

Maesha Champion-Read LCSW
Maesha Champion-Read, LCSW
Clinical Social Worker

MCR/ga/SOCIALHX/3633E
d. 7/9/02
t. 7/10/02 (draft)
dr/ft. 7/10/02

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

In the Matter of the Guardianship of:

WILLIAM S. BIGLEY,

Respondent.

Case No. 3AN-04-545 PR/G

PETITION FOR TEMPORARY AND PERMANENT GUARDIANSHIP

The State of Alaska, Department of Health and Social Services, through Patricia Garrett, Licensed Clinical Social Worker, whose address is 2900 Providence Drive, Anchorage, Alaska 99508, alleges that the respondent named above is in need of a temporary guardian pursuant to AS 13.26.140 and a guardian under AS 13.26.090, and in support of this petition states as follows:

1. The respondent is William S. Bigley, born January 15, 1953, Social Security Number 574-24-6052, who currently resides at 905 Richardson Vista Building 7, #134, Anchorage, Alaska 99501.

2. Office of Public Advocacy is the respondent's Conservator.

3. The respondent at this time has no guardian and is in need of someone to make responsible decisions concerning his welfare and care.

4. The facts that make the respondent in need of a temporary guardian pending the appointment of a permanent guardian are: Mr. Bigley's has been admitted fifty-seven times to Alaska Psychiatric Institute. His admissions are becoming more frequent with shorter stays outside the hospital. Mr. Bigley's delusional and grandiose thought disorder now involves calling Federal Bureau of Investigations, Senator Ted

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PHONE: (907) 269-5100

Stevens office and tying up telephone lines of Anchorage Police Department 911, which resulted in charges of illegal telephone use. Mr. Bigley was arrested and taken to Cook Inlet Pre-Trial Facility. Mr. Bigley was found incompetent to stand trial due to the severity of his regressed mental status. Mr. Bigley believes he can control the moon, sun and weather. Mr. Bigley believes he receives messages from the news, and has influence on the Iraqi war, the bombing of the Twin Towers and is the personal friend of several United States Presidents. Mr. Bigley is non-compliance with anti-psychotic medications and his actions have become more aggressive in nature. He is at risk of loosing his independent housing. Mr. Bigley's disorted body image causes him to not eat and his extreme weight loss places him at physical risk. Mr. Bigley has become increasingly aggressive and uncooperative, refusing outpatient mental health services. Mr. Bigley has required assistance managing his finances for a long time.

6. The known living relatives of the respondent are:

a. Rosalie Siberling, mother, Mayflower Trailer Park, Anchorage, Alaska (907) 337-1625.

7. Other persons who might be helpful in determining the capacity of the respondent are:

a. Dr. Daniel Thomson, Alaska Psychiatric Institute, 2900 Providence Drive, Anchorage, Alaska 99503, (907) 269-7100.

b. Dr. David Spurbeck, Alaska Psychiatric Institute, 2900 Providence Drive, Anchorage, Alaska 99503, (907) 269-7100.

c. Patricia Garrett, Licensed Clinical Social Worker, Alaska Psychiatric Institute, 2900 Providence Drive, Anchorage, Alaska 99503, (907) 269-7169.

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d. April Mosur-Chapman, Register Nurse, Alaska Psychiatric Institute, 2900 Providence Drive, Anchorage, Alaska 99503, (907) 269-7100.

e. Larry, Landlord, Anchorage, Alaska 99503, (907) 272-2591.

8. The respondent's finances are as follows:

a. On record at Office of Public Advocacy, 900 West Fifth Avenue, Suite 525, Anchorage, Alaska 99501 (907) 269-3500.

WHEREFORE THE PETITIONER PRAYS as follows:

1. For the court to appoint the Office of Public Advocacy, public guardian, as temporary guardian for the above-named respondent, until a permanent guardian can be appointed, pursuant to AS 13.26.140, as the facts herein described demonstrate that the respondent is in need of immediate services to protect him from serious injury, illness or disease.

2. For the court to appoint a permanent guardian for the above named respondent.

3. For the court to appoint an attorney for the respondent pursuant to AS 13.26.106(b).

4. For the court to appoint an expert to investigate the issue of incapacity pursuant to AS 13.26.106(c).

5. For the court to appoint a visitor as defined in AS 13.26.005(8), pursuant to AS 13.26.106(c).

6. For the court to have a hearing on the issue of temporary guardianship within 72 hours of the filing of this petition.

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7. For the court to have a hearing on the issue of guardianship within 120 days of the filing of this petition.

8. For such other and further relief as the court deems necessary and proper.

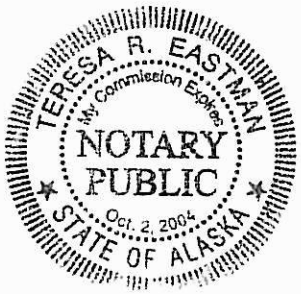
DATED: 4-14-04

STATE OF ALASKA
DEPARTMENT OF HEALTH AND
SOCIAL SERVICES

Patricia Garrett LCSW

Patricia Garrett
Licensed Clinical Social Worker

SUBSCRIBED AND SWORN to before me this 12th day of April 2004.



Teresa R. Eastman

Notary Public in and for Alaska
My commission expires: 10.02.04

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Report of the Visitor

This is the report of Betty L. Wells, court appointed visitor in the matter of the petition for guardianship as well as the review of the conservatorship for Mr. William Bigley, respondent.

This visitor was appointed in 3AN-99-1108 on April 16, 2004 to complete a review of the conservatorship. Mr. Bigley had complaints about how the Office of Public Advocacy was managing his money. A hearing in that case was scheduled for June 3, 2004. The visitor was also appointed on May 3, 2004 following the filing of a guardianship petition by the Alaska Psychiatric Institute, case 3AN-04-0545.

The visitor attempted to meet with Mr. Bigley regarding his concerns about the conservatorship and to notice him of his right to the guardianship case on May 20, 2004 at the Alaska Psychiatric Institute. Several attempts were made to engage William, however he refused to listen or discuss the paperwork with the visitor. A copy of the petition for guardianship was left with him and he was given the visitor's name and the court appointed attorney's name. Mr. Bigley has been in the system for a long time and is familiar with probate court proceedings.

The Office of Public Advocacy was appointed as expert, however a letter from Daniel D. Thomson, MD was filed with the original petition.

Persons contacted for this report include:

William Bigley	Respondent	Last known address 905 Richardson Vista Building 7, #134 Anchorage, Alaska 99501 Present address Alaska Psychiatric Institute 2900ProvidenceDrive Anchorage, Alaska 99508 (907) 269-7100
Pat Garrett	Social Worker	Alaska Psychiatric Institute 2900 Providence Drive Anchorage, Alaska 9908 (907) 269-7100
Daniel Thomson	Expert	Same as above

Kelly Bartholomew	Conservator	Office of Public Advocacy Anchorage, Alaska 99501 (907) 269-3500

PRIOR HISTORY:

William Bigley is a 51-year-old Alaska native male born on January 15, 1953 in Kodiak, Alaska. According to records, Bill moved to Sitka, Alaska as a child. It is not known how far Bill went in school. He does have one brother who reportedly still lives in Sitka.

At one time, Bill was married. He has two grown daughters who live in Sitka. Bill worked at the pulp mill there for many years. In 1996 a conservatorship petition was filed in Juneau and the Office of Public Advocacy was appointed as Bill's conservator. Prior to that appointment, Island Counseling was assisting Bill with financial management. He accused them of theft which when reviewed appeared to be unfounded. Since Bill was living in Southeast, the Juneau OPA office was in charge of his funds.

In 2000, a three-year review was completed on Bill's conservatorship and venue was changed to Anchorage as Bill had been in and out of API and had not returned to Sitka. Bill accused OPA of theft and mismanagement of his funds. At the time, he was on probation for telephone threats to his conservator. He was involved with Quyana House and the IDP program of Southcentral Counseling through the Department of Corrections. As Bill was quite agitated about the restrictions placed on his funds, a hearing was scheduled. The visitor recommended that the conservatorship continue. A hearing was held and the conservatorship continued with no changes.

More recently, Bill has been living in his Richardson Vista apartment. According to Kelly Bartholomew, his OPA conservator, this placement has been stable for almost four years. Unfortunately, Bill's behavior has escalated over the last few months and he was recently evicted. He has had more frequent API admissions in the last six months and appears to have decompensated both physically as well as mentally. During his previous API admission, the petition for guardianship was filed. Bill was discharged but readmitted within a week. When visited on May 20, he appeared to be out of control and quite angry.

CLIENT PROFILE:

MENTAL CONDITION: It appears that Mr. Bigley's present level of judgment is inadequate for managing his personal affairs as well as his finances. By record, he has a long history of API admissions. In the past, Bill has been more accepting of out patient

assistance, however in the resent past, he refuses all referrals. He is alert and aware, but his impulsive behaviors and active delusions have made it difficult for him to receive appropriate attention for his needs.

EMOTIONAL CONDITION: Mr. Bigley was angry and belligerent at the time of the interview. Records indicate some anger management problems. He has threatened OPA staff numerous times in the past. Mr. Bigley does have an ongoing mental illness. When not hospitalized he does not take medication. Unfortunately even when hospitalized and on medications, his behaviors don't appear to change much.

Formal diagnoses on his API records include Schizophrenia, paranoid type.

PHYSICAL CONDITION: William's physical condition is fair. He is ambulatory and has few problems with his ADL's other than refusing to tend to them at times. He is diagnosed with gastrointestinal problems that by report are not looked after appropriately when Bill is out of the hospital. At the time of the visit, he was disheveled and unkempt. Although Bill has always had a small build, he is clearly underweight at this time.

ADAPTIVE BEHAVIOR: Mr. Bigley's ability to manage his finances has been in question for eight years and OPA has served as his conservator. The new problems of ongoing medical care and eviction may indicate problems in managing those affairs as well. His adaptive behavior is limited. API admissions have increased in frequency and intensity.

ASSISTANCE NEEDED: Parties involved with William feel that he will benefit from having a guardian as well as a conservator appointed. This visitor tends to agree that he may need assistance with medical and mental health issues as well as assistance with financial management at least on a temporary basis.

The petitioner is asking that the Office of Public Advocacy be appointed. Since they have been Bill's conservator for eight years this appears appropriate. A private agency may be considered, however Bill's funds are limited.

VOCATIONAL/EDUCATIONAL NEEDS: William Bigley is not involved in any vocational services or in any vocational program at this time.

PROGNOSIS: Guarded. It does appear that Bill has decompensated both medically as well as physically. Hospitalization and psychotropic medication have not helped stabilize him.

PLACEMENT: William is currently an inpatient at API. He has been evicted from his apartment so placement when discharged will be an issue.

ALTERNATIVES TO GUARDIANSHIP: Mr. Bigley already has a conservator and although he has complained about the mismanagement of his money, he is unable to handle it himself. A petition for guardianship has been filed. While the visitor is uncertain if a protective order will help stabilize Mr. Bigley, the visitor believes it is worth a try, especially for medical and mental health treatment.

Because of a tenuous outcome to an appointment, the visitor is recommending that the court enter a temporary order and have the parties come back to court in six months for further review.

FINANCIAL: Mr. William Bigley (SSN 574-24-6052) receives a monthly social security check in the amount of $1396.00. He is a native corporation shareholder and currently the Office of Public Advocacy is acting as his conservator. Bill resents the restrictions they impose on his money and has accused them of theft and mismanagement in the past.

A review of funds currently held for Bill at OPA did not reveal any wrongdoing on their part. A transaction journal listing income and expenses from January 1, 2004 through May 19, 2004 is attached. Bill uses every bit of his monthly income on rent, allowance, cigarettes, utilities, cable and personal items, often depleting his account to zero at the end of the month. He does have a small native account at OPA listed under Office 2 and this money often supplements his monthly income.

The $1396.00 a month puts Bill over the limit for Medicaid and services that the program might cover.

There are no other known assets or debts.

FNDINGS: It is this visitor's opinion that William Bigley is "spinning out of control". His physical and mental health are deteriorating. He seems to be in a revolving door program at the Alaska Psychiatric Hospital. Whether a guardian for medical and mental health issues can help him remains to be seen since he is known to be belligerent and noncompliant. However, the visitor believes it is in Mr. Bigley's best interest to have a limited guardian appointed to address the medical and mental health issues. Perhaps the guardian can advocate for long-term treatment and medications for Mr. Bigley, which might lead to a more stable existence.

Since the effect of such an order is unknown, the visitor believes that the order should be temporary and limited to the medical and mental health issues. Parties should be prepared to come back to court in six months to assess any results of having a limited guardian. The visitor recognizes the difficulty in dealing with Mr. Bigley and that having such a protective order may not result in any change in Bill's circumstances.

RECOMMENDATIONS OF THE VISITOR:

1. For the court to appoint the Office of Public Advocacy as limited temporary guardian for Mr. William S. Bigley. The order should include authority over medical and mental health treatment and care. The conservatorship should remain in place.

2. For the Court to schedule a hearing in six months to address the results of the protective proceeding and any further recommendations of the visitor and/or limited guardian.

Betty L. Wells

Betty L. Wells, Court Visitor
4754 Mills Drive
Anchorage Alaska 99504
(907) 333-9480

5-25-07
Date

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT

In the Matter of the Guardianship of:)
)
WILLIAM BIGLEY,)
Respondent.)
)

Case No. 3AN-04-545 P/G

LETTERS OF TEMPORARY FULL GUARDIANSHIP

A hearing on the petition for appointment of temporary full guardian in the above captioned matter was held on June 3, 2004, and after hearing and findings, the Office of Public Advocacy is hereby appointed as temporary full guardian of the respondent; namely, WILLIAM BIGLEY, to serve without bond, until a hearing can be held for further determination.

The duties and powers of the Temporary Full Guardian shall be those in conformity with A.S. 13.26.090 through A.S. 13.26.150, including authority to authorize administration of psychotropic medications. The duties and powers shall also include those provided in the Findings and Order of Temporary full guardianship issued by this court, along with the Temporary full guardianship Plan attached thereto.

DATED this 30th day of June, 2004, at Anchorage, Alaska.

Morgan Christen
SUPERIOR COURT JUDGE

Recommended for approval:
DATED: 6/30/04

John E. Duggan, Probate Master

ACCEPTANCE

The Office of Public Advocacy hereby accepts the duties of Temporary Full

LAW OFFICE OF ERNEST M. SCHLERETH, LLC
225 E. FIREWEED LANE, SUITE 301
ANCHORAGE, ALASKA 99503
(907) 272-5549
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Guardian and solemnly swear to perform according to the law the duties of Temporary Full Guardian as required and permitted by statute and as enumerated in AS 13.26.090 through .150 and in the Findings and Order of Guardianship filed in this court, along with the Guardianship Plan attached to the Findings and Order. I further state that I have read and understand the duties and powers of a guardianship under AS 13.26.150 with any restrictions imposed by the court, as well as the reporting requirement of AS 13.26.117 and AS 13.26.118. I hereby submit to the jurisdiction of the court.

DATED in Anchorage, Alaska, this 9th day of June, 2004.

The Office of Public Advocacy

Kelley L. Barth Olsen

By: Public Guardian

SUBSCRIBED AND SWORN to before me this 9 day of June, 2004.

Marsha A. Sandusk

Notary Public in and for Alaska
My commission expires: 12/25/05

MARSHA A. SANDUSKE NOTARY PUBLIC STATE OF ALASKA My Commission Expires

I CERTIFY THAT ON 7/8/04 COPIES OF THIS FORM WERE SENT TO CLERK wells opa ag schlereth

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ANCHORAGE, ALASKA 99503
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IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT

FILED in the Trial Courts
State of Alaska, Third District
JUN 30 2004
By Clerk of the Trial Courts
Deputy

In the Matter of the Guardianship of:)
)
WILLIAM BIGLEY,)
Respondent.)
)

Case No. 3AN-04-545 P/G

TEMPORARY FULL GUARDIANSHIP PLAN

A judicial determination has been made that WILLIAM BIGLEY has an incapacity.

The Office of Public Advocacy is appointed as Temporary Full Guardian of the respondent, without bond, until a hearing can be held for further determination.

The Temporary Full Guardian's authority is as specified in the following guardianship plan.

1. The guardian has full authority to provide for the ward's medical care, mental health treatment, and any necessary physical and mental examinations, including the authority to authorize administration of psychotropic medications.

2. The guardian has full authority to provide for the ward's housing in the least restrictive setting feasible.

3. The guardian has full authority to provide for the ward's personal care, comfort, maintenance, education and vocational services necessary for the physical and mental welfare of the ward.

4. The guardian has full authority to provide for health and accident insurance and any other private or governmental benefits to which the ward may be entitled, to meet any part of the costs of medical, mental health or related services provided to the ward.

5. The guardian has full control of the estate and the income of the ward to pay

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JUN 14 2004

for the cost of services that the guardian is authorized to obtain on behalf of the ward.

6. The guardian will encourage WILLIAM BIGLEY, to participate in all decisions that affect him and to act on his own behalf to the maximum extent possible.

7. The temporary full guardian has full discretion as temporary guardian to seek suitable placement housing (preferably not in arrangements where he shares housing with others) but has his own private quarters.

8. The temporary full guardian has full discretion as temporary guardian to attempt to make arrangements for the provisions of at least two meals a day costing approximately $15 per meal. (Again these are purely discretionary goals within the purview of the public Guardian's complete powers.)

9. The temporary full guardian has full discretion as temporary guardian to attempt to obtain an ice chest so that the respondent has a place for keeping his soda pop cold.

10. The temporary full guardian has full discretion as temporary guardian to help make arrangements so that the respondent can find his clothing that was presumably misplaced or lost when he was removed from his apartment. To the extent clothing can be found from the apartment from which the respondent was evicted, the public guardian will attempt to make arrangements to help pack up clothing of the respondent for transport to his new location.

11. The temporary full guardian has full discretion as temporary guardian to attempt to assure that the respondent has a sufficient supply of cigarettes, and will help budget accordingly for the respondent to accomplish this.

12. The temporary full guardian has full discretion as temporary guardian to mail allowance checks to Tina Bolling, who has on occasions acted as payee and accompanying helper for the respondent, so that Tina may on occasion bring the respondent to a Red Apple restaurant or other such restaurant for a restaurant meal.

13. The temporary full guardian has full discretion as temporary guardian to

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make allowance funds available to the respondent as spending money. The respondent agrees not to give out his allowance money freely to others.

14. The respondent agrees to take his medications as prescribed, which currently is prolix, once weekly. The Public Guardian will attempt to work with psychiatric staff and health care providers to determine the best regimen of medication administration for the respondent, and help the respondent maintain consistency with a medication regimen.

DATED this 30th day of June, 2004, at Anchorage, Alaska.

Morgan Christen
SUPERIOR COURT JUDGE

Recommended for approval:
DATED: 6/30/04

John E. Duggan, Probate Master

I CERTIFY THAT ON 7/8/04 ag
COPIES OF THIS FORM WERE SENT opa
TO [illegible] wells
CLERK schlereth

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IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT

In the Matter of the Protective Proceedings of:)
)
WILLIAM BIGLEY,)
Respondent.)
) Case No. 3AN-04-545 P/G

FINDINGS AND ORDER OF TEMPORARY FULL GUARDIANSHIP

A hearing on the petition for temporary full guardianship in the above-entitled matter was held on June 3, 2004, at the hour of 11:00 a.m., before the Honorable John E. Duggan, Superior Court Probate Master, in the above entitled matter.

Present were Ernest M. Schlereth, respondent's court appointed attorney; respondent, William Bigley; petitioner's attorney, Holly Chari, Assistant Attorney General; Kelly Bartholomew, public guardian of the Office of Public Advocacy; and Tina Bolling, payee and acquaintance of respondent. Present telephonically was Betty Wells, the court appointed visitor.

The parties stipulated to the entry into evidence of the court visitor's report and further stipulated to a temporary full guardianship with the Office of Public Advocacy. Based on the foregoing, the court finds as follows:

1. The respondent has an incapacity which requires a protective order.

2. The court finds that it has jurisdiction by virtue of respondent's residency in Anchorage, Alaska.

3. The Office of Public Advocacy is the appropriate choice to be appointed as guardian on behalf of the respondent..

4. No less restrictive order is appropriate at this time.

5. Notice has been given as provided.

Based on the foregoing findings, the court hereby enters the following:

LAW OFFICE OF ERNEST M. SCHLERETH, LLC
225 E. FIREWEED LANE, SUITE 301
ANCHORAGE, ALASKA 99503
(907) 272-5549
FAX (907) 274-7401

ORDER

1. The Office of Public Advocacy is hereby appointed as temporary full guardian of the respondent, without bond, until a hearing can be brought for further determination.

2. The Office of Public Advocacy's powers shall be those in conformity with AS 13.26.090 through 13.25.150, including authority to authorize administration of psychotropic medications.

3. The temporary full guardianship plan attached hereto shall be incorporated herein.

4. The appointment of the court appointed attorney and court appointed visitor shall continue until a further hearing, unless sooner terminated by order of this court.

DATED this 30th day of June, 2004, at Anchorage, Alaska.

Morgan Christen
SUPERIOR COURT JUDGE

Recommended for approval:
DATED: 6/30/04

John E. Duggan, Probate Master

I CERTIFY THAT ON 7/8/04 COPIES OF THIS FORM WERE SENT TO _____ CLERK
ag
opa
wells
schlereth

LAW OFFICE OF ERNEST M. SCHLERETH, LLC
225 E. FIREWEED LANE, SUITE 301
ANCHORAGE, ALASKA 99503
(907) 272-5549
FAX (907) 274-7401

IDENTIFYING DATA: This is the 61st admission for Mr. William "Bill" Bigley. He is a 51-year-old, slight Inupiat male, not married, unemployed, disabled, nonveteran. He is at API now on an Ex Parte that was initiated by his OPA guardian, Steven Young (269-3500). Mr. Bigley lives alone in his own apartment. He is able to complete his own ADL's independently and had previously been able to come to API for medications until fairly recently.

This information is mainly compiled by conversations with his guardian, Steven Young.

PRESENTING PROBLEM, FUNCTIONING & EXPECTATION FOR TREATMENT: Mr. Bigley has come to API for his 61st time, according to Steven Young, his guardian, by Ex Parte initiated by Mr. Young. This was because of an unusual visit at the OPA office where Steve reports that everyday visits are the norm, but the last one in particular Mr. Bigley began to get tearful and to become "desperate," indicating some suicidal ideation, saying that he "wants to die," and that he wanted to "end it all." He was angry at first, then tearful and threatened people at the office, stating he wants retribution for an aunt. This aunt, Marcella Anderson, apparently lives in Southeast Alaska who had cared for him as a child, or at least many, many decades ago. This was new for Mr. Bigley and OPA staff were quite alarmed. He was telling OPA staff to "watch out for themselves."

Mr. Bigley previously had gone to court for a protective order for this aunt. As far as OPA knows, this aunt has not had contact with him for years. The petition was denied as the court felt the petitioner was not at risk. There were no recent behaviors shown by this said aunt to harm Mr. Bigley. The police even showed up previously at OPA when the petition was first filed, thinking that it was a current situation. Meanwhile, Mr. Bigley had also gotten kicked out of some downtown businesses such as a couple of coffee houses downtown as well as the Glacier Brew House because of escalating behavior and threatening remarks, per Steven Young in OPA. Mr. Bigley had been off his medications, which is risperidone Consta injection. His last medication schedule was October 29, 2004. October 16 was his last known injection of medications. The last few months, Mr. Bigley has been complaining that the medications have been making him ill, that he does not want to be messed with, that he wants to remain independent and he doesn't want to bother coming to get his shots. He continues with med-noncompliance in this manner. Steven Young at OPA believes that a forced med-compliance is necessary upon discharge and while living in the community for Mr. Bigley to remain out of the hospital and to lead a "normal" life.

MOST CURRENT PSYCHOSOCIAL HISTORY UPDATE: Mr. Bigley is currently refusing medications. He appears very angry and antisocial. He would not participate in helping to obtain information for this history update. He is exhibiting many angry behaviors. He continues to need services in the community as he refuses services at Southcentral Counseling Center. Other outpatient providers such as ANMC, aside from the emergency room. Southcentral Foundation's Behavioral Health had previously indicated they would not take on Mr. Bigley as a patient as he had previously thrown a brick through the window of their Clubhouse and he had been invited not to come back. The problem remains as Mr. Bigley will not accept services in the community. He maintains that he does not fit in with the other mentally ill folks that attend Quyana House or Be-

havioral Services at Southcentral Foundation's program. He is still gravely disabled, but yet demonstrates a need for these services. It is unclear how to link Mr. Bigley with Southcentral Foundation's Behavioral Health as that appears to be the best program for him at this time. They also have Risperidone Consta on their formulary at ANMC, making this choice probably the most viable one for him.

CURRENT STATUS CHANGES: There are no status changes for Mr. Bigley at this time legally. He also continues to remain non med-compliant.

ASSESSMENT: Mr. Bigley at this time is not very coherent. He will not engage in any type of conversation and is no where being able to be discharged to the community and to his apartment that he holds. It is hoped that he will tire of not being able to smoke and miss his home and perhaps he will become med-compliant in the near future. Mr. Bigley does indeed present as being gravely disabled and needing services.

DISCHARGE RECOMMENDATIONS: Discharge recommendations this time are mainly to Mr. Bigley to agree to be med-compliant. Secondly, services in the community, when they are found, need to be agreed upon by Mr. Bigley and accepted by him in order for them to work for him. He is hooked in through the Office of Public Advocacy and through the Catholic church, specifically Holy Family Cathedral, and Father Gary there continues to work with him and is a good resource for him (276-3455).

Anne O'Brien, LMSW
Clinical Social Worker

AO/ga/SOCIALHX/13617F

d. 12/1/04
t. 12/3/04 (draft)
dr.&ft. 12/17/04

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Anne O'Brien, LMSW
Clinical Social Worker

AO/ga/SOCIALHX/13617F

d. 12/1/04
t. 12/3/04 (draft)
dr.&ft. 12/17/04

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT

In the Matter of the Protective Proceedings of:)
)
WILLIAM BIGLEY,)
Respondent.)
)

Case No. 3AN-04-545 P/G

LETTERS OF FULL GUARDIANSHIP/CONSERVATORSHIP

A hearing regarding the above captioned matter was held on December 6, 2004, and after hearing and findings, the Office of Public Advocacy is hereby appointed as full guardian and full conservator of the respondent; namely, WILLIAM BIGLEY, to serve without bond, for an indefinite period of time.

The duties and powers of the full guardian shall be those as set out in AS 13.26.090 through 13.26.150. The full conservator's powers and duties shall be those set out in AS 13.26.165 through 13.26.320. These powers and duties shall include those as set out in the Findings and Order of Full Guardianship and Full Conservatorship filed herewith, along with the Guardianship Plan attached thereto.

DATED this 26 day of December, 2004, at Anchorage, Alaska.

Morgan Christen
SUPERIOR COURT JUDGE

Recommended for approval:
DATED: 12/29/04

John E. Duggan, Probate Master

ACCEPTANCE

The Office of Public Advocacy hereby accepts the duties of full guardian/conservator and solemnly swears to perform according to the law the duties of

LAW OFFICE OF ERNEST M. SCHLERETH, LLC
225 E. FIREWEED LANE, SUITE 301
ANCHORAGE, ALASKA 99503
(907) 272-5549
FAX (907) 274-7401

full guardian/conservator as required and permitted by statute and as enumerated in AS 13.26.090 - .150 and AS 13.26.165 - .320, and in the Findings and Order of Full Guardianship/ Conservatorship filed in this court, along with the Guardianship Plan attached to the Findings and Order. I further state that I have read and understand the duties and powers of a guardianship/conservatorship under AS 13.26.150 and AS 13.26.245-315, with any restrictions imposed by the court, as well as the reporting requirement of AS 13.26.117 and AS 13.26.118 and AS 13.26.250. I hereby submit to the jurisdiction of the court.

DATED this 14th day of December, 2004.

The Office of Public Advocacy

Steven D. Young

By: Public Guardian

SUBSCRIBED AND SWORN to before me this 14 day of Dec., 2004.

MARSHA A. TANDESKE
My Commission Expires
NOTARY PUBLIC
Dec 25, 2005
STATE OF ALASKA

Marsha A. Tandeske

Notary Public in and for Alaska
My commission expires: _____

I certify that on 1-25-05 a copy of the above was mailed to each of the following at their addresses of record (List names if not an agency)

☐ CSED ☐ AG ☐ PD ☐ DA AG OPA (X10) WELS SCHLERETH

Deputy Clerk / Secretary

LAW OFFICE OF ERNEST M. SCHLERETH, LLC
225 E. FIREWEED LANE, SUITE 301
ANCHORAGE, ALASKA 99503
(907) 272-5549
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IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT

In the Matter of the Protective Proceedings of:)
)
WILLIAM BIGLEY,)
Respondent.)
) Case No. 3AN-04-545 P/G

FINDINGS AND ORDER OF FULL GUARDIANSHIP/CONSERVATORSHIP

A hearing was brought in the above entitled matter on December 6, 2004, at the hour of 9:30 a.m., before the Honorable John E. Duggan, Probate Master of the Superior Court for the State of Alaska.

Present in the courtroom were petitioner's attorney, Holly Chari, Assistant Attorney General; and Steven Young, public guardian of the Office of Public Advocacy. Present for the hearing by telephone from Alaska Psychiatric Institute (API) were the respondent, William Bigley; the respondent's court appointed attorney, Ernest M. Schlereth; Anne O'Brien, social worker for API and representing Petitioner State of Alaska; Dr. Thompson, psychiatrist at API. The court appointed visitor was not present but her report was filed with the court.

The parties stipulated to the entry into evidence of the court visitor's report dated December 3, 2004. The parties further stipulated to the appointment of the Office of Public Advocacy as full guardian/conservator of the respondent. Based on the foregoing, the court finds as follows:

1. The court has jurisdiction by virtue of respondent's residency.

2. It has been shown by clear and convincing evidence that the respondent is incapacitated, as that term is defined by statute, due to a diagnosis of schizophrenia, paranoid type.

3. The respondent is unable to manage property and/or financial affairs

because of incapacity.

4. It is in the best interests of the Respondent to have the Public Guardian serve as conservator of the respondent as well as guardian.

5. Alternatives to guardianship were considered and are not feasible, and it is in the best interests of the respondent to have the public guardian serve as guardian.

6. Notice has been given as required by law.

Based on the foregoing findings, the court hereby enters the following:

ORDER

1. The Public Guardian is appointed as full guardian and full conservator of the respondent, to serve without bond, for an indefinite period of time.

2. The guardian's powers and duties shall be those as set out in the Guardianship Plan and pursuant to AS 13.26.090 through .155, including the power to make medical decisions and to approve administrations of any and all medications to be prescribed for the respondent, and to approve medical procedures and administration of psychotropic medications.

3. The Public Guardian shall also act as conservator for the respondent. The powers and duties as conservator shall be those set out in AS 13.26.280.

4. The full guardianship plan attached hereto shall be incorporated herein.

5. The Public Guardian shall file a guardianship and conservatorship implementation report with the probate court within 90 days from the date of appointment.

6. The Public Guardian shall file a report with the probate court concerning the status of the guardianship on or before January 1, 2006, and each January 1, thereafter.

LAW OFFICE OF ERNEST M. SCHLERETH, LLC
225 E. FIREWEED LANE, SUITE 301
ANCHORAGE, ALASKA 99503
(907) 272-5549
FAX (907) 274-7401

7. The appointment of the court appointed attorney and court appointed visitor shall terminate with the entry of this order.

DATED this 26 day of December, 2004, at Anchorage, Alaska.

Morgan Christen
SUPERIOR COURT JUDGE

Recommended for Approval:
DATED: 12/21/04

Probate Master

I certify that on 1.25.05 a copy of the above was mailed to each of the following at their addresses of record (List names if not an agency)

☐ CSED ☐ AG ☐ PD ☐ DA AG OPA (X10) WELLS SCHLERETH

Deputy Clerk / Secretary

LAW OFFICE OF ERNEST M. SCHLERETH, LLC
225 E. FIREWEED LANE, SUITE 301
ANCHORAGE, ALASKA 99503
(907) 272-5549
FAX (907) 274-7401

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT

In the Matter of the Protective Proceedings of:)
)
WILLIAM BIGLEY,)
Respondent.)
)

Case No. 3AN-04-545 P/G

GUARDIANSHIP PLAN D

A judicial determination has been made that WILLIAM BIGLEY is incapacitated and the services of a full guardian/conservator are necessary.

The Office of Public Advocacy is appointed as full guardian and conservator of the respondent, to serve without bond, for an indefinite period of time. The full guardian's authority is as specified in the following guardianship plan.

1. The guardian has full authority to provide for the ward's medical care, mental health treatment, and any necessary physical and mental examinations.

2. The guardian has full authority to provide for the ward's housing in the least restrictive setting feasible.

3. The guardian has full authority to provide for the ward's personal care, comfort, maintenance, education and vocational services necessary for the physical and mental welfare of the ward.

4. The guardian has full authority to provide for health and accident insurance and any other private or governmental benefits to which the ward may be entitled, to meet any part of the costs of medical, mental health or related services provided to the ward.

5. The guardian has full control of the estate and the income of the ward to pay for the cost of services that the guardian is authorized to obtain on behalf of the

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(907) 272-5549
FAX (907) 274-7401

ward.

6. The guardian will encourage WILLIAM BIGLEY to participate in all decisions that affect him and to act on his own behalf to the maximum extent possible.

DATED this 26 day of December, 2004, at Anchorage, Alaska.

Morgan Christen
SUPERIOR COURT JUDGE

Recommended for Approval:
DATED: 12/22/04

John E. Duggan, Probate Master

I certify that on 1-25-05 a copy of the above was mailed to each of the following at their addresses of record. (List names if not an agency)

☐ CSED ☐ AG ☐ PD ☐ DA AG
OPA (X10)
WELLS
SCHLERETH

Deputy Clerk / Secretary

LAW OFFICE OF ERNEST M. SCHLERETH, LLC
225 E. FIREWEED LANE, SUITE 301
ANCHORAGE, ALASKA 99503
(907) 272-5549
FAX (907) 274-7401

IDENTIFYING DATA: This is the 65th admission for this 52-year-old Alaska Native, divorced male. He is a nonveteran of military services and unemployed as a result of his mental illness. The patient listed his religious faith as Nazarene. The patient has a guardian appointed through the Office of Public Advocacy, Steve Young.

PRESENTING PROBLEM: The patient arrived to API on a Title-12, incompetent to stand trial order. The patient had been arrested for trespassing at the airport in Anchorage. He was reportedly demanding that his jet be pulled up so that he could depart. While at mental health court in front of Judge Stephanie Rhoades, he was found incompetent to stand trial due to his behaviors and delusional statements in the courtroom.

MOST RECENT SOCIAL HISTORY UPDATE: The patient was last discharged from API on April 12, 2005. Since that time, he has been residing in his own apartment in Anchorage. He receives outpatient follow up care through Dr. Thomson at API. The patient had been coming to API bimonthly for his Risperidone Consta injection. He has refused to work with any community mental health agencies in town.

CLINICAL SOCIAL WORK ASSESSMENT: The patient refused to engage in the interview with the social worker. The patient is demanding on the unit; yelling profanities, and insisting to speak with various persons of authority. The patient is delusional and paranoid and lacks insight into his mental illness. The patient continues to be combative to staff members on the unit and has limited, if nonexistent, insight into his mental illness.

DISCHARGE PLANS: The patient will be discharged once competency is deemed restored or his condition improves. The patient will need to decrease his aggressive and verbally assaultive behaviors and will need to show a decrease in his desire to go to the airport to obtain his jet. Other referrals and recommendations will be made as treatment continues.

Malinda Natanek, LMSW
Mental Health Clinician II

MN/mh/SOCIALHX/19744F

d. 01/27/06
t. 02/01/06 (draft)
dr.&ft. 02/09/06

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
AT Anchorage

2005 SEP -1 PM 2:57

In the Matter of the Necessity for the Hospitalization of: William Bigley, Respondent.	Case No. 3AN-06-1031PR PETITION FOR INITIATION OF INVOLUNTARY COMMITMENT

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

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

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

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

Facts in support of this request are as follows:

1. The respondent named above is 53 years of age and resides at Anchorage, Alaska.

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

Case No. _____

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

09-01-06
Date

Steven D.
Petitioner's Signature

Steven D. Young
Type or Print Name

900 W. 5th Avenue #525 Anchorage AK 99501
Petitioner's Address

907-269-3541
Petitioner's Phone

Verification

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

Subscribed and sworn to or affirmed before me at Anchorage, Alaska on 09-01-06 (date).

HELENA ADAMSON My Commission Expires NOTARY PUBLIC Expiring with Office STATE OF ALASKA

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

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

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

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

Clerk: _____

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

In the Matter of the Protective Proceeding of:

William Stanley Bigley,

Respondent.

Case No. 3AN-99-1108

AFFIDAVIT OF PUBLIC GUARDIAN

STATE OF ALASKA)
)ss.
THIRD JUDICIAL DISTRICT)

Steven Young, duly sworn, deposes and states:

1. That I am the Public Guardian with the Office of Public Advocacy Anchorage assigned to the above-captioned matter.

2. That the Office of Public Advocacy Anchorage was appointed guardian for the respondent June 30, 2004.

3. That William Bigley experiences a chronic mental illness that renders him persistently psychotic and often so gravely disabled that he is unable to remain safe in the community.

4. That William Bigley has been told he must stay away from the Office of Public Advocacy until October 1, 2006 due to an incident in which he accosted a number of OPA staff using threats and profanity, but that he has been unable to refrain from coming to the office.

ANCHORAGE CIVIL SECTION
OFFICE OF PUBLIC ADVOCACY
900 West 5th Avenue, Suite 525
Anchorage, Alaska 99501
Phone (907) 269-3500 • Fax (907) 269-3535

5. That William Bigley accosted the managers at this apartment and was issued a five-day notice to quit from his landlord for violating noise and nuisance rules and that his landlord intends to evict him if he is not moved within the five day period.

6. That I usually assist William Bigley with weekly food shopping because he is unable to do so independently and because the mental health system has been unable to serve him; however, that in his current state I do not believe that I can safely assist him at this time.

7. That I believe William Bigley meets the criteria for being gravely disabled due to his recent complete neglect of his basic needs, for example; he was given a cigarette check and recently ground a hole in the check he received from this office, making the check unusable. This action shows how far he has decompensated. Unless his condition is treated, he will continue to experience an extreme level of distress that he is now exhibiting every time he comes to this office, which has been averaging four times per day. He is exhibiting a high level of aggressive behavior and hostility and recently has continued to use hateful, racial epithets within hearing of minority persons who is denigrating. This is a recent development and demonstrates how far along he is in his decompensation. That I belive he presents an immediate risk to self due to the severity of his psychosis, is unable to purchase needed food supplies, obtain housing or protect him from harm.

Public Guardian

SUBSCRIBED AND SWORN TO before me this 1 day of September 2006 HA

Helena Adamson
Notary Public In and For Alaska.
My Commission Expires: with office

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-06-01039 P/S
	)	ORDER FOR 30-DAY COMMITMENT

FINDINGS

A petition for 30-day commitment was filed on SEPTEMBER 6, 2006.

A hearing was held on SEPTEMBER 6, 2006, to inquire into the mental condition of the respondent. Respondent (was)(XXXXXXX) personally present at the hearing and was represented by K. GIBSON, attorney. Representing the State was H. SMITH.

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

1. Respondent is mentally ill and, as a result, is

   |__| likely to cause harm to himself/herself or others.

   |XX| gravely disabled.

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

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

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

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

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

6. The facts which support the above conclusions are:

1. Clear and convincing evidence of mental illness including Dr. Worrall's expert psychiatric diagnosis of paranoid schizophrenia. Dr. Worrall testified that Mr. Bigley missed his medication shot on August 20th and became very paranoid and psychotic without medication. The doctor said that Mr. Bigley's thinking is very disorganized and that he is delusional and irrational.

2. Clear and convincing evidence the respondent is gravely disabled including Dr. Worrall's diagnosis and his testimony that Mr. Bigley is unable to access reality and has a very paranoid view of things around him. The doctor said that Mr. Bigley perceives almost everything as a threat and has "all sorts of delusional material."

3. There is not a less restrictive treatment option at this time.

ORDER

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

9-18-06
Date

Superior Court Judge

Nunc pro tunc 09/06/06

I certify that on 10/5/06 a copy of this order was sent to:

respondent
respondent's attorney
attorney general
treatment facility

Clerk: SMH

Recommended for approval 9/18, 2006

Master

NOTICE OF RIGHTS

TO: Respondent

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

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-06 1039 PR

PETITION FOR 90-DAY COMMITMENT

As a mental health professional who has examined the respondent, the petitioner alleges that:

1. The respondent is mentally ill and as a result is

☐ likely to cause harm to himself/herself or others.

☒ gravely disabled as previously alleged in the Petition for 30-Day Commitment.

2. The respondent:

☒ continues to be gravely disabled and there is reason to believe that the respondent's mental condition could be improved by a continued course of treatment.

☐ has attempted to inflict or has inflicted serious bodily harm upon himself/herself or another since his/her acceptance for evaluation.

☐ was committed initially as a result of conduct in which he/she attempted or inflicted serious bodily harm upon himself/herself or another.

☐ demonstrates a current intent to carry out plans of serious harm to himself/herself or another.

3. The evaluation staff has considered, but has not found, any less restrictive alternatives available that would adequately protect the respondent or others.

4. API is an appropriate treatment facility for the respondent's condition and has agreed to accept the respondent.

5. The respondent has received appropriate and adequate care and treatment during his/her 30-day commitment.

6. The respondent has been advised of the need for, but has not accepted, voluntary treatment.

The petitioner respectfully requests the court to commit the respondent to the above-named treatment facility for not more than 90 days.

Bigley

Case No. 3AN06 1039PR

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

patient remains psychotic and pressured speech and irritable, very delusional, not responding to Risperdal alone, refuses mood stabilizer medication. Refuses assisted living placement due to impaired judgement from mental illness. ~~denies~~ staff of various delusional activities (perceived conspiracies)

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

Steve Young OPA guardian – telephonic 269-3541
Melinda Matarek MSW
W Worrall MD

10-4-06
Date

William Worrall MD
Signature of Professional Person In Charge or that Person's Professional Designee

William Worrall MD
Print Name and Title

Verification

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

Subscribed and sworn to or affirmed before me at Anchorage Alaska on 10/4/06 (date).

(SEAL)

Clerk of Court, Notary Public or other person authorized to administer oaths.
My commission expires: 10/5/07

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 06 1039 PR

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

William Worrall MD petitioner, requests a hearing on the respondent's capacity to give or withhold informed consent to the use of psychotropic medication, and alleges that:

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

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

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

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

10-4-06 — mood stabilizer medication or second antipsychotic — William Worrall MD

Date — Signature (Representative of evaluation or designated treatment facility)

William Worrall MD
Printed Name

Title Psychiatrist

Verification

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

Subscribed and sworn or affirmed before me at Anchorage, Alaska on 10/6/06 (date).

Mary Martinez NOTARY PUBLIC STATE OF ALASKA My Commission Expires 10/5/07

Clerk of Court, Notary Public, or other person authorized to administer oaths.
My commission expires: 10/5/07.

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-06-01039 P/S
	)	ORDER FOR 90-DAY COMMITMENT

FINDINGS

A petition for 90-day commitment was filed on OCTOBER 4, XX 2006.

A hearing was held on OCTOBER 10, XX 2006, to inquire into the mental condition of the respondent. Respondent (was) XXXXXXXXX personally present at the hearing and was represented by K. GIBSON, attorney. Representing the State was L. HARTZ.

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

1. Respondent is mentally ill and, as a result, is

   ☐ likely to cause harm to himself/herself or others.

   ☒ XX gravely disabled.

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

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

4. Respondent was given verbal notice that if commitment or other involuntary treatment beyond the 90 days is sought, respondent will have the right to a full hearing or jury trial.

5. No less restrictive treatment alternative has been found which would adequately protect the respondent or others.

Case No. 3AN-06-01039 P/S

6. The facts which support the above conclusions are:

1. Clear and convincing evidence the respondent continues to suffer a mental illness including Dr. Worrall's ongoing diagnosis of schizophrenia, bipolar type. Dr. Worrall testified that Mr. Bigley exhibits symptoms consistent with his diagnosis including grandiose delusions, intensive affect and pressured speech.

2. Clear and convincing evidence the respondent is gravely disabled including Dr. Worrall's testimony that Mr. Bigley's judgment is impaired. The doctor said that Mr. Bigley exhibits impulsivity and labile emotions which symptoms impair his judgment and ability to function independently.

3. There is no less restrictive treatment option for Mr. Bigley until the symptoms of his illness subside.

ORDER

Therefore, it is ordered that respondent, WILLIAM BIGLEY, is committed to ALASKA PSYCHIATRIC INSTITUTE for a period of time not to exceed 90 days.

11/3/06
Date

Superior Court Judge

Nunc pro tunc 10/04/06

I certify that on _____ a copy of this order was sent to:
respondent
respondent's attorney
attorney general
treatment facility

Clerk: _____

Recommended for approval on 11/2, 19 06.

Master

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
AT ANCHORAGE

In the Matter of the Necessity for the Hospitalization of:	)	
	)	Case No. 3AN-06-01039 P/S
WILLIAM BIGLEY, Respondent.	)	FINDINGS AND ORDER CONCERNING COURT-ORDERED ADMINISTRATION OF MEDICATION

FINDINGS

A petition for court approval of administration of psychotropic medication was filed on OCTOBER 9, 2006.

Respondent was committed on OCTOBER 10, 2006 for a period of time not to exceed 90 days.

A hearing was held on OCTOBER 10, 2006, to inquire into respondent's capacity to give or withhold informed consent to the use of psychotropic medication.

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

_____A. The respondent has the capacity to give informed consent concerning administration of psychotropic medication for purposes of AS 47.30.836 as respondent is not found by clear and convincing evidence to be incompetent to make mental health and/or medical decisions.

XXXX B. By clear and convincing evidence that the respondent is not competent to provide informed consent concerning administration of psychotropic medication and the treating facility's proposed use of psychotropic medication is approved for the respondent's present commitment.

FINDINGS AND ORDER
CONCERNING COURT-ORDERED
ADMINISTRATION OF MEDICATION

Page 2

2. The facts which support the above conclusion are:

Clear and convincing evidence the respondent is unable to give or withhold informed consent concerning antipsychotic medication including the court visitor's report and recommendation and Dr. Worrall's testimony. Ms. Vassar reported that Mr. Bigley was sent to the hospital on an exparte petition after he allegedly accosted OPA staff. Mr. Bigley told her he was very opposed to medications because they cause sexual dysfunction. The visitor said that Mr. Bigley did not elaborate.

Mr. Bigley's court appointed guardian, Steve Young, testified that he has been Mr. Bigley's guardian for six years and is concerned because Mr. Bigley is getting worse psychiatrically, has poor judgment and becomes easily frustrated. He said that Mr. Bigley is highly delusional and his level of agitation quickly escalates.

ORDER

_____Therefore, the court having determined that the patient is competent to provide informed consent, it is ordered that the treating facility shall honor respondent's decision about administration of psychotropic medication.

XXXX Therefore, it is ordered that the treating facility's proposed use of psychotropic medication to treat the respondent is approved for the period of the respondent's current commitment.

If the treating facility wishes to continue the use of psychotropic medication without respondent's consent during a period of commitment that occurs after the present commitment period, it shall file a request to continue the medication when it files the petition to continue patient's commitment.

11/3/06
DATE
Nunc pro tunc 10/09/06

SUPERIOR COURT JUDGE

Dr. Worrall testified that Mr. Bigley has received Risperdal shots for the last two years which have been effective and not caused side effects for Mr. Bigley. The doctor said that Mr. Bigley has taken the Risperdal shots voluntarily but missed a recent shot which probably caused escalation of his symptoms. The doctor said there are no sexual side affects with the prescribed medication and that the prescribed medication is the least intrusive treatment for Mr. Bigley. The doctor opined that Mr. Bigley cannot give an informed consent.

No evidence was presented that Mr. Bigley has executed or otherwise communicated an advance directive concerning prescription of antipsychotic medications.

FINDINGS AND ORDER
CONCERNING COURT-ORDERED
ADMINISTRATION OF MEDICATION

Page 4

Recommended for approval on 12/12, 20 06.

SUPERIOR COURT MASTER

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

respondent
respondent's attorney
attorney general
treatment facility

Clerk: _____

OFFICE OF PUBLIC ADVOCACY

Anchorage Civil Section

900 W. 5th Avenue, Suite 525
Anchorage, AK 99501

Phone: 907-269-3500
FAX: 907-269-3535

CONFIDENTIAL FAX

DATE: 12-12-06 FAX: 274-9493

FAXED TO: Jim Gottstein

RE: B.B.

SENT BY: Jim Parkin

PHONE: 269-3545 FAX: 269-3535

NO. OF PAGES INCLUDING COVER SHEET: 7

COMMENTS:

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 06 1039 PR
)
) NOTICE OF RESPONDENT'S
ARRIVAL AT EVALUATION FACILITY

To: CLERK OF COURT

Anchorage, ALASKA

Please take notice that respondent arrived at

API-Return from Early Release to Outpatient Treatment

on 11-29-06 at 0334

11/29/06
Date

Signature

Mary Martinez, Legal Office
Printed Name

Title

Superior Court at
notified by telephone on
at
This notice sent to Anchorage court on
11-29-06

M Martinez, Legal Office
Name and Title

Distribution:
Original to court
Copy to evaluation facility

MC-400 (12/87) (st.2)
AS 47.30.715
NOTICE OF RESPONDENT'S ARRIVAL AT EVALUATION FACILITY

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

Attorney for Respondent

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

In The Matter of the Guardianship of	)	
	)	
of William S. Bigley,	)	
	)	
Respondent	)	Case No. 3AN 04-545 P/G

ENTRY OF APPEARANCE

The Law Project for Psychiatric Rights hereby enters its appearance on behalf of, William S Bigley, the Respondent in this matter.

DATED: 12/6/2006.

Law Project for Psychiatric Rights

By: _____
James B. Gottstein
ABA # 7811100

DESIGNATION OF ATTORNEY

I am the respondent in the above matter and employ the Law Project for Psychiatric Rights as my choice of attorney under AS 47.26.107(a)(3)(C), which is incorporated into the proceedings under the petition filed pursuant to AS 47.26.125(a), by AS 47.26.125(c).

William S Bigley
William S. Bigley

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

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

Attorney for Respondent

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

In The Matter of the Guardianship of	)	
	)	
of William (Bill) S. Bigley	)	**PETITION**
	)	
Respondent	)	
	)	Case No. 3AN 04-545P/G

Pursuant to AS 13.26.125(a), Respondent, William S. (Bill) Bigley (B.B.), by and through his attorney, the Law Project for Psychiatric Rights, hereby petitions 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.

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

DATED: 12/6/2006.

Law Project for Psychiatric Rights

By: _____
James B. Gottstein, ABA # 7811100

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

DATE OF BIRTH: 01/15/53

IDENTIFYING DATA: The patient is a 54-year-old Alaska Native male who is unmarried, a nonveteran, unemployed, and identifies Nazarene as his religious preference. He was admitted on an Ex Parte Order filed by his guardian, Steve Young from the Office of Public Advocacy. This is the patient's 68th admission; his last discharge was 01/03/2007 Against Medical Advice.

PRESENTING PROBLEM: Since the patient's last discharge, he was at risk of going hungry because he would not cooperate with any effort made to provide him with groceries. The patient presented himself to the Office of Public Advocacy where he was very emotionally labile and created public disturbances requiring the police to be called to escort him away on two occasions. The patient had quit taking his medications and was generally suspicious, angry, and delusional. At the time of admission, the patient made statements as saying he was a billionaire. He owned a jet, he knew that people were being beaten up, 300 per day, and did not want to work with anyone other than the new attorney that he met during his previous API hospitalization. The patient presented as being thin, and in fact had lost an additional 4 pounds since his last admission, however, patient vehemently denies that he was losing weight.

MOST CURRENT SOCIAL HISTORY UPDATE: At the time of discharge on 01/03/2007, the patient was refusing to live in an assisted living home, insisted on living independently, and had been encouraged by his attorney to not cooperate with his guardian from OPA or with case management services from Anchorage Community Mental Health Services. The patient insisted he did not need to work with anyone other than his new attorney. Therefore, the patient was discharged to an independent apartment, actually to the midtown motel and was taken to the bus station in order to renew his bus pass. The patient had SSI Benefits, as well as Medicaid.

CURRENT STATUS CHANGES: Patient still has Steve Young at the Office of Public Advocacy for guardian. He receives case management and medication management from Anchorage Community Mental Health and his financial benefits remain unchanged.

ASSESSMENT: The patient has again decompensated due to noncompliance with medications and through the encouragement of his attorney, has become even more distrustful and paranoid about mental health providers and his guardian.

DISCHARGE RECOMMENDATION: It will be recommended that the patient be discharged on an early release program so that he can be returned to API before he becomes decompensated

as severely as he did this time. It will be recommended that that the patient be discharged to an assisted living facility where he can be closely monitored for his safety.

Marilyn Lee LCSW

Marilyn Lee, LCSW
Mental Health Clinician III

ML/pal/SOCIALHX/25647F
d. 03/06/07
t. 03/13/07 (draft)
dr.&ft. 03/21/07

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

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.

RdK
3/20/07

DISTRIBUTION

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- [ ] **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 Guardianship of	)	
	)	
of William (Bill) S. Bigley	)	
	)	
Respondent	)	
	)	Case No. 3AN 04-545P/G

Confidential

SETTLEMENT AGREEMENT

Settlement Agreement made this 20th day of July, 2007, between and among (i) the respondent, William (Bill) S. Bigley (Respondent), (ii) the public guardian, Office of Public Advocacy (Guardian), and (iii) the original petitioner in this matter, the Alaska Psychiatric Institute (API).

Recitals

A. On December 26, 2004, based on the stipulation of the Respondent, the Guardian and API, the court entered (a) Letters of Full Guardianship, (b) Findings and Order of Full Guardianship/Conservatorship, and (c) Guardianship Plan.

B. On December 6, 2006, the Respondent filed a petition seeking 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, and
5. Amend the powers of the Guardian to eliminate the authority to consent to mental health treatment.

(Petition).

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Anchorage, Alaska 99501
(907) 274-7686 Phone ~ (907) 274-9493 Fax

C. The Respondent, Guardian and API have agreed to resolve the Petition by providing (i) certain rules for the administration of the Guardianship, and (ii) a clear set of criteria by which Respondent may increase his autonomy and, if satisfied, have the guardianship terminated.

NOW THEREFORE, IT IS AGREED and STIPULATED, as follows:

1. Settlement. The parties agree this Settlement Agreement resolves the Petition.

2. Reassignment. The Guardian agrees to reassign the person designated to perform its duties under the Guardianship.

3. Maximum Participation by Respondent. To the maximum extent possible, consistent with law and its duties, the Guardian will follow the Respondent's wishes in the administration of the Guardianship. In doing so, the Guardian will encourage and attempt to work with Respondent to allow him to (i) participate in all decisions that affect him, (ii) act on his own behalf (autonomy), and (iii) return to full capacity. In the event of conflict, the Guardian shall employ all available means to resolve the dispute, including involving Respondent's attorney James B. Gottstein, if available, and the utilization of appropriate alternative forms of dispute resolution acceptable to the parties. In the event agreement can not be reached, and it is deemed of sufficient importance, either party may file a motion with this Court to resolve the issue.

4. Finances. Respondent receives Social Security Disability Income (SSDI). Currently, each month, all of Respondent's SSDI payments are being deposited into a Qualifying Income Trust for the benefit of Respondent (Trust) in order to maintain

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

Medicaid eligibility.[1] From this, the Guardian may pay Respondent up to a monthly amount set each year or to third parties under such circumstances that Medicaid policy deems such disbursement to be income to Respondent. These funds are hereinafter referred to as "unrestricted." Currently, the monthly amount of unrestricted monthly income is $1,176 per month, while Respondent's monthly SSDI payment is $1541. The balance of $365 are "restricted" funds, meaning they can not be disbursed under such circumstances that Medicaid policy deems them to be income to Respondent. During the first quarter of 2007, the monthly budget for Respondent was as follows:

OPA's First Quarter 2007 Monthly Budget		
SSDI Income	$	1,541
Restricted Funds	$	365
Unrestricted Funds	$	1,176
Rent	$	725
$50/wk Spending Money	$	217
$60/wk for Food	$	260
Phone	$	10
Bus Pass	$	12
Balance before ANCSA Dividends	$	(48)
ANCSA Dividends	$	134
Balance After ANCSA Dividends	$	86

4.1. Budget Modifications. The Guardian will supply Respondent with a copy of the budget each time it changes and upon request by Respondent. Consistent with the Guardian's duties to provide Respondent with housing, food and

[1] Respondent's right to receive the SSDI income is not assigned to the Trust; instead each payment is made into the Trust and becomes irrevocably committed to the Trust when that occurs.

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Anchorage, Alaska 99501
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other necessaries, and to otherwise follow the law, the Guardian shall accommodate Respondent's request(s) for modifications of the budget.

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.

4.3. Utilization of Restricted Funds. To the maximum extent possible, and consistent with the Trust, law and the Guardian's obligations, the Guardian shall utilize Restricted Funds in the manner requested by Respondent from time to time.

4.4. Method of Disbursements. The Guardian will accommodate, to the maximum extent possible, Respondent's ability to spend his Discretionary Funds himself. To this end, it is contemplated that to the maximum extent possible checks will be made out to Respondent and/or Respondent will be given a pre-paid credit card or similar vehicle(s) by which he will be able to make purchases and obtain cash, without having to cash checks (which identify him as having a guardian).

5. Housing. To the maximum extent possible, the Guardian will work with Respondent with respect to acceptable housing.

5.1. Subsidized Housing. As set forth above, the Guardian shall make its best efforts to obtain subsidized housing for Respondent that will allow an increase in Respondent's discretionary income.

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5.2. Consultation Before Termination of Housing. In the event the Respondent is faced with the loss of housing, the Guardian shall consult with Mr. James B. Gottstein and allow him to help attempt to resolve the difficulty.

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.[2]

6.1. Extended Services. Extended services, such as Case Management, Rehabilitation, Socialization, Chores, etc., beyond the standard limits for such services.

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

LAW PROJECT FOR PSYCHIATRIC RIGHTS, INC.
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Anchorage, Alaska 99501
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[2] By agreeing to this stipulation API is not making any judgment regarding eligibility standards under Medicaid regulations.

7.1. 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 Respondent~~ to which Respondent objects.

9. Criteria for Termination of Guardianship. If and when, Respondent meets the following conditions, Respondent may make application to the Court for modification or termination of the guardianship, which shall be granted unless there are compelling reasons for failing to do so:[3]

(a) Maintains his weight at 110 pounds or higher for six months.

(b) Maintains housing for four months.

(c) Is not escorted from the Guardian's premises by the police after failing to leave upon the Guardian's request for four months.

(d) Other than the financial payments made by the Guardian, satisfies his need to obtain food without the assistance of the Guardian for two months;

[3] In such event, unless the parties can agree on a set of criteria, the Court shall set specific criteria by which, if met, the guardianship shall be modified or terminated.

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

Respondent utilizing other available resources, such as case management, friends, etc., constitutes compliance with this condition.

10. Dispute Resolution. Any dispute(s) arising hereunder may be taken to the Court for resolution, HOWEVER, prior to doing so the parties shall make their best efforts to resolve such disputes, including through negotiation and mediation. The Court may defer making a binding determination pending referral to mediation.

11. Amendments. In the event, the Guardian and Respondent, from time to time, agree on any amendment(s), they shall jointly make application to the Court, which shall be granted unless there is a compelling reason(s) for failing to do so.

DATED: this 20th day of July, 2007, at Anchorage, Alaska.

FOR RESPONDENT:

William S. Bigley

Law Project for Psychiatric Rights

By: James B. Gottstein
Bar No. 781110

FOR GUARDIAN:

Office of Public Advocacy

By: James H. Parker
Bar No. 8310141

FOR API:

TALIS J. COLBERG
ATTORNEY GENERAL

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

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

IT IS SO ORDERED

DATED: this 20th day of July, 2007, at Anchorage, Alaska.

Morgan Christen

Morgan Christen, SUPERIOR COURT JUDGE

I certify that on 7/25/07 a copy of the above was mailed to each of the following at their addresses of record List names if not an agency)

☐ CSED ☐ AG ☐ PD ☐ DA

Russo Parker Goltstein

thJ

Deputy Clerk Secretar

LAW PROJECT FOR PSYCHIATRIC RIGHTS, INC.
406 G Street, Suite 206
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IN THE SUPREME COURT FOR THE STATE OF ALASKA

WILLIAM S. BIGLEY, Applicant, vs. THE ALASKA PSYCHIATRIC INSTITUTE, Respondent.	)	Case No. S-12851 Trial Court Case No. 3AN-07-1064 PR[1]

OPPOSITION TO ORIGINAL APPLICATION FOR INJUNCTIVE RELIEF

The State of Alaska, Department of Health and Social Services, Division of Behavioral Health, Alaska Psychiatric Institute, by and through the Office of the Attorney General, opposes the respondent's Motion for Injunctive Relief. There is no need for such an injunction because, in compliance with AS 47.30.838 (c), the order for emergency medication has been cancelled.

Alaska Statute 47.30.838 (c) states, "If the crisis situations as described in (a)(1) of this section occur repeatedly, or if it appears that they may occur repeatedly, the evaluation facility or designated treatment facility may administer psychotropic medication during no more than three crisis periods without the patient's informed consent only with court approval under AS 47.30.839."

As Mr. Bigley has had the statutory allowance of emergency medication, Dr. Worrall stopped the order this morning. See Attachment A. Until there is a final decision on the Petition for the Administration of Psychotropic Medication, Mr. Bigley

[1] The caption used by the respondent in his pleadings is incorrect and although this has been pointed out in response to other pleadings, he continues to flaunt court rules and practice to vent his personal frustrations. The correct form of the caption is as seen above. Dr. Worrall has only ever acted within the scope of employment and Bigley has not made any allegation to the contrary.

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will not receive any emergency medication. Thus, his Original Application for Injunctive Relief and the underlying Emergency Motion for Injunctive Relief should be denied.

Moreover, the Alaska Psychiatric Institute (API) would object to the automatic entry of any stays of an Order Approving the Administration of Psychotropic Medication (order). API is an acute-care psychiatric hospital. It is not a home for the mentally ill. One of the purposes of civil commitment is that the commitment has, "a reasonable expectation of improving [the patient's] mental condition." AS 47.30.655(6). API practices an evidence-based medical approach to treating psychiatric illness. Housing someone at API is not treatment. The stays proposed by Bigley actually impede his freedom and forces API into the untenable position of housing him without providing treatment. Thus, any automatic stays of duly entered orders should be denied.[2] Should the court grant such an order and Mr. Bigley chooses to appeal it, the matter can be taken up at that time.

API also renews its objections to any pleadings submitted along with any of Mr. Bigley's pleadings that are not directly related to this case or that purport to encapsulate "testimony." Specifically, with regards to the pleadings filed on September 10, 2007, that include: Appendix pp. 52-73; and 111- 129. API also objects to Bigley's version of the "facts" which were included in his pre-trial brief and are part of the appendix. However, as this is clearly only one side's proposed version of what may possibly be entered into evidence, API is confident the court will be able to discriminate the true facts. API moved to strike the entire appendix and the "affidavits" to Bigley's pre-trial brief both in writing and at the hearing on September 5, 2007. There has yet not been any ruling made on the topic. The status of such pleadings and information is

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[2] API wishes to point out that any prospective order would have resulted after significant testimony. That fact, taken with the known litigious nature of Mr. Bigley, make it highly unlikely that any order written in this case—either granting or denying the medication petition would be written without due consideration and careful thought.

questionable and it is completely inappropriate to again include them in the pleadings filed today.

DATED: September 10, 2007

TALIS J. COLBERG
ATTORNEY GENERAL

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

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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 08-00247PR

MEMORANDUM IN SUPPORT OF RENEWED MOTION FOR A TEMPORARY RESTRAINING ORDER and PRELIMINARY INJUNCTION

Pursuant to Civil Rule 65, William S. Bigley, the Respondent in this matter, by and through his counsel the Law Project for Psychiatric Rights (PsychRights), has renewed his motion for a temporary restraining order and preliminary injunction prohibiting the Alaska Psychiatric Institute (API) from administering any psychotropic drugs to Mr. Bigley without further order of the court.[1]

[1] On March 12, 2008, the clerk of the probate court, presumably on the instructions of the Court, "returned" Mr. Bigley's previous motion on the grounds that PsychRights was not "a party" in this case and also stating, "Documents may be refiled upon the Determination of Commitment and upon the filing of a new entry of appearance." An appropriate new limited entry of appearance pursuant to Civil Rule 81(d) has been filed contemporaneously herewith, but the commitment proceeding has not yet been determined. The problem, as demonstrated in yesterday's filing, is that in spite of efforts to get the Public Defender Agency to deal with API's blatantly improper forced drugging of Mr. Bigley pending the commitment hearing and before a forced drugging order might be issued pursuant to AS 47.30.839, it has failed to do so. Therefore, PsychRights is renewing Mr. Bigley's motion

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I. SUMMARY

On March 10, 2008, purportedly under the authority of AS 47.30.838, API forcibly injected Mr. Bigley with Haldol, a very powerful neuroleptic, the intrusiveness of which the Alaska Supreme Court has equated with lobotomy and electroshock,[2] and Ativan, a benzodiazepine, which is in the same class of drugs as Valium (Emergency Order).[3] API has a history of flouting the restrictions of AS 47.30.838 in forcibly drugging Mr. Bigley. The Emergency Order, on its face, proves that the conditions required before psychotropic drugs could be forced upon Mr. Bigley pursuant to AS 47.30.838 did not exist. In light of this Mr. Bigley should be protected by this Court from the irreparable harm inflicted on him by the improper forcible drugging to which he has repeatedly been subjected, including as recently as two nights ago.

II. DISCUSSION

AS 47.30.838(a)(1) allows emergency drugging only to "preserve the life of, or prevent significant physical harm to, the patient or another person." On its face, the

---

for a temporary restraining order and preliminary injunction. Every single forced drugging is an effront upon whom it is being inflicted and Mr. Bigley is entitled to have an attorney represent his interests in preventing him from being improperly forcibly drugged. Since PsychRights is willing to do so, Mr. Bigley is also entitled to have PsychRights represent him. No disrespect is meant to the Court in this filing.

[2] *Myers v. Alaska Psychiatric Institute*, 138 P3d 238, 242 (Alaska 2006); *Wetherhorn v. Alaska Psychiatric Institute*, 156 P.3d 371, 382 (Alaska 2007)

[3] Exhibit A.

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Emergency Order proves no one's life was in danger nor was there any danger of significant physical harm to anyone.[4]

According to the Emergency Order, the drugging was ordered because Mr. Bigley was yelling, and scaring other patients. The form also checks the box that Mr. Bigley was "threatening w/fists, poised to strike," and "charging/lunging/close physically." With respect to these check boxes, they don't show that anyone's life was in danger or there was any real threat of significant physical harm. They are also almost certainly untrue, not only because they are contradicted by the written narrative, but because, it is completely out of character for Mr. Bigley to engage in such behavior despite the extreme provocation to which he is subjected. The temporary restraining order should be granted and then the true facts about Mr. Bigley's behavior giving rise to API's decision to forcibly drug him as an "emergency" can, if necessary, be developed during consideration of the motion for preliminary injunction.

As mentioned, API has a history and pattern of flouting the restrictions of AS 47.30.838 in purporting to forcibly drug him as an emergency. In Mr. Bigley's February,

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[4] Counsel for API makes the bald assertion that "My client believes it has complied with the law and stands on that position." A hearing on the motion for preliminary injunction should be held to test that unsupported assertion. Under what circumstances API may properly invoke AS 47.30.838 is an important issue upon which API should be given guidance and to protect psychiatric respondents from improper "emergency" forced drugging. *See*, *Myers*, 138 P.3d at 242, citing to AS 47.30.838 ("our opinion does not extend to the use of psychotropic medication in crisis or emergency situations").

2007, commitment hearing, Dr. Worrall, his then treating psychiatrist, who had known Mr. Bigley off and on for 20 years[5] testified as follows:

> And on the unit, he did require two emergency injections of Haldol and Ativan, which are psychotropic medications that the staff gave him under emergency conditions when he was creating dangerous situations on the unit. And it wasn't that he was assaulting anybody, but he was in a state of mind where he was screaming so loudly that it was upsetting other patients who were becoming unstable, and the staff felt that was an emergency.[6] . . .
>
> He's very hard to tolerate, and the only thing that fixes that is medication.[7] . . .
>
> He's not assaulted anybody.[8] . . .
>
> He could be pretty scary, but it's really all talk. He's really not the kind of guy that goes around hitting people.[9]

Thus, Dr. Worrall testified (unknowingly) that Mr. Bigley was improperly subjected to "emergency" forced drugging in February of last year because "upsetting other patients" is far from satisfying the requirements of AS 47.30.838. In addition, Dr. Worrall's testimony makes clear that the real reason Mr. Bigley is being drugged is because "He's very hard to tolerate" (when he yells at them and slams doors for locking him up and forcibly drugging him, often improperly). Dr. Worrall testified that Mr. Bigley has "not assaulted anybody" and that while he can be scary he doesn't hit people. API did not have a good faith belief that anyone's life was in danger or anyone was in danger of significant

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[5] Exhibit B, p.8(27):22.
[6] Exhibit B, p. 9(30):13-22.
[7] Exhibit B, p. 11(41):6-7.
[8] Exhibit B, p. 14(51):13.
[9] Exhibit B, p.15(54-55):25-2.

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physical danger when it forcibly drugged Mr. Bigley two nights ago with the Emergency Order.

In September of 2007, when API could not obtain an immediate forced drugging order under AS 47.30.839, it forcibly drugged him anyway. This resulted in motions for emergency injunctive relief to both the Superior Court and the Alaska Supreme Court.[10] API responded that it wouldn't do it any more.[11] More specifically, API stated:

> There is no need for such an injunction because, in compliance with AS 47.30.838(c), the order for emergency medication has been cancelled. . . .
>
> Until there is a final decision on the Petition for the Administration of Psychotropic Medication, Mr. Bigley will not receive any emergency medication.[12]

API has now done it again and emergency injunctive relief in the form of a temporary restraining order is warranted until, if necessary, a hearing on the motion for preliminary injunction is held.

As set forth above, the Alaska Supreme Court has acknowledged that forced psychiatric drugging is as intrusive as lobotomy and electroshock and can only be allowed with full compliance with the law and Alaska Constitution.[13] Each forced drugging is a physical and mental assault on the patient. The following will give the Court an idea of what it feels like to be given a neuroleptic such as Haldol:

---

[10] Exhibit C. The Emergency Motion to the Alaska Supreme Court refers to Dr. Worrall as having ordered the forced drugging, but Dr. Worrall, Mr. Bigley's treating psychiatrist at the time, asserted later that the forced drugging had not been done on his order, but the admitting psychiatrist days earlier. This appears to be technically correct.

[11] Exhibit D.

[12] *Id.*

[13] *Myers* 138 P3d 238, 242 (Alaska 2006); *Wetherhorn*, 156 P.3d 371, 382 (Alaska 2007).

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> These drugs, in this family, do not calm or sedate the nerves. They attack. They attack from so deep inside you, you cannot locate the source of the pain. . . .
>
> The muscles of your jawbone go berserk, so that you bite the inside of your mouth and your jaw locks and the pain throbs. For hours every day this will occur. Your spinal column stiffens so that you can hardly move your head or your neck and sometimes your back bends like a bow and you cannot stand up.
>
> The pain grinds into your fiber . . . . You ache with restlessness, so you feel you have to walk, to pace. And then as soon as you start pacing, the opposite occurs to you: you must sit and rest. Back and forth, up and down you go in pain you cannot locate; in such wretched anxiety you are overwhelmed, because you cannot get relief even in breathing.[14]

Mr. Bigley has been subjected to so much forced drugging over so many years with so many drugs that he probably doesn't experience this level of effect, but it is bad enough.

III. IRREPARABLE HARM/BOND

The harm from every improper forced drugging is irreparable. In this situation, there is no need for a bond, and none should be required.

IV. NOTICE HAS BEEN GIVEN

The Temporary Restraining Order requested herein is being requested after notice to API so the provisions of Civil Rule 65(b) pertaining to the granting of Temporary Restraining Orders without notice are inapplicable.

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[14] JACK HENRY ABBOT, IN THE BELLY OF THE BEAST: LETTERS FROM PRISON, 35–36 (Vintage Books 1991) (emphasis omitted).

V. CONCLUSION

Since API asserts that it has complied with AS 47.30.838,[15] Mr. Bigley requests that the Temporary Restraining Order be granted until such time as an evidentiary hearing can be held for a preliminary injunction, if necessary. Such a hearing should be set for a time after the undersigned has been given a copy of Mr. Bigley's records at API and has time to subpoena witnesses to compel attendance at such a hearing.[16]

DATED: March 12, 2008.

Law Project for Psychiatric Rights

By: _____
James B. Gottstein
ABA # 7811100

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[15] Exhibit A, p.1.

[16] It would conserve judicial time if Mr. Bigley were also allowed time to conduct a few depositions to (1) flesh out what actually happened before Mr. Bigley was forcibly drugged on March 10, 2008, and (2) ascertain API's training and actual policy for emergency drugging under AS 47.30.838.

Date: Tue, 11 Mar 2008 15:39:55 -0800
From: "Twomey, Timothy M (LAW)" <tim.twomey@alaska.gov>
Subject: Records
To: Jim Gottstein <jim.gottstein@psychrights.org>,
"Brennan, Elizabeth (DOA)" <elizabeth.brennan@alaska.gov>
Thread-topic: Records
Thread-index: AciD0MlaSXyyQFrzQc2c84iCPqlwPwAACGig
X-MS-Has-Attach: yes
X-MS-TNEF-Correlator:
X-OriginalArrivalTime: 11 Mar 2008 23:39:58.0984 (UTC)
FILETIME=[37EE8080:01C883D1]

Hello Jim and Liz:

Attached are the records pertaining to last evening's emergency medication. My client believes it has complied with the law and stands on that position.

Thanks, Tim

Tim Twomey (907) 269-5168 direct
-----Original Message-----
From: State of Alaska Dept. of Law
[mailto:lawallinfosys@law.state.ak.us]
Sent: Tuesday, March 11, 2008 3:37 PM
To: Twomey, Timothy M (LAW)
Subject:

This document was digitally sent to you using an HP Digital Sending device.

Document.pdf


Twomey, Timothy M (LAW)2.vcf

EMERGENCY MEDICATION ORDER GUIDELINES:

- Each LIP order for emergency medications is only valid for 24 hours. Each crisis period is limited to 72 hours.
- The order may include an initial dose and may authorize additional PRN doses. If additional doses are ordered, the order must specify the medication, the quantity of each dose, method of administration, the specific emergency conditions under which the medication may be given (e.g. "prn danger to self or others"), and the maximum amount of medication that may be administered to the patient in a 24 hour period.
- If a second or third order is required, this order may be renewed by a LIP, only after a face to face assessment of the patient prior to ordering a continuation order. The purpose of this assessment is to determine if there is still a crisis situation. The order may be renewed every 24 hours up to a total of 72 hours during the crisis period.
- If crisis situations occur repeatedly, or if it appears that they may occur repeatedly, the facility may administer psychotropic medication during no more than three crisis periods without the patient's informed consent only with court approval under AS 47.30.839.

- **Name of LIP notified of crisis situation:** (print)_____
- **If order is received by a LIP other than the Primary LIP the RN must notify Primary LIP by the end of the shift via e-mail.**

Primary LIP name: (print) Carolyn Seegamma, ANP

Notified Date: 03/11/08 **Time:** 0840

LIP Assessment:

Pt sleeping in NAD at time of my interview nattempt report received from Nursing Staff regarding pt's agitation and symptom criteria met warranting emergency medication. I consider c interventions by clinical staff. No involuntary movements reported. I will reassess pt for any s/e and provide opportunity for therapeutic processing and education upon awakening.

LIP Signature: Carolyn Seegamma ANP **Date:** 03/11/08 **Time:** 0840

BIGLEY, WILLIAM S 02/23/2008 00-56-55 01/15/1953

Emergency IM Medication – INITIAL ASSESSMENT

API Form # 06-15026A Rev 1/23/08

Pt. Identification

ALASKA PSYCHIATRIC INSTITUTE

DATE	TIME	ORDER	NURSE SIGNATURE
2/26/08	1255	Emergency I M po order Lorazepam 2mg po Q 4h PRN NTE 4doses in 24 hours AAR Haloperidol 5mg po Q4h PRN	agd
DATE	TIME		
2/26/08	1310	Clarified PRN orders: Lorazepam 2mg PO and Haloperidol 5mg PO Q 4 hours PRN AAA NTE 4/24 If refused give: Lorazepam 2mg IM and Haloperidol 5mg IM Q 4 hours PRN AAA NTE 4/day order expires 24 hours p̄ initiation TORB Dr. Kushan	2/26 1440
Just had 1 injection 1830 3/10			
DATE	TIME		
3/3/08	1[illegible]	Patient permitted to visit with lawyer PRN in written order - including Gottstein	3/3/08 1305

BIGLEY, WILLIAM S
02/23/2008 00-56-65
01/15/1953

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

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

ORDER SHEET
API Form #08-8010A Rev. 12/02

Emergency IM Medication—INITIAL ASSESSMENT

Initial crisis situation began: Date: 3/10/08 Time: 1830

1. Patient behavior/justification for emergency meds: (check all that apply)				Directed at: (check all that apply) Staff			
Behavior	Threat	Attempt	Actual	Self	Peer	Staff	Other
[ ] Threatening w/fists, poised to strike	✓					✓	
[ ] Charging/lunging/close physically	✓					✓	
[ ] Jumping/shoving/grabbing/pinching							
[ ] Spitting							
[ ] Throwing objects at people							
[ ] Bouncing off walls/pounding doors							
[ ] Banging head							
[ ] Jumping/pushing from height							
[ ] Ingesting poison/foreign objects							
[ ] Cutting/stabbing/striking w/object							
[ ] Tying objects around neck							
[ ] Scratching/biting							
[ ] Hitting/kicking							
[ ] Other: Yelling, slamming doors			✓			✓	

2. Alternatives attempted: (check all that apply)	Results:
[✓] Verbal de-escalation	Replied "Go to hell" Refused
[✓] Offer of oral PRN medication	
[ ] Pain management	
[ ] Voluntary time-out	
[✓] Remove from stimuli	Kept slamming door
[ ] Separate patients	
[ ] Rest/nap	
[ ] Relaxation music/video	
[ ] 1:1 supervision	
[ ] Warm bath/shower	
[ ] Journaling	
[ ] Take a walk	
[ ] Help w/personal matter	
[ ] Other:	

RN Assessment Summary within 1 hour: (include patient's response to intervention)

Pt has been escalating since returning from Court. Pt has been up at desk making multiple demands. Yelling at staff. Several complaints from other pts that Bill was scaring them. Pt refused PRNs. Held pt in bed using MANDT technique. Haldol 5mg IM and Lorazepam 2mg IM given. Pt continued to yell profanities at staff, verbally abusive. We tried to encourage pt to stay in room but pt kept getting OOB and yelling and slamming doors. Pt placed in quiet room for approx 1.5 hours. Continued to monitor —

RN Signature: Patty Burgess Date: 3-10-08 Time: 1925

P BIGLEY, WILLIAM S 02/23/2008 00-56-65 01/16/1953

Emergency IM Medication – INITIAL ASSESSMENT

API Form # 06-15026A
Rev 1/23/08

IN THE TRIAL COURTS FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT

AT ANCHORAGE

In the Matter of the Necessity
for the Hospitalization of
W.S.B.,

Respondent.

No. 3AN-07-247 PR

30 DAY COMMITTMENT HEARING

PAGES 1 THROUGH 86

BEFORE THE HONORABLE ANDREW BROWN
MASTER

Anchorage, Alaska
February 24, 2007
2:41 p.m.

APPEARANCE:

FOR STATE OF ALASKA: Elizabeth Russo
Attorney General's Office
Human Services Division
1031 West 4th Avenue, Suite 200
Anchorage AK 99501

FOR W.S.B.: Leslie Dickson
Office of Public Advocacy
900 West 5th Avenue, Suite 525
Anchorage AK 99501

NOTE: DUE TO THE EXTREME POOR QUALITY OF THE RECORDING, MANY "INDISCERNIBLE" PORTIONS APPEAR IN THE TRANSCRIPT.

PROCEEDINGS

2607-34

SIDE A

872

THE COURT: This is the case of the hospitalization for William Bigley. (Indiscernible) number 07-247. The Petition for 30 Day Commitment was filed February 23rd, and also the court received the Petition for Court Approval of Administration of Psychotropic Medication.

Note for the record that I am doing this hearing telephonically from my chambers at 303 K Street. (Indiscernible) The assistant attorney general and (indiscernible) are at API, along with Mr. Bigley, with his attorney, (indiscernible) are there. Also, on the phone is the court appointed guardian for Mr. Bigley -- guardianship case -- and I think at this point I need to hear from Ms. Dickson. Is it all right with your client that (indiscernible) on the phone, or does she want me to be there in person.

MS. DICKSON: Well, Your Honor, I think it's (indiscernible). First of all, I did talk to Mr. Bigley...

UNIDENTIFIED MALE: (Indiscernible).

MS. DICKSON: I did talk to Mr. Bigley

(indiscernible) to court about you presiding over this matter by phone.

THE COURT: Uh-huh (affirmative).

MS. DICKSON: And he did represent to me, that was okay...

MR. BIGLEY: Yeah, that's okay.

MR. DICKSON: Okay. Um...

MR. BIGLEY: (Indiscernible).

MS. DICKSON: Okay.

MR. BIGLEY: (Indiscernible).

MS. DICKSON: The other issue is representation, Your Honor. This was continued on Friday. The Public Defender Agency is aware that Jim Gottstein represents Mr. Bigley in other matters. So we did confirm with him whether or not he would be representing Mr. Bigley on this case.

MR. BIGLEY: (Indiscernible).

MS. DICKSON: He told my office that, no, he was not going to represent him on this case.

Mr. Bigley, in discussing with him the telephonic issue, has asked that he represent himself, Your Honor.

MR. BIGLEY: I can represent myself (indiscernible) no problem (indiscernible).

MS. DICKSON: I th -- I think -- I think the

general practice is for (indiscernible).

MR. BIGLEY: (Indiscernible).

THE COURT: Mr. Bigley wants to represent himself at this hearing?

MS. DICKSON: Um, that's what he informed me. I think, Your Honor, I'm not requesting to withdraw. I think the general practice is that the Public Defender's Office remains appointed in this case, for purposes of (indiscernible).

THE COURT: Okay.

MS. DICKSON: But, I just -- Mr. Bigley, I didn't want him to get upset, because he did tell me that, and I just wanted to explain that that's what he said to me prior to coming into court.

THE COURT: Okay. Well, then, what I am going to do is speak to Mr. Bigley (indiscernible).

Now, Mr. Bigley, this is Master Brown. Can you hear me all right?

MR. BIGLEY: Yeah. Y -- yo -- you sound good. Comin' in great.

THE COURT: Okay. But -- but -- okay. Now, the thing is, I want to make sure -- Ms. Dickson is there to help you. If you do not want her to represent you in the hearing, she can still stay there and if you have questions that you want to ask her -- you know,

questions as to how -- (indiscernible).

MR. BIGLEY: (Indiscernible).

THE COURT: Mr. Bigley, this is Master Brown. And (indiscernible).

MR. BIGLEY: (Indiscernible).

THE COURT: And, listen to me. Ms. Russo will be asking the questions of her witnesses, Dr. Worrall, and then you'll have the right to ask questions of the doctor. Then you will have the right to testify, if you want. And we'll just see how things go. Okay? Is that all right with you?

MR. BIGLEY: (Indiscernible) TV or radio, or, ah, you know, news?

THE COURT: Okay. Well, there's not gonna be anything in the TV...

MR. BIGLEY: (Indiscernible).

THE COURT: Okay. Well, I'm going to proceed with the hearing as best I can. Ms. Dickson, I would appreciate you standing by, because...

MR. BIGLEY: (Indiscernible).

THE COURT: ...at some point I may just have to ask you to represent Mr. Bigley, so I will (indiscernible) be prepared to cross examine, in case Mr. Bigley doesn't have the ability, so.

MS. DICKSON: I will, Your Honor.

THE COURT: Okay.
MR. BIGLEY: Where'd this come from?
THE COURT: So, with that, Ms. Russo, who is your first witness?
MS. RUSSO: Your Honor, I was gonna call Steve Young. Typically, we ask the court visitor to go first, but since Mr. Young is on the phone...
MR. BIGLEY: He's my guardian.
MS. RUSSO: ...is it okay with Ms. Dickson if I call Mr. Young first?
MR. BIGLEY: No. (Indiscernible). That's it.
THE COURT: Okay. Mr. Bigley, this is Master Brown. Now, I don't want you interrupting...
MR. BIGLEY: Okay. I'll (indiscernible). I'm sorry, Your Honor.
THE COURT: (Indiscernible) it's very important, okay?
MR. BIGLEY: Okay. I'm sorry, Your Honor.
THE COURT: But especially because I'm on the phone and it just makes it more difficult for me to sort out who is saying what.
MR. BIGLEY: (Indiscernible).
THE COURT: Okay. So, let's get -- is it okay for Mr. Young to be the first witness?
MS. DICKSON: Yes, that's fine, Your Honor.

THE COURT: Okay. So, Mr. Young, I'll just swear you in. Do you swear or affirm to tell the truth, the whole truth, and nothing but the truth?
(Side conversation)

STEVE YOUNG

called as a witness, being first duly sworn upon oath, testified as follows:
(Oath administered)
WITNESS: I do, Your Honor.
THE COURT: And, state your full name for the record?
WITNESS: My name is Steven Young.
THE COURT: Okay. Ms. Russo, if you want to inquire.
MS. RUSSO: Thank you.

DIRECT EXAMINATION

BY MS. RUSSO:
Q Mr. Young, are you familiar with Mr. Bigley?
A Yes, I am. I -- the Public Guardian's Office has been Mr. Bigley's conservator for a number of years, and his guardian...
MR. BIGLEY: Six years.
A ...for around two years.
MR. BIGLEY: Six years (indiscernible).
Q And so you've known him for approximately six

years?
A Ah, longer than that. I have known Mr. Bigley since approximately 1997.
Q And how is Mr. Bigley currently doing?
A Poorly, in my opinion. Um, Mr. Bigley was discharged from API on or around the 3rd of January, and has not been compliant with any mental health treatment since that time, and has gradually gotten worse, in terms of his psychosis.
And recently he was (indiscernible) I'm going to go back to the 5th of February. That's the day when we had to ask Mr. Bigley to stay away from the Office of Public Advocacy because he was unable to maintain any appropriate level of behavior coming into our office. And he was unable to follow that request. He came in repeatedly after that, and we attempted to refer him to his attorney, Jim Gottstein's office. And we began trying to work with Mr. Gottstein and Mr. Bigley together. The issue was, how we were going to provide services -- guardianship service to Mr. Bigley.
It's a complicated case...
MR. BIGLEY: (Indiscernible) work for you,

Steve.
A Our office provides some unconventional assistance to Mr. Bigley because of his uniqueness. He doesn't readily accept, nor do agencies readily provide out patient mental health services to him. In fact, he said (indiscernible) from several agencies. And when he was released on the 2nd of January, ah, Mr. Gottstein obtained some outpatient assistance through a new agency called Choices, which he evaporated after a week. And, so, although he was not compliant with his medication, and was deteriorating, we were still in a position of trying to make sure that he had a place to live, and regular food purchasing was going on, and that sort of thing. Which we did up until the time that we felt it was dangerous to go into the grocery store, and that kind of thing. And then we were trying to coordinate with Mr. Gottstein as to how we would do this.
And, neither Mr. Gottstein nor Mr. Bigley were able to assist in coming up with any kind of a plan after...
MR. BIGLEY: Hey, he's my lawyer, you know. Gottstein, he's -- he's (indiscernible). Why do you

always have to bring him in for. You don't know him.
A (Indiscernible). So we were trying to come up with a plan to provide needed groceries to Mr. Bigley, and he was completely unable to focus on the issue. He was (indiscernible) -- his belief that he's worth a lot of money, and that (indiscernible) to him, and -- and -- and that was his focus, over, you know, his recognized needs.
On top of that, he was beginning to make threats against, um -- he would make them against our office, which...
MR. BIGLEY: Yeah. You, Jim, the secretaries, all (indiscernible) there. I'm not buyin'.
A Right. And...
MR. BIGLEY: (Indiscernible).
A ...the threats could include the entire building...
MR. BIGLEY: That's right.
A ...and that sort of thing.
MR. BIGLEY: (Indiscernible).
A My opinion, after that, said he was not able to look after his basic needs, and, as his guardian...
MR. BIGLEY: Guard me.

A ...I needed to follow the formal proceeding to ask that he be evaluated at API.
Q And so you talked about that you were trying to...
MR. BIGLEY: (Indiscernible) go home.
Q ...assist him in purchasing food. Has Mr. Bigley been able -- have -- have you been doing that?
A I (indiscernible) take Mr. Bigley grocery shopping once ever seven to 10 days or so. And I take him to the store, and we go through and he helps pick out things that he wants, and then we bring them home...
MR. BIGLEY: (Indiscernible)...
A ...(indiscernible)
MR. BIGLEY: ...no food.
A And, ah -- and that's the way he gets groceries purchased.
Q And then what else -- when you had characterized the assistance that you were providing him as "unconventional," could you describe what you meant by that?
A Well, the Office of Public Advocacy is appointed as his guardian. But OPA typically does not act as a direct service provider.

(Side conversation)
A I mean, (indiscernible) in a (indiscernible) position (indiscernible) and coordinator needed assistance. And, so, generally speaking, we're working with a community health provider...
MR. BIGLEY: They're diggin' in my pockets.
A ...(indiscernible) Mr. Bigley's needs. And we would make sure that they're receiving those services. And we -- we've advocated for services for Mr. Bigley from (indiscernible). In fact, they have (indiscernible) -- they've taken -- they had somebody assigned to his case, but when Mr. Gottstein began representing him and finding a third party agency called Choices (indiscernible).
MR. BIGLEY: They're diggin' in my pocket.
A Mr. Bigley declined the community mental health services that they've quite rapidly backed out. Or, you know, stopped providing that once a week contact.
And then -- then (indiscernible) a week, and then the person that Mr. Gottstein had lined up for the (indiscernible) was either unable to continue, or -- or, Mr. Bigley also declined his assistance. And then he came back to the Public

Guardian's Office asking for assistance.
Q Okay.
MR. BIGLEY: (Indiscernible).
Q And then has Mr. Bigley been able to maintain for longer period of time, than the most recent period of six -- or, approximately six weeks in the past -- indicated that he -- that was the very -- has he -- when he's doing well, has he been able to maintain outside of API for longer?
A He has. Although, (indiscernible) -- when he was discharged, I want to say in the spring of 2004, thereabouts...
MR. BIGLEY: (Indiscernible).
A ...he went more than six months without any API admission, and it was when his medications were changed...
MR. BIGLEY: Yeah. He called the cops on me this time.
A ...(indiscernible) medication, and API was acting as the outpatient provider. Bill voluntarily came to API every week to get a (indiscernible) injection.
MR. BIGLEY: (Indiscernible).
A And he was much better off with that medication than he...

MR. BIGLEY: (Indiscernible) rob my money.
A ...(indiscernible) better off. Characterizing that, I would say that he was able to maintain some modicum or appropriate behavior...
MR. BIGLEY: (Indiscernible) be stupid.
A (indiscernible) wouldn't get upset, but that he would actually apologize when he got upset. He had a sense of humor. He -- he wasn't yelling and screaming, and...
MR. BIGLEY: Yeah. Right.
A ...and be hostile, which is (indiscernible).
MR. BIGLEY: Am I schizophrenic?
Q And do you think that Mr. Bigley would be able to maintain outside...
MR. BIGLEY: Yeah. Yeah. Yeah. (indiscernible), yeah.
Q ...right now?
MR. BIGLEY: Yeah. (Indiscernible).
A (Indiscernible) without his (indiscernible).
MR. BIGLEY: (Indiscernible).
A Mr. Bigley was...
MR. BIGLEY: (Indiscernible) ya'. (Indiscernible)...
A (Indiscernible).
MR. BIGLEY: (Indiscernible) ...pay the bills.

A In September, October of 2006, and, ah, it was because, in his agitated state, he tends to become angry and hostile at virtually everybody. And he had become angry at the department manager, and they had evicted him.
MR. BIGLEY: No, he wouldn't pay the bill when I was in here. He made sure that (indiscernible) too much stuff. Don't like to me.
A It's charged to an (indiscernible)...
MR. BIGLEY: (Indiscernible).
A And, ah, that...
MR. BIGLEY: (Indiscernible)
A .... (indiscernible) his living arrangements was -- did not work out well. He (indiscernible) and ended up...
MR. BIGLEY: (Indiscernible).
A ...back in the hospital for a brief period.
MR. BIGLEY: (Indiscernible).
A There was the (indiscernible) that hospitalization that Mr. Gottstein stepped in and decided to represent Mr. Bigley. And it's since that time that he has declined medication and even declined...
MR. BIGLEY: You can't force medication on (indiscernible).

A ...(indiscernible) with the Office of Public Advocacy.
Mr. Bigley came out of the hospital in early January believing that...
MR. BIGLEY: (Indiscernible).
A ...he no longer had a public guardian; would never have to take medication again; and was going to be able to move to California, all with the help of Mr. Gottstein. And it was quite evident right early on that...
MR. BIGLEY: It's horrible down there, man.
A ...there was a large difference from, um...
MR. BIGLEY: (Indiscernible).
A ...(indiscernible) discharged from API in the past. (Indiscernible) speaking...
MR. BIGLEY: (Indiscernible).
A ...(indiscernible) been his primary source of support.
MR. BIGLEY: (Indiscernible).
MS. RUSSO: Those are all the questions I have for Mr. Young.
THE COURT: All right. Ms. Dickson, because of what (indiscernible)...
MR. BIGLEY: (Indiscernible).
THE COURT: ...strictly following what's going

on, I'm gonna ask you to really step in and represent him. And if you have any questions, cross examination, go ahead.
MS. DICKSON: I do, Your Honor.
CROSS EXAMINATION
BY MS. DICKSON:
Q Mr. Young, what is your educational background?
A I have an undergraduate degree in psychology, and I went to graduate school to teach biology.
MR. BIGLEY: Do you have (indiscernible).
Q So are you qualified -- are you qualified to make any type of mental health diagnosis?
A No, ma'am.
Q Okay. And, does Mr. Bigley currently have an apartment?
A He does.
Q Does he currently have enough financial resources to pay his rent?
A Yes, he does.
Q Does he have enough financial resources to pay his bills?
A He does.
Q Okay. Mr. Young, one of your big concerns that I think you testified to a couple times, was

regarding groceries. And that you had a hard time making arrangements with Mr. Bigley. And I could speaking wrong. Was it delivered groceries?

A It was to be able to provide groceries to Mr. Bigley somehow. That was the -- that was the question...

MR. BIGLEY: (Indiscernible) a hundred dollar check, a $10 cab ride, and (indiscernible) my house, but you wouldn't do it.

Q Now, Mr. Bigley -- does Mr. Bigley have -- do you give him any disposable income to spend on (indiscernible)?

MR. BIGLEY: No. $50 a week. That's it.

A I -- I provide Mr. Bigley with a $50 personal spending (indiscernible) each week, and a check to purchase a carton of cigarettes.

MR. BIGLEY: (Indiscernible).

MS. DICKSON: Okay.

A And then depending upon what arrangements there is for groceries, either a check is provided for -- payable to a vendor, so that somebody can help him -- help with the transportation and the shopping, and (indiscernible) in the event that I'm doing it, I

simply go and get what he wants, and then...

MR. BIGLEY: (Indiscernible).

A (indiscernible) assist in getting them back to his apartment (indiscernible), then I seen the reimbursement for that through the channels here at OPA.

Q So, Mr. Bigley is able -- he knows where your office is, is that correct?

MR. BIGLEY: I can go down there.

A Yes, he does.

Q And so he's able to transport himself down to meet with you at your office?

MR. BIGLEY: I don't go down there.

A He -- apparently -- I mean, he has a bus pass, and he's able to get on the bus and ride it downtown.

Q And you say you give him money to buy a carton of cigarettes. So, is he able to go to the store and buy a carton of cigarettes -- or a pack of cigarettes when he wants them?

A Not always, no. Ah, he has been kicked out of the cigarette store (indiscernible)...

MR. BIGLEY: (Indiscernible) exactly -- he wants to know where his money's at...

A ...(indiscernible) or they will ask him for

his (indiscernible) when he brings the carton to the register. And he has been asked to stay away from -- but, you know, he's had to find new places to buy cigarettes when that happens.

MR. BIGLEY: (Indiscernible) don't want your stinkin' (indiscernible).

A And sometimes he's torn up the check, (indiscernible)...

MS. DICKSON: (Indiscernible).

MR. BIGLEY: (Indiscernible).

A ...had torn it up, and at those times we usually (indiscernible) to the grocery shopping.

MR. BIGLEY: No, you don't.

Q But, Mr. Bigley, when you go grocery shopping, he's able to pick out what he would like to eat?

A Not really. He's able to hold on to the back of the cart, and somebody has to hold onto the front so that he doesn't run into things.

MR. BIGLEY: They ram my cart.

A (Indiscernible) if somebody comes between and an item that he's looking for on the shelves, or in a case, or whatever, it's usually necessary to position yourself in front of him so that he doesn't begin verbally accosting the person who is standing between him and something that he's

looking for. (Indiscernible)...

MR. BIGLEY: They know who I am (indiscernible).

A ...(indiscernible) in his way, and he's generally...

MR. BIGLEY: They know who I am. (Indiscernible).

A ...(indiscernible), and that he's (indiscernible)...

MR. BIGLEY: (Indiscernible).

A ...(indiscernible) that somebody is listening to what he is saying, or trying to get close to him to touch him, or something of that like.

Q Okay. And, Mr. Young, I understand that he has personality qualities that make good shopping at a grocery store difficult. But I'm talking about his basic ability to go pick up food, and purchase it, and eat it?

A He lacks that ability (indiscernible). He's not...

MR. BIGLEY: (Indiscernible).

A He would not be capable, in my opinion,...

MR. BIGLEY: (Indiscernible).

A ...of getting through the grocery...

MR. BIGLEY: (Indiscernible).

A ...(indiscernible). Back when -- when this -- just prior to me filing the petition, I -- I asked him if this is something that he would prefer to do. He wasn't even able to give me response to the question. His response was completely unrelated to the question.
But that's -- the problem is (indiscernible). Number one, he is usually pretty agitated, which makes the grocery store, where there are a lot of people, and lines, and that kind of thing...
MR. BIGLEY: I always go shoppin' by myself, man. I go to (indiscernible) stores.
A And that's not his personality -- it's not just his presentation. He's just not -- he's not disposed to being able to deal with people appropriately.
Q Okay. Well, in his apartment, you had someone coming in and preparing his meals?
A No. As I said, we buy food that he can either readily eat or...
MR. BIGLEY: I can't eat in the restaurant.
A ...(indiscernible) microwave, or...
MR. BIGLEY: That's cool.
A ...(indiscernible)...
MR. BIGLEY: You gotta make sure I couldn't do

it.
A ...we buy some foods that he would have to put in a pan, but that's usually the last...
MR. BIGLEY: (indiscernible) -- a hundred dollars in my pocket or my hand.
MS. DICKSON: (Indiscernible).
MR. BIGLEY: Okay. Let him talk (indiscernible).
MS. DICKSON: I just need to be able to hear his answers.
THE COURT: Mr. Bigley, (indiscernible)...
MR. BIGLEY: Okay. I -- I -- I'm sorry. I'm sorry.
THE COURT: (Indiscernible) Mr. Bigley, this is Master Brown.
MR. BIGLEY: I'm sorry.
THE COURT: Yeah. I -- I know you're trying, but, you know, but try a little more (indiscernible).
MR. BIGLEY: Okay. Okay. Okay. I'm sorry. I'm sorry, Your Honor.
Q Okay. And, Mr. Young, I didn't hear the end of the answer. But, I mean, again, he can prepare the food. The problem is him going into a store with other people that presents problems?
A It all presents problems. And the reality is

-- yeah, obtaining the food is one of his biggest obstacles, certainly. But preparing it also difficult for him. He buys food, or we purchase food for him, but it is readily eatable. And -- and which requires very little, if any, preparation.
You know, for example we would buy food in the deli counter that he could heat easily, it its own container, in a microwave oven. That's mostly what we buy.
MR. BIGLEY: (Indiscernible).
A Mr. Bigley could not, in my opinion, shop independently. He's not capable. That's actually one of the reasons we...
MS. DICKSON: (Indiscernible).
A ...attempted assisted living, to see if he would do better in a (indiscernible)...
MR. BIGLEY: (Indiscernible).
A ...but that isn't readily available.
Q But, Mr. Young, it does sound like, when he's out (indiscernible), you have made arrangements for his grocery needs to be met?
A We -- we...
Q Either you go shopping with him, or you make other arrangements?

A We -- we -- we have to, because he -- he requires that.
Q I have no...
A The reason -- one of the reasons why this petition was filed was because we have been unable to do that for 10 days or more, and even with the assistance of his attorney, we were unable to...
MR. BIGLEY: (Indiscernible)...
A ...(indiscernible) provide for him that he had been claiming that he was (indiscernible).
Q I have no further questions.
THE COURT: Okay. Ms. Russo, do you have other questions?
(Background conversation)
MS. RUSSO: Not of Mr. Young.
THE COURT: Okay. Mr. Young, thank you for your testimony. And let me ask -- I want to make sure. Ms. Russo and Ms. Dickson, is it all right with you, or do either of you want Mr. Young, as Mr. Bigley's guardian, to stay on the line?
MS. RUSSO: He's free to, if he wishes, but he isn't required.
THE COURT: Oh, okay. So, Mr. Young, do you want to stay on the line?

A Yes, please.
THE COURT: Okay. Ms. Russo -- so I guess we're (indiscernible) -- Ms. Russo, your next witness?
MS. RUSSO: I'll -- well, I guess I'd ask if the court would like to have Ms. Taylor give her visitor's report now, or if we should wait for the completion of...
THE COURT: Well, I -- (indiscernible) you haven't had the doctor testify yet. I'd prefer it at least after the doctor's testimony.
MS. RUSSO: Okay. Then I'll cal Dr. Worrall.
THE COURT: Okay. Dr. Worrall, (indiscernible), and I'll swear you in.

WILLIAM WORRALL, M.D.

called as a witness, being first duly sworn upon oath, testified as follows:

(Oath administered)
WITNESS: I do.
THE COURT: Okay. So, Ms. Russo, if you want to go ahead and inquire.
MS. RUSSO: Thank you.

DIRECT EXAMINATION

BY MS. RUSSO:

Q Dr. Worrall, are you familiar with Mr. Bigley?
A Yes, I am.

MS. DICKSON: (Indiscernible).
MS. RUSSO: Excuse me.
MS. DICKSON: Your Honor, I just -- generally, Dr. Worrall is qualified as an expert, and so I'm assuming Ms. Russo is going to ask to make that qualification. I have had numerous opportunities to cross examine Dr. Worrall, and have inquired into his qualifications, and I'm satisfied that his credentials meet that of an expert in the area of psychiatry.
THE COURT: Okay. So, I'll qualify him as an expert in psychiatry.
MS. RUSSO: (Indiscernible).
MS. DICKSON: (Indiscernible).
Upon Ms. Russo making the motion for (indiscernible).
MS. RUSSO: Yes. No. I appreciate that.
Q So, Dr. Worrall, you are familiar with Mr. Bigley?
MR. BIGLEY: (Indiscernible).
A Yes. I'm his psychiatrist here.
Q Okay. And how long have you known Mr. Bigley?
A Oh, off and on for 20 years. Mostly over the last six months, more (indiscernible).
Q And what were Mr. Bigley's pro -- presenting problems on admission?

A Um, primarily very emotional and getting very, very upset, and loud, and scaring people with things that he would say, very disruptive, a delusional, paranoid. Those were his primary problems.
He was brought to us on an ex parte, related to the issue of whether he was at risk because he couldn't get his groceries, and whether he was at risk because he was so disruptive that the police were escorting him off properties, and somebody might assault him, (indiscernible) speculation.
Q And what is his current diagnosis?
A Schizo-Affective disorder, bi-polar type.
Q How does that manifest itself with him?
A Um, paranoia, delusions, irrational thinking, poor judgment, quick emotional reactions, assaultive behavior. That's pretty much (indiscernible).
Q And does that cause him to -- (indiscernible) it manifests itself? (Indiscernible) cause him to not be able to live safely in the community?
A Um, well, I think that's a conclusion that I -- I can't make. I think that's why we're here today. I can tell you that he has severe impairment of judgement because of his delusions

and his paranoia thinking processes. He doesn't do what any rational person would do when presented with a set of options to take steps towards something that's in his interest.
Whether or not he's gonna freeze to death, or starve to death, something like that, I really don't have reason to think that that is gonna happen.
He did -- he lost three and a half pounds since he left the hospital January 3rd. That's not very much weight loss. He's a little thin to start with, but he's certainly not in any medical jeopardy because of the three pound weight loss.
He hasn't been to an emergency room with an assault, because of his relative behavior. But under the existing statute, I felt comfortable filing for grave disability, because he is certainly suffering. He has very impaired thinking processes that cause him to process, but because of his mental illness. And that's the basis for filing the petition, of whether or not he's safe or not, I think is the question here.
Q How -- you said he doesn't do what any rational person would do. (Indiscernible). Can you give an example of what you mean by that?

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A Well, for example, I've gone on the unit and encouraged him to try and be quiet. He wants to get out of the hospital. So I worked with him to encourage him to not be disruptive in the courtroom, so that he could show that he has self control. I've encouraged him to try to come up with a plan for how he's gonna have food and provide for his food, and negotiate some plan with his guardian, who he needs to work with at this point in time, for his food.

As you can see, I've made no progress with that, from a counseling approach.

And on the unit, he did require two emergency injections of Haldol and Ativan, which are psychotropic medications that the staff gave him under emergency conditions when he was creating dangerous situations on the unit.

And it wasn't that he was assaulting anybody, but he was in a state of mind where he was screaming so loudly that it was upsetting other patients who were becoming unstable, and the staff felt that was an emergency.

The result of those two shots lasted one -- it was two days of those. But he's actually a little more stable today, and a little bit more

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redirectable. A little bit calmer today than he was when he got here. So he's certainly not as bad as he was before he was brought to us because of that two doses of medication.

Q And how would you intend to treat Mr. Bigley?

A Well, I would treat him the way I treated him last time. With Risperdal and Seroquel and the Depakote, and he had a remarkable improvement, despite the fact that he was extremely difficult to work with regarding realistic discharge planning, because of the disruption that's occurred with the intrusion of this new attorney. Despite that, he was the calmest I've ever seen him. You could sit in a room with him and talk about difficult things, and he didn't get upset, he didn't get loud, he didn't try to take over the conversation. He was remarkably improved in his self regulation of his emotional condition. He was still delusional and paranoid, but he wasn't upset by those delusions and driven by the paranoia.

Despite him being in that grave condition, that's the best I've ever seen him is on those medications. He didn't take any medicine as soon as he left the hospital.

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So we didn't get him to such a point that he had such insight that he wanted to continue medication, and he rapidly deteriorated. But I firmly believe that that is because he's been empowered by this new -- new attorney that he has, and he really thinks he's driving the show.

Q And what -- have you discussed the -- the medications you prescribed with Mr. Bigley?

A Yeah. You can't get anywhere talking to him about it. He doesn't want it. He doesn't have to talk to me about it. It -- you can't reason with him at all about something like medication. You can kinda reason with him about how he could get to a point of having privileges (indiscernible) smoking privileges, but he doesn't even want to consider medication, so I can't have that conversation with him.

Q And have you had that conversation, though, on past admissions with him?

A Um, yes. And the longer he's been on medication -- particularly if he's on a mood stabilizer, like Depakote, the easier it is to have those conversations. You know, for example, he was on something that he had side effects with, and he told me about it, and we reduced the

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dose, and he reported he felt better on it. But the whole time that he was telling me this, when he gets out he won't have to take medication because his attorney told him he doesn't have to.

Q And beyond -- I guess, previous to this most recent -- to the most recent prior admission, in the past, had you been agreeable to taking medication?

A Ah, I think it's almost always been involuntary medications at the start. He's almost always had to be committed, and involuntary med hearings. And then when he's gone more than 30 days, I think he -- he's usually had to go to a 90-day commitment. I don't think it's ever -- I can't recall a time when he's voluntarily taken medication. But after the first two to three weeks of taking medication, he's usually pretty cooperative, even though he won't consent, really, verbally, voluntarily. He's usually pretty cooperative. He doesn't, you know, have to be a shot, or that kind of thing. He's willing to take pills. But initially, very common that he has to have forced medication.

Q And what would you -- you had stated that he's

better able at -- or, he's not as upset or driven by delusions when he's on the medication. What other benefits did you expect to see from the medications?

A Well, his judgment -- apart from the question of getting rid of his guardian, and taking -- getting rid of his medications, and then being free to go wherever he wants, because he would get his own income and not have to answer to a guardian, which is all related to the guardianship lawsuit he has going on. Apart from that, his judgment was improved. And he -- he would -- he was very good at being able to keep his smoking privileges, for example, (indiscernible). So he knew exactly what he needed to do. How many rooms he had to go to. What he could and couldn't do. And he followed -- followed the guidelines and showed good judgment and self control and be able to do that, for example.

He -- a prior -- on the prior admission to this -- to the past admission -- so, two admissions ago -- he was much more workable after he was on medication with regards to discharge planning. You know, for example, you

could talk with him to considering an assisted living facility towards the end of the hospital stay, that kind of improvement. But certainly very workable with his guardian. The guardian would come in and sit down, and the two of them would have a good discussion.

He used to quiet down and listen to his guardian, when he wouldn't listen to any of us. And now he just -- just completely -- I mean, you couldn't get more uncooperative, the way he is with his guardian now. And that's a complication that really is unrelated to medication.

The empowerment that he's gotten for -- from his new litigation that he has going, has fed into his grandiose delusional -- and, so, you'll hear him talking in this hearing about the White House, and this and that. He's got all kinds of conspiracies, delusions, and it all gets fed into by his -- by his new -- and he actually told me right before the hearing that President Bush was gonna make sure he gets food. That the White House would get him his food. And that the White House -- that President Bush gave him a jet airplane, too.

MR. BIGLEY: (Indiscernible).

A That...

MR. BIGLEY: (Indiscernible).

A That's the kind of stuff that quiets down when he's on medication.

MR. BIGLEY: (Indiscernible).

A He doesn't talk like that, and he doesn't say, "Well, I don't need to worry about food, because the White House is gonna give me medicine and give me food." He doesn't say that kind of stuff when he's been (indiscernible). Instead, he figures out a realistic plan for how he's going to (indiscernible). But anymore you can't even get that because now he has this psychosocial force operating. Not just the mental illness, but the psych-social force with the empowerment he's getting from his recent litigation. So it's really complicated, his treatment.

Q And does Mr. Bigley have any insight to his mental illness?

A That's zero. He has no appreciation that he has a mental illness. He has no insight that he has a mental illness. He thinks that everything that's happening to him is because everyone around him is conspiring to ruin his life.

(Background conversation)

Q And have you tried to talk with him about why (indiscernible)?

A Yes. But, if you can't have a reasonable discussion about that at this time. He insists that I went out and dragged him into the hospital. That I went out and intentionally pulled him off the street. That it was something that I did to him. And doesn't have any insight into the fact that his failure to cooperate was ensuring that he had food, with his guardian. A factor that led to an ex parte and (indiscernible).

Q And when -- this last time in January, when Mr. Bigley was most recently at API and left, and he stopped taking the medicine. Did he -- do you think he had the capacity to really make an informed decision at that time?

A Um, not really. No. I -- I was -- the day we discharged him -- a couple days before, I had to decide if I was gonna petition for 180 day commitment, because he was at the end of his 90 days -- having been out of the hospital. And, because we did an early release before. And with this new thing about "safely survive outside of API," I just didn't really feel like I could take

him to court, because he was being very reasonable about most thing. Yeah, he wouldn't cooperate with his guardian, but, it wasn't, kind of like, related around that. I thought he'd be safe outside of the hospital, and I didn't petition. But as far as the ability to make a competent decision about whether he should take medication or not No, I still think he was competent to decide that he shouldn't stop is medication, because he's so delusional, so paranoid, he doesn't have the capacity to make a reasonable decision without (indiscernible).

Q And I think -- (indiscernible) -- Risperdal, Seroquel, Depakote -- those are all medications he's been on in the past?

A (Indiscernible) we stabilized him with Risperdal shots -- every two weeks, Risperdal (indiscernible) injection. But it wasn't quite enough to help him with the psychosis, so oral Seroquel -- a second anti-psychotic helped to make the difference there. But then that pill wasn't enough to help him with the emotional instability that he had, pressured speech, and what we call labile affect, or just extremely emotional upset. And the Depakote, which is a

mood stabilizer, took care of that component of his symptoms. So on those three medications, he was about the best I've ever seen him.

Q And did Mr. Bigley experience any side effects from those medications?

A Not in the last two to three weeks of his stay. When we first started it, he had some side effects; tiredness. He had a little dizziness. He complained of some headaches.

Interestingly, whenever he visited with his attorney, he would immediately go to the staff and report side effects. And, at no other time would he report side effects.

The next say when I'd ask him about the side effects, he'd say he didn't have any. But when you first start these medications and you're increasing the dose, there are side effects that are commonly seen. He wasn't complaining of side effects when he left.

He does tend to report that he can't have normal sex or normal sexual functions, and he was -- he was consistently complaining about that. But the benefits of the medication far outweigh that side effect.

Q And are there (indiscernible) medication is

proposed as a standard of care of the community?

A Yes, I think so. It's two antipsychotics which we use typi -- very commonly in what we call "treatment resisting cases." Where patients don't respond readily to one medication. And you try that medication -- one medication in a sufficient dose, and for a sufficient amount of time to make sure it's not gonna work.

And then it's really very common in what we call a "refractory," or difficult to treat cases, to add a second antipsychotic medication.

Q And are there any less intrusive treatments available?

A Less than medication?

Q Yes.

A No. I think the way he was when he came here -- he's been off medication for several weeks, and that's -- that's the way Bill is when he's not on medication, and that's not affective. Psychotherapy wouldn't do anything. There's no psychotherapy approach. He's not gonna acquire social skills from social skills training groups, when he's argumentative and emotionally upset.

MR. BIGLEY: (Indiscernible).

A A residential -- if he was in a residential

housing therapeutic program that didn't use medication. I don't even think that would work, because he would get kicked out in a few days because of his disruptive behavior.

(Background conversation)

A He's very hard to tolerate, and the only thing that fixes that is medication.

Q Do you believe that treatment will be a benefit to Mr. Bigley?

A It would be, especially if there was a way to keep him on that treatment beyond the walls of t his hospital. And the last time we didn't have an early release because we were at the end of the 90 days, and I didn't feel like we could successfully argue that he was still gravely disabled when he had such improved conditions. But, ideally, we need to have an early release kind of situation where he can be brought back in for a very short stay, after he's only been off his meds for a very short amount of time, and the idea would be to kinda get him trained.

"Gee, I guess I have to stay on my medication," and then he would eventually be able to go back to living in the community.

The period of time that Steve Young described,

when he was stable as an outpatient, was a period of time when he was accepting the constraints he was under. He was accepting that he had to go to API and get a shot. He was accepting that he had to work with a guardian. And he got by out there in the community under those conditions, until he missed two of his shots, as I've indicated, he became too disruptive and upset and had to be readmitted.

At that point in time, ah, we were trying to get him to take different kinds of medications, such as the Depakote. We couldn't get him to cooperate with the oral medications...

SIDE B

A ...services from the community, such as living in an assisted living facility and having a mental health center work with him, where they had case management services. But none of those things worked out, as Steve Young mentioned. They just didn't work out because even the professional mental health staff at Anchorage Community Mental Health Services would have case managers that are trained to work with people like Bill, they couldn't stay on working with Bill. They didn't wanna help him.

And so, if it weren't for Steve Young, nobody would be helping this guy out there.

So -- but that had got way worse when he decided that he doesn't have to listen to Steve Young, and he doesn't have to listen to people who tell he has to take medication. That's the complication with his new litigation.

Now it's almost impossible to treat him with the situation he's under now. I don't know what we're gonna do.

Q Okay. But do you think that if were committed to API, and that the medication order was granted...

MR. BIGLEY: (Indiscernible).

A ...is that treatment would be a benefit to him?

MR. BIGLEY: (Indiscernible).

A I know that I could get him back into the same good shape I had him in before I discharged him on January (indiscernible).

MR. BIGLEY: (Indiscernible).

Q But, unfortunately, if he still thinks that he can get rid of his guardian, and that he can get all...

MR. BIGLEY: (Indiscernible).

A ...get all his money and fly to California, and that he doesn't have to take medication, I'm not sure what good that does. You know, I can get him well while he's here, but I'm gonna need to come back and get...

MR. BIGLEY: (Indiscernible).

A ...an early -- you know, go for a 90-day and get an early release, so that we can assure that this continues beyond these walls.

MR. BIGLEY: (Indiscernible).

THE COURT: (Indiscernible) Master Brown again. I know you're trying (indiscernible), but I really appreciate if you could be quiet, okay?

MS. RUSSO: Those are all the questions I have for Dr. Worrall.

THE COURT: Okay. Ms. Dickson, do you want to inquire?

MS. DICKSON: Yes.

CROSS EXAMINATION

BY MS. DICKSON:

Q Dr. Worrall, what kind side effects does Depakote, Risperdal and Seroquel have?

A Oh, a huge list of side effects.

Q (Indiscernible) as to what's the most concerned side effects?

MR. BIGLEY: (Indiscernible).

A Well, there's very rare things that of great concern, because they -- they could be potentially lethal, and something like, maybe one in 10, one in 20,000 people could have side effects, such as bone marrow problems, and we don't make blood cells, or severe liver disease could develop. They're extremely unlikely.

The common side effect, such as, for example, sexual dysfunction, difficulty ejaculating, for example. Which is a complaint that he's had. Something that could be reversed with Viagra, for example.

MR. BIGLEY: No, no, (indiscernible).

A The -- the common side effects of constipation, dryness, dizziness, things like that, are resolved with time. The side effects go away by themselves when the patient gets used to the medication. The body handles it better.

But you can get skin problems, stomach ache -- just about anything that you can think of, the medications have been accused of causing.

On the other hand...

MR. BIGLEY: (Indiscernible).

A Risperdal and (indiscernible) -- also have a

neuroprotective effect on the brain, as they help to prevent degenerative brain process that's associated with schizophrenia, schizo-affective disorder from proceeding further. And there's been research showing that brain volume is protected. That the loss of brain volume that occurs over the course of the illness, stops happening. In fact there's some increase in brain volume that occurs. So there's a protective effect, too.

But these aren't -- these aren't medications to be taken lightly. They can only be used when there's a severe problem with the (indiscernible) treatment, and Mr. Bigley has that problem.

Q Dr. Worrall, you mentioned (indiscernible) the protective coating in the brain that helps prevent (indiscernible) some studies. Are those studies conclusive? I mean, have you -- I mean, when you're looking at the studies, how (indiscernible) -- I guess "conclusive" is the best -- better word. I mean, are you convinced that that protective coating is there?

A It's not a coating. It's not like Teflon or something.

Q Right.

A It's a protective effect. How it works is unknown. But the studies were very conclusive. Way beyond (indiscernible). The research in that area is still early, but it is something on the cutting edge of medication.

The older medications that he used to take, Haldol, for example, Prolixin, that cause a lot of tartar dyskinesia, and not have that protective effect. The new medications, Risperdal, Seroquel -- very unlikely to cause tart dyskinesia. Much, much safer with regards to the problems like that, and have a protective effect on -- against the neuro-degenerative process of schizophrenia.

Q Now, do the pharmaceutical companies who make Risperdal, are they -- are they the ones who conducted the studies?

A They don't even talk about it yet. I don't think -- I don't think they're talking about it. That's something -- I learned about it in on-going medical education -- I don't know who paid for the study, but (indiscernible)...

MR. BIGLEY: (Indiscernible).

A ...call me to tell me about it.

Q Have you ever talked to your colleague, Dr.

(indiscernible)?

A We've talked about research. There's another area of research, like the (indiscernible) studies that compare the old drug versus the new drug. The old Haldol, for example, versus Risperdal. And they looked at the patient's quality of life, and how many times people came into the hospital on the different medications. And they had similar results. One was no better than the other. Certainly, the Haldol was a lot cheaper.

So what they didn't talk about, was the neuroprotective effect, because that's a brand new cutting edge thing. And they didn't talk about the tartar dyskinesia differences in the two groups.

Q Um...

A But, basically, those older drugs are the cheaper, less expensive, more side effect prone way to treat the same illness. And there's evidence that the old cheaper medications pretty much work just as well, but I wouldn't want to be on them if I had schizophrenia. I would want to be on the more expensive new drug.

Q Dr. Worrall, in the 20 some years that you've

known Mr. Bigley, has he ever agreed or (indiscernible) his medication?

A Oh, he has -- towards the end of the hospital stay he said, "Yeah, I'm gonna take my medicine when I get out of here," but I didn't really believe him.

MR. BIGLEY: (Indiscernible).

A But he has said that. He has said that the medicines help him, a few times. But he has -- he has the tendency, like most people, to say what you want to hear sometimes, if they think it's gonna help them.

In general, no, he doesn't like the idea of taking medications. He is only, for the most part, taking it when he believed that he had to take it.

Q I'm not sure that Mr. Bigley is (indiscernible) in better shape than a lot of (indiscernible) patients (indiscernible).

A Yes. Well, particularly given that he has a guardian that goes out of his way to provide for his needs.

MR. BIGLEY: (Indiscernible).

A We have -- I have a lot of patients with guardians, and I -- I have never seen this kind

of effort from a guardian. So he has -- he has a lot of support, both financial and otherwise.
MR. BIGLEY: (Indiscernible) money.
Q (Indiscernible) Mr. Bigley (indiscernible) when he didn't take his medication (indiscernible) was able to function in the community, isn't that correct?
A When he was out this time not taking medication? Well, he was escorted from a couple of properties by the police for being disruptive, but he wasn't arrested. He wasn't beaten up and taken to an emergency room.
MR. BIGLEY: (Indiscernible).
A But I don't think I would say that he was able to function in the community. I would say that he survived.
Q Well, let me paraphrase that. Would he be able to survive in the community -- he may not be living healthy, but he's able to do that without being (indiscernible)?
A Well, obviously, yes.
MR. BIGLEY: (Indiscernible).
THE COURT: Mr. Bigley, this is Master Brown again. I have to ask you to be quiet, because I have to be able to hear Dr. Worrall. Okay?

MR. BIGLEY: Okay. Sorry, sir. Okay.
Q While he's on the unit, is he able to take care of his basic needs?
A Yes.
Q Hygiene? Is he able to eat?
A Well, he doesn't do a whole lot of hygiene efforts, but, he -- oh, he's definitely taking care of his eating. He makes sure he gets double portions, and you hear about it if he doesn't get two of everything. He's definitely looking out for his dietary needs. And we don't have to assist him with walking, or bathroom function, or anything like that. He's not assaulted anybody. He doesn't -- he's upset people to the point that some people have wanted to assault him -- but they assault him. He survived on the unit.
Q Dr. Worrall, I've asked you to (indiscernible), and I guess I'll just repeat it again. When you have someone like Mr. Bigley, who has a history of poor medication, and then when you gave him this revolving door, why (indiscernible) when it appears that he could survive in the community without the medication?
A Well, I think the answer is, the way the law is set up. It's set up to deal with emergencies,

and the peoples mental conditions improve on mediation, and then they gradually deteriorate off medication, until they reach the point of having emergencies, and then all of a sudden you can treat them.
Q What kind...
A It's built into the law.
Q What kind of damage (indiscernible) that are maybe occurring by having him on drugs for a couple months, and off drugs for a couple months. You put him on drugs for a couple months, and then he's of.
A That's a good question. I don't think we know the answer to that. I'm not aware of studies. I don't think we have any scientific research on that topic. At least not that I'm aware of, having, say, five weeks of medication, and then going for five weeks without medication. I don't know what that does. The natural history of the illness. My best answer to that is what I know about psychiatry is that it's probably not harming him to be on medicine for five weeks, and off medicine for five weeks. It's probably better than being on medicine for 10 weeks.
MR. BIGLEY: (Indiscernible)

Q And (indiscernible) studies on whether the (indiscernible)?
A Gee, I'm not aware of research. You know, other than drug holidays. You know, where people stop medicine for a weekend, just to reduce the risk of (indiscernible). Stopping medicine for a month or something like that, and resuming it for a month or two, I'm not aware of any literature like that.
Q And, Dr. Worrall, do you have any knowledge of whether Mr. Bigley has ever used substances that are illicit drugs or alcohol?
A He has some history of that, but it's not been a recent problem.
MR. BIGLEY: No, it's (indiscernible).
A Really, compared to most patients, it's not much of a problem, especially in his recent history.
Q Do you have any concerns -- and I'm going your word, but do you have any concern if Mr. Bigley was discharged today, whether or not he could continue to survive?
A Well, do I have any concerns that he would continue to survive?
Q Right.

A Well, yeah, I have some concerns, but I don't have a conclusive opinion that he won't survive.
MR. BIGLEY: (Laughter) (Indiscernible).
Q And do you think that he can survive safely -- do you have any conclusory -- again, I'm going to use your word -- concerns -- (indiscernible).
A No, I don't have any reason to think he can't survive for a few weeks. Even if he did nothing for the next few weeks, he's gonna survive for at least two weeks. As long as he has housing, a warm place to go to, he's gonna freeze to death. We haven't had to admit him with hypothermia, or such impaired judgment, that he sleeps outdoors in winter. He doesn't drink a lot of alcohol. He hasn't passed out in a snow bank. You know, sometimes...
MR. BIGLEY: (Indiscernible).
A But there's a chance that he is gonna get himself severely assaulted. I think the chance is low because of his disruptive behavior.
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I think there's a better chance that he'll get arrested because of his disruptive behavior in public. Frightening -- concern he's gonna frighten people. He could be pretty scary, but

it's really all talk. He's really not the kind of guy that goes around hitting people. But I don't have a firm opinion that he won't survive outside of API if it was a reasonable period of time, weeks or months or more. But under the existing...
MR. BIGLEY: (Indiscernible).
A ...statute that applies to the petition I filed, I think he's gravely disabled.
MS. DICKSON: Your Honor, I have no further questions.
THE COURT: All right. Ms. Russo, do you have any redirect?
MS. RUSSO: Just briefly, Your Honor.
Q Dr. Worrall, when Ms. Dickson was asking you about the side effects, and you were talking about the uncommon side effects of the medications, such as the bone marrow issues, and the liver disease. Are those things that could be monitored or tested for?
MR. BIGLEY: (Indiscernible) five years from now, because I (indiscernible).
A Yes.
THE COURT: Okay. Mr. Bigley, this is Master Brown. I cannot hear what Ms. Russo is asking Dr.

Worrall, so you do have to be quiet. Okay.
MR. BIGLEY: Okay. I'm sorry.
THE COURT: Okay. Ms. Russo, could you repeat the question.
MS. RUSSO: Thank you.
Q The question, Dr. Worrall, was the side effects -- the severe side effects, such as the bone marrow issues and the severe liver disease, were those things that could be monitored?
A Yes. We do routine blood tests, a blood count and liver function, as for example. He's refused the blood work here an this admission already, so we haven't been able to monitor that as yet. But in the past he's not had any problems with liver side effects or bone marrow side effects.
Q And the fact that he hasn't had a problem with them in the past, does that indicate whether or not he wold have a problem with them in the future?
A That makes it a lot less likely. Usually a first six to eight weeks of the medication are the riskiest times for those kinds of side effects.
Q And then the less severe side effects, those are all -- I think you stated that the sexual

dysfunction could be reversed with Viagra. Is the constipation, dryness -- are those other things that are fixed -- that either resolve with time, or can be monitored, as well?
A Yeah. The thing that he was complaining about before, tired, headache, light headed. They resolve with time. The body -- the (indiscernible) nervous system makes adjustments to the medication and those things go away, and they did go away.
The risks of these medications are far -- far less than the -- the damage that's done to his brain by not treating his mental illness. He's gonna get worse, and worse, and worse every year. He's gonna have worse and worse (indiscernible). And he may reach the point when he does become a danger to himself and others on a constant basis now, instead of being verbally upset, and so forth, he may be so much worse off, and he's tried to hurt people because he thinks they're gonna hurt him. Certainly his level of functioning is going to go down over time if he's not treated. And he suffers. I mean, if you spend enough time with him, you can see that he really believes what he's talking about, and

really, really suffers from his delusions.
I mean, he came up to me the other day and with all the stress, because -- he told me that 300 people a day are eaten alive in this country...
MR. BIGLEY: It's true.
A ...what are we gonna do about it? And he was always...
MR. BIGLEY: (Indiscernible).
A ...(indiscernible). Well, when he's on his medication, he's not suffering.
MR. BIGLEY: I'm not (indiscernible).
A And he certainly isn't suffering from side effects. So, if you compare the suffering from his illness with the little tiny risks of side effects, they're incomparable.
Q And that was my next question, was when -- with the -- even if he is cycling on and off medicine when he is at API and for a period of time after discharge, and then he stops taking the medicines. But the medication -- being on it even for a brief period of time, helps slow down the eventual deterioration of the brain, or?
A Oh, I don't know about a brief period of time. I think the research was looking at six months.

Q Okay.
A If he took medicine for a week, I wouldn't expect that would do much. And you really don't see much improvement in a week in symptoms.
Q Uh-huh (affirmative).
A Particular with Bill, it's like it takes longer and longer each time we treat him before the medicines take affect. I mean, beyond the order of one to two months, the stabilization of the brain would occur.
Q If it were for a longer period of time, I guess, then, five weeks -- but for two or three months, then would that help stop the -- or, at least slow down the progression of the disease?
A As I understand it from some of the newer research, yes. But even without that neuroprotective effect of preventing the future of degeneration, is a clear affect on (indiscernible) and -- and distress from the medication.
Q And then let's say that Mr. Bigley had upset some people on the ward -- on the unit, to the point where they had wanted to assault him.
MR. BIGLEY: (Indiscernible) all over the place. I didn't do nothin' wrong.

Q Why -- why -- were those assaults stopped by staff, or?
A Um, well staff has to take -- well, two things had to happen. One, the staff had to take Mr. Bigley into the quiet room and give him an injection of...
MR. BIGLEY: The staff (indiscernible) me up.
A (Indiscernible) Haldol and Ativan.
MR. BIGLEY: Did it on purpose.
A Which is just like an eight hour acting medication just to calm him down.
MR. BIGLEY: That did it.
A To take him out of the situation.
MR. BIGLEY: (Indiscernible).
A To de-escalate the situation. And then they had to go to this other patient who wanted to assault Bill because he was appearing to the other patient that he was gonna assault staff. They were afraid that Bill might...
MR. BIGLEY: I didn't (indiscernible).
MS. RUSSO: Those were all my questions for Dr. Worrall.
THE COURT: Okay. Ms. Dickson, any re-cross examination?
MS. DICKSON: No, Your Honor.

THE COURT: Okay. Ms. Russo, any other witnesses?
MS. RUSSO: Would the court want me to call Ms. Taylor, or should Ms. Taylor just be called by the court.
MR. BIGLEY: (Indiscernible).
THE COURT: Well, (indiscernible) -- I think just witnesses for the State?
MS. RUSSO: Yeah. No, I don't have any other witnesses.
THE COURT: Oh, okay.
MR. BIGLEY: (Indiscernible).
THE COURT: Ms. Taylor -- well, actually (indiscernible) to be honest, frankly, up to (indiscernible) sometimes about what (indiscernible) report, because it's dealing with the medication issue, and we haven't finished up with the commitment issue. I haven't made any findings about that. I mean, if the parties want to hear the visitor's report now, before I (indiscernible) any findings on commitment, you know, that's fine with me. I'm flexible on that.
So, Ms. Russo, Ms. Dickson, any -- do you want to just hear from Ms. Taylor now, and then I'll make my findings.
MS. RUSSO: Yes. Your Honor, actually, I

think it makes sense that we address the issue of commitment before we address medication.
THE COURT: Okay.
MS. RUSSO: So, can we briefly argue...
MR. BIGLEY: I'll go home.
THE COURT: Well, okay. Yeah. Before you argue, I'm gonna ask Ms. Dickson, did you want your client to testify?
MS. DICKSON: So, did you want to testify (indiscernible)?
MR. BIGLEY: (Indiscernible) started the damn thing. (indiscernible) the hell out'a me (indiscernible).
MS. DICKSON: Your Honor, just briefly. I think that...
Why don't you just (indiscernible).
MR. BIGLEY: (indiscernible). Master Brown?
THE COURT: Yes.
MR. BIGLEY: Ah, I -- I got -- I got -- I got a two-bedroom apartment. I always live by myself. All my stuff is there. (Indiscernible). But nobody comes to my house. Nobody -- and, ah, Steve Young comes to the house, delivers groceries, but I don't him never around ever again. I have no medicine there. I -- I have no dope there, no drugs, no alcohol. I never did.

I don't talk to neighbors. I don't wanna be around nobody. I sit there and listen to music, or sing to it. Ah, I -- I -- I've -- I've done -- I've done so many good things. Um, I went to church. Talked to -- to, ah, Father Gary. I told him a lot of things. To the Presbyterian Church. Lot of things (indiscernible). I (indiscernible) the Bible. You ruined me. Um, (indiscernible). I went over and over -- six years, (indiscernible) and stuff, what Steve Young did. What those two billings were. They wouldn't touch it. They paid people off. Okay? They got (indiscernible) to pay people off. Steve Young and Jim Parker.
I went to court -- I went to court because I got thrown in there...
MS. DICKSON: Let's just focus on...
MR. BIGLEY: I wanna go home. (Indiscernible).
MS. DICKSON: Yeah. Just tell him what you wanna do. You wanna go home.
MR. BIGLEY: I -- I'm just tryin', like, to -- um, you know...
MS. DICKSON: Okay.
MR. BIGLEY: I wanna go home. Drug free. Drug free.

THE COURT: Okay.
MS. DICKSON: I have no further evidence, Your Honor.
MR. BIGLEY: I'm fine. (Indiscernible) my brain.
THE COURT: Okay. Mr. Bigley, thank you.
Ms. Russo, I assume you don't have any questions, do you?
MS. RUSSO: No, Your Honor.
THE COURT: Okay. So, I guess next -- let me just hear -- the (indiscernible) remarks as to the commitment issue, and then if I recommend commitment, then we'll deal with the visitor's report, and then any further evidence concerning the medication issue.
So, Ms. Russo, do you want to make closing remarks.
(Background conversation)
MS. RUSSO: Thank you, Your Honor. I believe that the court has heard testimony today that -- and through the testimony, there is clear and convincing evidence that Mr. Bigley is indeed mentally ill, and that he is gravely disabled. It's very -- given the recent (indiscernible)...
MR. BIGLEY: (Indiscernible).
MS. RUSSO: ...maybe caused some change in the

interpretation of what it means...
MR. BIGLEY: (Indiscernible) about that.
MS. RUSSO: ...to be gravely disabled.
But Mr. Young testified about the extraordinary lengths that he had gone to -- or that he's arranged for insuring that Mr. Bigley is able to live safely outside of the community, and to make sure that he's able to meet his basic needs, such as with grocery shopping and such.
And Dr. Worrall also testified that Mr. Bigley actually wasn't able to function. He -- he -- when (indiscernible), he wouldn't characterize Mr. Bigley as being able to function, but being able to survive.
MR. BIGLEY: Who said that?
MS. RUSSO: And I think that -- I think that...
MR. BIGLEY: (Indiscernible).
MS. RUSSO: ...to have to wait until somebody is on their death bed, to be able to commit them as being gravely disabled, would be an injustice to them.
Dr. Worrall testified about how Mr. Bigley really does suffer from his...
MR. BIGLEY: (Indiscernible) knows.
MS. RUSSO: ...illness, and that it does cause him great consternation and...

MR. BIGLEY: Well, that's because (indiscernible).
MS. RUSSO: ...he's severely affected by that, and...
MR. BIGLEY: (Indiscernible).
MS. RUSSO: ...his ability to make rational decisions...
MR. BIGLEY: (Indiscernible).
MS. RUSSO: ...to affect this -- that would affect his ability to live outside is compromised by that element.
MR. BIGLEY: (Indiscernible) that stuff, too.
MS. RUSSO: And that treatment at API would be a benefit to Mr. Bigley, and that it would be able to at least -- well, that it would a benefit to him.
MR. BIGLEY: I just wanna be left alone.
THE COURT: Okay. Ah, thank you.
Ms. Dickson?
MS. DICKSON: Yes, Your Honor. At this time we'd ask that you dismiss the petition and release Mr. Bigley.
MR. BIGLEY: Please.
MS. DICKSON: I think Your Honor is aware that the supreme court has really scrutinized these commitment hearings, and, you know -- and -- and,

essentially, the court needs to understand that committing someone to API takes away their liberty. It takes away their freedom. I mean, it's not a treatment. Anyway, it does provide treatment. It does deprive a person of their liberty. And the court has to consider a person's liberty as being very important, and that that liberty be only taken away when absolutely necessary.
And I think when you look at the supreme court decision, they are strictly construing these statutes to protect an individual's right to liberty.
Ms. Russo cited Weatherhorn v. API, which is a recent decision, 2007. And in that decision they specifically construed the definition of "gravely disabled." And, you know, part of the definition was -- you know, when you talk about the second part of grave disability, which I'm assuming is what Dr. Worrall is relying on when he testifies to grave disability. When you talk about the stress, the level of distress that's necessary is significant. And, essentially the question comes down to whether someone can live safely outside of the controlled environment.
Mr. Bigley has been living outside API, on his own, several years, and -- and why he's been in API, in and out -- when he is out, he is able to survive. And

he doesn't survive, maybe, perhaps to the level we would want to see. And maybe he's not living to the potential that he could if he was on medication, as suggested by Dr. Worrall. But he is able to do it. That is how he wants to live. That is his choice. He doesn't want to take medication. He doesn't want to be committed into API.
He does have financial resources to be able to maintain an apartment, so the risk of him freezing to death is minimal. He does have a guardian who is assisting him. And while that relationship right now is not at its best, and it's uncooperative, it does provide some level of safety that allows him to live out in the community.
And Dr. Worrall testified that between the period of time since his last discharge...
MR. BIGLEY: (Indiscernible).
MS. DICKSON: ...that he was able to do it.
So, Your Honor, I think if you strictly construe grave disability, in light of a person's fundamental right to liberty, I think we would ask that you dismiss the petition and not commit Mr. Bigley today.
MR. BIGLEY: I can't have (indiscernible) because I'm mentally ill.

THE COURT: All right. Thank you.
All right. At this time I'll make my findings on...
MR. BIGLEY: Please.
THE COURT: ...the issue concerning the -- the commitment issue in the Petition for 30 Day Commitment.
I'll find that, first of all, the evidence is clear and convincing that Mr. Bigley is suffering from a mental illness, as testified to by Dr. Worrall. The diagnosis was affective disorder bi-polar type.
(Background conversation)
Both Dr. Worrall's and Mr. Young's testimony is clear and convincing that Mr. Bigley has been suffering from paranoid delusions, irrational thinking. He's had severe emotional reactions. Dr. Worrall testified that Mr. Bigley has severe impaired judgment. That he does irrational things.
MR. BIGLEY: Can't do that.
THE COURT: And this is...
(Background conversation)
THE COURT: ...-- he is unable to perceive or understand reality that he is -- Dr. Worrall testified -- used the term, Mr. Bigley is gravely disabled. And that's backed up very clearly (indiscernible) by Mr. Young's testimony as to the extraordinary lengths that

the guardian has tried to accommodate Mr. Bigley, but, nonetheless, Mr. Bigley still is jeopardizing his own well being.

Mr. Young testified that Mr. Bigley is unable to do his own shopping for food. That the guardian has had to go to the store with him. Even at the store there are -- what I would refer to as extraordinary measures to avoid other shoppers from -- from being accosted either verbally by Mr. Bigley, which would cause additional problems. That Mr. Young also testified how Mr. Bigley has been threatening at Mr. Young's office.

MR. BIGLEY: That's right.

THE COURT: Mr. Young's testimony is convincing...

MR. BIGLEY: (Indiscernible).

THE COURT: ...that he is unable to maintain himself...

(Background conversation)

THE COURT: ...without the strict assistance of the -- of his guardian. While Mr. Bigley may have financial resources to pay for an apartment and for a food allowance, he still does not have the independent ability to manage himself and his affairs, and it's to the point where it (indiscernible) he would be unable

to obtain his own necessary food and other necessities, and would -- his well being would diminish.

And I have had in front of me the recent case -- the Weatherhorn case, and I've been looking at this language about what the supreme court is requiring as to -- grave disability requires that there be a level of incapacity so substantial that the respondent is incapable of surviving faithfully in freedom. And I don't have any doubt that that standard is met, because, as Mr. Young's and Dr. Worrall's testimony shows that Mr. Bigley has severe delusions, paranoia, and is prone to cause problems with others. And that I don't -- while he may have an apartment and funds, I do not believe he can survive safely for long outside of the hospital setting, which is highly structured environment. So, while he may be eating well and doing his (indiscernible) in the hospital, that's because it's a highly structured environment, which he needs. And to me it's clear that he really is severely gravely disabled because there would be a severe and a substantial deterioration of his ability to function independently, which is the statutory standard, if he was out on his own.

So, for all of these reasons I am going to find that he should be committed to API for up to 30

days. There is no less restrictive place...

MR. BIGLEY: (Indiscernible). I trusted you.

THE COURT: ...(indiscernible) at this time. And, so...

MR. BIGLEY: You wanna dope me up.

THE COURT: ...with that, I'll deal next with the medication issue. And, first I...

MR. BIGLEY: I'm goin' out'a state -- I have a right to leave state right now!

THE COURT: Listen, Mr. Bigley, I know you're...

MR. BIGLEY: You stay in this place and get doped up! I (indiscernible) all of my life!

THE COURT: Mr. Bigley, please be quiet. I know you're doing...

MR. BIGLEY: No. (Indiscernible) is gonna find out!

THE COURT: Okay.

Ms. Russo, do you have any additional witness before we hear...

MR. BIGLEY: I don't wanna be put in a cage in this shit hole!

THE COURT: ...from Ms. Taylor?

MS. RUSSO: No. I would just...

MR. BIGLEY: (Indiscernible).

MS. RUSSO: ...rely on the prior testimony of Dr. Worrall and Mr. Young.

MR. BIGLEY: (Indiscernible).

THE COURT: Okay.

MR. BIGLEY: (Indiscernible) President Bush. You think I'm lyin' to ya'?

THE COURT: Okay. Ms. Taylor...

MR. BIGLEY: (Indiscernible) now too.

THE COURT: Mr. Bigley, if you can't quiet down, I'm going to have to ask that you be taken...

MR. BIGLEY: I just wanna go home.

THE COURT: Okay. So if you're quiet I can -- you can stay in the courtroom. But if you're not, I have to have -- you're gonna have to leave the courtroom. Okay?

MR. BIGLEY: (Indiscernible).

THE COURT: Ms. Dickson, does he understand that?

MS. DICKSON: I think so, Your Honor.

THE COURT: Okay.

Ms. Taylor, I'm gonna swear you in.

DEBORAH TAYLOR

called as a witness, being first duly sworn upon oath, testified as follows:

(Oath administered)

MS. TAYLOR: Yes, sir, I do.
THE COURT: And, just state your name for the record?
MS. TAYLOR: Deborah Taylor, court visitor.
THE COURT: Okay. So, ah, Ms. Taylor if you wanna go ahead with your visitor's report.
MS. TAYLOR: Certainly. I observed Mr. Bigley the end of December, before he was discharged from API. He was calm. He was actually very helpful to me. He was very pleasant.
I then met with Mr. Bigley last Friday, and it was the polar opposite. He was very agitated, he was yelling, he was making very inappropriate comments. He told me he had a 35 billion dollar jet that...
MR. BIGLEY: Pick it up.
MS. TAYLOR: ...within Washington, D.C. He told me that he had been on the phone with President Bush.
MR. BIGLEY: (Indiscernible).
MS. TAYLOR: His agitation was such that I could not redirect him to the point of asking the questions that I needed to ask.
After 45 minutes with Mr. Bigley, I left the room in which we were conducting our meeting.
MR. BIGLEY: (Indiscernible).

MS. TAYLOR: I then met with Mr. Bigley this morning, and while he was much calmer than he was on Friday, he still was having the same type of delusions. He told me that he had been speaking with God.
MR. BIGLEY: (Indiscernible). There's nothin' wrong with that. (Indiscernible), do you pray?
MS. TAYLOR: And that he was definitely going to go home.
I have not been able to get Mr. Bigley to answer our medication -- I mean, my questions about whether he understands that he has a mental illness. Whether he has any understanding...
MR. BIGLEY: (Indiscernible) illness?
MS. TAYLOR: I have not been able to talk -- talk...
MR. BIGLEY: Do you have mental illness? Anybody have mental illness? Cured me of it. (Indiscernible) mental illness? (Indiscernible)...
THE COURT: Okay, Mr. Bigley. This is Master Brown. And I'm only gonna give you one more chance.
MR. BIGLEY: I am fightin' for my life in here.
THE COURT: Mr. Bigley, please try to be quiet. Okay? Thank you.
Go ahead, Ms. Taylor.

MS. TAYLOR: Thank you, sir.
Um, and, you know, I have not been able to get him to discuss with me if he has any understanding of side effects.
MR. BIGLEY: Ahhh, (indiscernible) shit.
MS. TAYLOR: I have reviewed the chart for Mr. Bigley. I have talked with Dr. Worrall; I talked to staff on the floor. And it's my opinion that,...
MR. BIGLEY: (Indiscernible).
MS. TAYLOR: ...based upon chart review, based upon my personal interactions with Mr. Bigley, both from the end of December until now, that he would benefit from having some type of medication that would help him become more calm and help him, hopefully, try and come up with an appropriate discharge (indiscernible).
MR. BIGLEY: I won't talk to nobody -- do nothin' to nobody anymore. (Indiscernible) my brain.
THE COURT: Ms. Taylor, anything else?
MS. TAYLOR: No, sir.
THE COURT: Okay. Ms. Russo, do you have any questions?

EXAMINATION

BY MS. RUSSO:
Q Ms. Taylor, were you able to make inquiry

about any kind advanced directive or anything?
MR. BIGLEY: If you give medicine, I won't talk to nobody anymore. Not a livin' soul.
A Not for Mr. Bigley.
MR. BIGLEY: I don't want no meds or nothin'. Go home.
Q In your review of the chart, was there anything?
A I didn't notice anything.
Q Those are all my questions.
THE COURT: All right.
Ms. Dickson, questions?

EXAMINATION

BY MS. DICKSON:
Q Yeah. Did Mr. Bigley make it clear to you that he didn't want medications?
A In all honesty, I had difficulty understanding what Mr. Bigley wanted, other than to leave.
MR. BIGLEY: I got a million dollar jet.
Q As the court visitor, and knowing Mr. Bigley's history, any -- do you think this is a futile process that we force medication on him now, (indiscernible) he's appropriately discharged him to stop?
MR. BIGLEY: (Indiscernible).

Q (Indiscernible) take his medication?
A If I find that (indiscernible) Mr. Bigley, as well as everybody else (indiscernible).
MR. BIGLEY: (Indiscernible) in Anchorage?
A But, I think that...
MR. BIGLEY: Got files.
A ...that Mr. Bigley needs to have the opportunity to...
MR. BIGLEY: (Indiscernible).
A ...participate as much as...
MR. BIGLEY: No.
A ...he can...
MR. BIGLEY: No. No.
A ...in some type of...
MR. BIGLEY: I don't talk to nobody.
A ...a plan...
MR. BIGLEY: I don't want to.
A ...so that hopefully, at some point...
MR. BIGLEY: (Indiscernible).
A ...he will, as he has demonstrated in the past, be...
MR. BIGLEY: (indiscernible) with pills? You have.
A ...to have, um, the medication that he needs.
MR. BIGLEY: Yeah. (Indiscernible) some

pills. (indiscernible) get a junky.
MS. DICKSON: I have no further questions, Your Honor.
THE COURT: Ms. Russo, any other questions?
MS. RUSSO: No, Your Honor.
THE COURT: So, closing remarks, Ms. Russo, about the medication issue?
MS. RUSSO: Thank you, Your Honor. I...
MR. BIGLEY: Didn't matter. Don't dope me up. I won't to talk to nobody, though. Just wait. Wait 'til you find out.
MS. RUSSO: I believe that you have clear and convincing testimony that Mr. Bigley is currently unable to -- to provide informed...
MR. BIGLEY: (Indiscernible) around them anymore.
MS. RUSSO: ...consent to the medication. That there has been evidence that Mr. Bigley has been on these medications in the past, and...
MR. BIGLEY: (indiscernible) started out first.
MS. RUSSO: ...has experienced positive results from these medications. And hopefully he would be able to remain on them longer this time.
MR. BIGLEY: Tryin' to drain me, man.

Tryin'...
MS. RUSSO: It...
MR. BIGLEY: (Indiscernible)...
MS. RUSSO: The evidence before the court is that this is -- the medications which are prescribed are really the only way to be able to enable...
MR. BIGLEY: (Indiscernible) take me out.
MS. RUSSO: ...Mr. Bigley to be able to -- as Ms. Taylor stated (indiscernible)...
MR. BIGLEY: (Indiscernible).
MS. RUSSO: ...participate as much as he could in a treatment plan. So we would ask that you grant the petition.
MR. BIGLEY: (Indiscernible) out of state. Out of state. (Indiscernible) find out.
THE COURT: I'm sorry, Ms. Russo. Are you done?
MS. RUSSO: Yes, Your Honor.
THE COURT: Okay. So, Ms. Dickson?
MS. DICKSON: Yes, Your Honor. We would ask that you deny the petition for medication. Mr. Bigley doesn't want to take medication.
MR. BIGLEY: I just go home...
MS. DICKSON: He has been fairly through the years about his position...

MR. BIGLEY: Yeah.
MS. DICKSON: ...regarding medication. Um, you know, I think the court has to look -- especially under the (indiscernible) Myers case, and may (indiscernible) judgment, just the futility of this.
Dr. Worrall testified regarding, you know, years of experience with Mr. Bigley. He doesn't take the medication when he gets out. There's really no clear answer what the stopping and starting of medication...
MR. BIGLEY: Do you take medication?
MS. DICKSON: Mr. Bigley, let me finish.
...will do for Mr. Bigley on a long term...
MR. BIGLEY: (Indiscernible).
MS. DICKSON: And I think, also, what's most important,...
MR. BIGLEY: Throw you in here.
MS. DICKSON: ...when he was discharged in January of this year, and I think Dr. Worrall...
MR. BIGLEY: (Indiscernible).
MS. DICKSON: And I'm relying on my notes, so I may not be completely accurate, but I think -- I think Dr. Worrall said that was the best he's ever seen him, in January, when he was on medication. And despite Mr. Bigley being the best that he's ever been,

he made the decision to stop medication when he was released from custody.

So his position regarding that medication has been consistent. He doesn't want...

MR. BIGLEY: (Indiscernible).

MS. DICKSON: ...to take medication, and we would ask that you deny the petition allowing the hospital to force medicate him.

MR. BIGLEY: (Indiscernible).

THE COURT: All right.

MR. BIGLEY: (Indiscernible).

THE COURT: All right. So I'll make my findings concerning the medication petition. And the evidence...

MR. BIGLEY: (Indiscernible).

THE COURT: ...is clear and convincing that Mr. Bigley has a mental illness, and the evidence is clear and convincing, he does not understand or appreciate that he has the mental illness, and (indiscernible). The evidence is clear and convincing, he is unable to give an informed consent...

MR. BIGLEY: Out of state.

THE COURT: ...to have an appropriate course of treatment, as recommended by the doctors, the different medications.

MR. BIGLEY: I wanna go home.

THE COURT: (Indiscernible) Mr. Bigley made a statement -- well, commented in the past that -- expressed a reliable manner...

MR. BIGLEY: (Indiscernible) he knows.

THE COURT: ...(indiscernible) his treatment with psychotropic medication.

(Background conversation)

THE COURT: I note that the doctor's testimony shows that not only Mr. Bigley's (indiscernible) mental illness, (indiscernible) that the medications will probably have some slight side effects (indiscernible) beneficial effects. That there's nothing indicating the -- that these (indiscernible) medications are in the nature of experimental. They appear to be -- these medication are accepted by the...

MR. BIGLEY: (Indiscernible).

THE COURT: (Indiscernible)...

MR. BIGLEY: (Indiscernible) medications. Okay? It's a law.

THE COURT: Well, there's certainly -- to a certain extent (indiscernible)...

MR. BIGLEY: Be independent, Judge!

THE COURT: ...Mr....

MR. BIGLEY: Be independent, Judge!

(indiscernible) force medicate anybody.

THE COURT: (Indiscernible).

MR. BIGLEY: Watch it! It's gonna get'cha!

THE COURT: (Indiscernible)...

MR. BIGLEY: (Indiscernible).

THE COURT: And if there's anything in the administration, all I can see would be -- if there are shots. But, again, the beneficial effects...

MR. BIGLEY: (Indiscernible) do that.

THE COURT: ...not only for him, but also to anyone around him, far outweigh the momentary pain. And, so I would find that the evidence is clear and convincing that this proposed treatment -- the use of medications -- (indiscernible), and there is no (indiscernible) an intrusive alternative...

MR. BIGLEY: (Indiscernible)

THE COURT: So I will rec...

(Tape off) (Tape on)

UNIDENTIFIED MALE: Thank you, Your Honor.

MR. BIGLEY: (Indiscernible).

THE COURT: So this will end the phone call, and, ah...

MR. BIGLEY: (Indiscernible).

THE COURT: ...the hearing, okay?

MR. BIGLEY: Go fuck off!

THE COURT: Thank you. Good bye.

(Background conversation)

UNIDENTIFIED FEMALE: Off -- off record.

END

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CERTIFICATE

SUPERIOR COURT)
) SS.
STATE OF ALASKA)

I, Georgi Ann Haynes, Certified Professional Court Reporter for the Third Judicial District, State of Alaska and verbatim reporter for H & M Court Reporting, Inc., hereby certify:

That the foregoing transcript is a transcription of testimony of said proceedings to the best of my ability, prepared from extreme poor quality tapes recorded by someone other than H & M Court Reporting, therefore "indiscernible" portions may appear in the transcript;

I am not a relative, or employee, or attorney, or counsel of any of the parties, nor am I financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal this 29th day of March, 2007.

Notary Public in and for Alaska
My commission expires: 10/05/2007

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

COPY
Original Received
Probate Division

SEP 10 2007

Clerk of the Trial Courts

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

MEMORANDUM IN SUPPORT OF MOTION FOR INJUNCTIVE RELIEF

Respondent has moved for the issuance of an injunction against William A. Worrall, MD and the Alaska Psychiatric Institute from administering any psychotropic medication to Respondent William S. Bigley on any grounds except as follows:

1. The enjoined parties may seek to administer psychotropic medication only through court approval.
2. In the event the Superior Court grants such approval, such authority shall be stayed for seven days for Mr. Bigley to seek review by the Alaska Supreme Court.
3. If such review is sought, Mr. Bigley may seek a further stay in this court, and the stay granted in 2, above, shall remain in effect until the this court has ruled on his request and, if not granted, Mr. Bigley has had seven days from denial to seek further review in the Alaska Supreme Court.

The grounds for this motion is that Dr. Worrall, without restraint by API, is flouting the requirements of AS 47.30.838 as set forth in the Application for Original Relief and Emergency Motion for Injunctive Relief filed in the Alaska Supreme Court, copies of which have also been filed herein.

DATED September 10, 2007

Law Project for Psychiatric Rights, Inc.

By: _____
James B. Gottstein, ABA # 7811100

LAW PROJECT FOR PSYCHIATRIC RIGHTS, INC.
406 G Street, Suite 206
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EMERGENCY

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Attorney for Applicant

IN THE SUPREME COURT FOR THE STATE OF ALASKA

WILLIAM S. B BIGLEY Applicant, vs. WILLIAM A. WORRAL, M.D., and THE ALASKA PSYCHIATRIC INSTITUTE Respondents	Supreme Ct. No. S-12851

Trial Court Case No. 3AN 07-1064 P/S

EMERGENCY MOTION FOR INJUNCTIVE RELIEF

COMES NOW, WILLIAM S. BIGLEY, Applicant (Mr. Bigley), and pursuant to Appellate Rule 504, moves for an immediate injunction against Respondents William A. Worrall, MD (Dr. Worrall), and the Alaska Psychiatric Institute (API) from any more forced psychiatric drugging[1] of Mr. Bigley without court authorization and a meaningful opportunity to seek review before it recommences.

[1] Respondent uses the term "Forced Psychiatric Druggings," to reinforce this Court's acknowledgment in *Myers v. Alaska Psychiatric Institute*, 138 P.3d 238, 242 (Alaska Cont.

I. Counsel Contact Information

Mr. Bigley is represented by James B. Gottstein, whose address is 406 G Street, Suite 206, Anchorage, Alaska, 99501, and telephone number is 274-7686. Dr. Worrall and API are represented by Elizabeth Russo, whose address is 1031 West 4th Ave., Suite 200, Anchorage, Alaska 99501, her direct telephone number is 269-5144 and main office number is 269-5140.

II. Statement of Facts (and Analysis) in Support of Motion

Mr. Bigley is being illegally and, on pretexts, subjected to forced psychiatric drugging purportedly under the police power justification of AS 47.30.838, mentioned in *Myers v. Alaska Psychiatric Institute*, 138 P.3d. 238, 242 (Alaska 2006). There is not only no factual justification in Mr. Bigley's medical record as required by AS 47.30.838(a)(1), it is not justified in fact[2], and Mr. Bigley has been forcibly drugged more than allowed under AS 47.30.838(a)(2)(C) & (c). In sum, (1) API employs a psychiatrist, Respondent William A. Worrall, Mr. Bigley's treating psychiatrist, who believes he is able to forcibly drug any of his patients in any way he decides in flagrant disregard of the patients' rights with impunity, and (2) Respondent Alaska Psychiatric Institute (API) has allowed this flagrant violation of Mr. Bigley's rights, by its employee, Dr. Worrall.

2006), and *Wetherhorn v. Alaska Psychiatric Institute,* 156 P.3d 371, 382 (Alaska 2007) that these drugs have been equated with the intrusiveness of Electroshock and Lobotomy.

[2] The psychiatrist testified that while Respondent makes severe threats he is never actually violent and that as a professional he isn't concerned with them; the Probate Master also made specific factual recommendations regarding this. A39, 40,

Mr. Bigley is here requesting an injunction be issued against Dr. Worral and API from any more forced psychiatric druggings without court approval, including a meaningful opportunity to seek review.

A. Proceedings

Mr. Bigley has been repeatedly involuntarily committed and drugged against his will for 27 years in over 70 admissions to API.[3] API's approach is to haul him in, drug him up, then discharge him knowing he will quit the drugs until hauled in again and forced to endure them again.[4]

The Law Project for Psychiatric Rights (PsychRights®) first began representing Mr. Bigley on December 6, 2007, in his guardianship case, 3AN 04-545P/G, filing a petition to terminate the guardianship and, in the alternative, for other relief, including eliminating the guardian's authority to consent to forced drugging.[5] At that time Mr. Bigley was subject to 90-Day commitment and forced drugging orders in 3AN 06-01039 P/S, which were due to expire in early January. PsychRights entered its appearance before then[6] filed an election to have a jury trial if API filed for a 180 day petition,[7] and instead of doing that, API didn't file such a petition. On January 12, 2007, this Court

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[3] *See*, Appendix, pp 19-29 for a fuller recitation of facts. Hereinafter, pages to the Appendix shall be referred to as "A__." An Original Application for Relief has been filed contemporaneously herewith and the same Appendix is being used to prevent unnecessary proliferation of paper.

[4] A20-22.

[5] Judicial Notice may be taken of these and the other proceedings cited below.

[6] Through Steven J. Priddle, while Mr. Gottstein was out of town.

[7] There is no *statutory* right to a jury trial for 30 day commitments, but there is for 90 and 180-day commitments under AS 47.30.770(b) and AS 47.30.745(c), respectively.

issued the *Wetherhorn* decision, holding "AS 47.30.915(7)(B) is constitutional if construed to require a level of incapacity so substantial that the respondent is incapable of surviving safely in freedom."[8]

Since then, in Case Nos. 3AN 07-247 P/R and 3AN-07-598 PR, API has successfully petitioned for 30 day commitments and forced drugging orders,[9] but lost both jury trials.[10] In the first jury trial, Mr. Bigley was represented by counsel here and in the second one, counsel testified on behalf of Mr. Bigley as a fact witness.

That brings us to the current proceeding. Due to Mr. Bigley losing his housing and then getting evicted from the Brother Francis Shelter, Mr. Bigley deteriorated and a number of people became concerned for his safety. On August 28, 2007, an *ex parte* petition was jointly signed by Wendy Shackelford of the Anchorage Police Department and Paul Cornils, [11] which was granted.[12] Petitions for Involuntary Commitment and Forced Drugging were filed August 30, 2007, by API and hearings on both petitions were scheduled for the next day.[13] PsychRights filed a limited entry of appearance to represent Mr. Bigley solely as to the Forced Drugging Proceeding.[14]

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[8] Upon re-hearing, slight modifications to this opinion not relevant here were issued on April 13, 2007.
[9] PsychRights has not represented Mr. Bigley in any of the 30-day proceedings until this one, but did file an appeal on his behalf on the first one, which is in the briefing stage.
[10] Judicial Notice.
[11] Mr. Cornils is a case manager for CHOICES, Inc., which they call "Recovery Coordinators."
[12] A103.
[13] A103-109.
[14] A110.

At the Friday, August 31, 2007, hearing, as relevant here, over the objection of API, Mr. Bigley obtained a short continuance until Wednesday, September 5, 2007.[15] In spite of Dr. Worrall's testimony that Mr. Bigley never acts on the threats he makes,[16] API said it needed to be able to drug him during the continuance because he was disruptive to other patients and threatening to staff.[17] In response, the Probate Master pointed out that in an emergency, API could follow the procedures set forth in AS 47.30.838,[18] which was also discussed in *Myers*.[19]

However, Dr. Worrall has been ordering forcible injections of Mr. Bigley ever since without any justification under AS 47.30.838 in his medical records and the total amount of time allowed for forced drugging under AS 47.30.838 without a forced drugging order in AS 47.30.839 being in place has been exhausted. Dr. Worrall and API are flouting the law and this Court's decisions in *Myers* and *Wetherhorn* and Mr. Bigley is seeking to have it stopped immediately, and procedures put in place to give him a meaningful opportunity to object and seek review before it recommences.

B. AS 47.30.838 Requires Documentation Supporting the Emergency Drugging Be in the Patient's Medical Record and Should Be Immediately Available

AS 47.30.838 provides in pertinent part:

> (a) Except as provided in (c) and (d) of this section, an evaluation facility or designated treatment facility may administer psychotropic

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[15] A43-7.
[16] A38, 39.
[17] A44.
[18] A45.
[19] 138 P.3d at 242.

medication to a patient without the patient's informed consent, regardless of whether the patient is capable of giving informed consent, only if

> (1) there is a crisis situation, or an impending crisis situation, that requires immediate use of the medication to *preserve the life of, or prevent significant physical harm to, the patient or another person*, as determined by a licensed physician or a registered nurse; the behavior or condition of the patient giving rise to a crisis under this paragraph and the staff's response to the behavior or condition *must be documented in the patient's medical record*; the documentation must include an explanation of alternative responses to the crisis that were considered or attempted by the staff and why those responses were not sufficient;[20]

Therefore, Dr. Worrall and API should be able to immediately produce this documentation. It does not exist because there never has been a sufficient emergency.

Moreover, AS 47.30.838(a)(2)(C) and (c) provide.

> (C) [the physician's order] is valid for only 24 hours and may be renewed by a physician for a total of 72 hours, including the initial 24 hours, only after a personal assessment of the patient's status and a determination that there is still a crisis situation as described in (1) of this subsection; upon renewal of an order under this subparagraph, the facts supporting the renewal shall be written into the patient's medical record.
>
> * * *
>
> (c) If crisis situations as described in (a)(1) of this section occur repeatedly, or if it appears that they may occur repeatedly, the evaluation facility or designated treatment facility may administer psychotropic medication during no more than three crisis periods without the patient's informed consent only with court approval under AS 47.30.839.

Thus, it is now an impossibility for any future forced drugging orders to be valid under AS 47.30.838. In light of the blatant and routine violation of his rights by Dr.

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[20] Emphasis added.

Worrall and API, Mr. Bigley is requesting the protection of the courts before any more forced drugging occur.

III. Great Irreparable Harm Will Result if Relief is Not Granted

The written testimony of Robert Whitaker sets forth the scientific evidence for the great irreparable physical and mental harm being done to people who are being given these drugs as well as the great diminishment of their quality of life.[21] This includes that people are much more likely to recover if they are not put on these drugs,[22] very harmful side effects, including increases in violence and suicidality,[23] and that the newer drugs are worse than the older ones.[24] The research literature thus shows 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.

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.[25]

In addition, all of the force and coercion is very harmful itself. Dr. Ron Bassman also submitted written testimony, including that "Adults with serious mental illness treated in public systems die about 25 years earlier than Americans overall, a gap that's

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[21] A116-129.
[22] A119, 113.
[23] A123-125.
[24] A125-128.
[25] A128-9.

widened since the early 1990s when major mental disorders cut life spans by 10 to 15 years,"[26] which is when the new generation of drugs came to market.

Dr. Bassman's written testimony included that the drugs do not work for many people and/or have intolerable side effects. Many people refuse to take them and when that happens there are other viable options.[27] Dr. Bassman's testimony included that even people who have been very mentally ill for a long time can recover if other choices are offered.[28] This was confirmed by the in-court testimony of Sarah Porter of New Zealand, who was qualified by the Probate Master as an expert on alternatives to the current standard of care.[29] She testified that coercion is very traumatic and countertherapeutic and that even people who have been in the system for a long time can do much better if one engages in a negotiation process, rather than one based on coercion and force.[30]

IV.Grounds Submitted to Trial Court

Contemporaneously with the filing of this Motion, this relief was requested in the trial. This procedure was used because of the grievous and irreparable harm if relief is not immediately granted. Mr. Bigley is requesting relief from this Court if the trial court does not grant it by 4:00 Monday, September 10, 2007.

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[26] A111.
[27] A111-115.
[28] A113.
[29] A97.
[30] A94.

V. Notification to Opposing Counsel

Opposing counsel was notified by e-mail on Sunday, September 09, 2007, where this application and supporting documents could be downloaded.[31] Full sets of the documents will have been served as early as possible on Monday, September 10, 2007 prior to filing.

VI. Conclusion

For the foregoing reasons, unless the Court is informed the Superior Court has done so by 4:00 PM, Monday September 10, 2007, Mr. Bigley respectfully requests the Court to immediately issue an injunction against Dr. Worrall and API from any more forced psychiatric drugging of Mr. Bigley without court authorization and a meaningful opportunity to obtain review.[32]

DATED: September 9, 2007.

Law Project for Psychiatric Rights

By: _____
James B. Gottstein, ABA #7811100

---

[31] http://psychrights.org/States/Alaska/CaseSeven.htm. This procedure was used because the Appendix is too large to e-mail.

[32] Respondent uses the term "Forced Psychiatric Druggings," instead of the euphemistic "involuntary administration of psychotropic medications" to reinforce this Court's acknowledgment in *Myers v. Alaska Psychiatric Institute*, 138 P.3d 238, 242 (Alaska 2006), and *Wetherhorn v. Alaska Psychiatric Institute*, 156 P.3d 371, 382 (Alaska 2007)

Appendix

IN THE SUPREME COURT FOR THE STATE OF ALASKA

WILLIAM S. BIGLEY, Applicant, vs. THE ALASKA PSYCHIATRIC INSTITUTE, Respondent.	)	Case No. S-12851 Trial Court Case No. 3AN-07-1064 PR[1]

OPPOSITION TO ORIGINAL APPLICATION FOR INJUNCTIVE RELIEF

The State of Alaska, Department of Health and Social Services, Division of Behavioral Health, Alaska Psychiatric Institute, by and through the Office of the Attorney General, opposes the respondent's Motion for Injunctive Relief. There is no need for such an injunction because, in compliance with AS 47.30.838 (c), the order for emergency medication has been cancelled.

Alaska Statute 47.30.838 (c) states, "If the crisis situations as described in (a)(1) of this section occur repeatedly, or if it appears that they may occur repeatedly, the evaluation facility or designated treatment facility may administer psychotropic medication during no more than three crisis periods without the patient's informed consent only with court approval under AS 47.30.839."

As Mr. Bigley has had the statutory allowance of emergency medication, Dr. Worrall stopped the order this morning. See Attachment A. Until there is a final decision on the Petition for the Administration of Psychotropic Medication, Mr. Bigley

[1] The caption used by the respondent in his pleadings is incorrect and although this has been pointed out in response to other pleadings, he continues to flaunt court rules and practice to vent his personal frustrations. The correct form of the caption is as seen above. Dr. Worrall has only ever acted within the scope of employment and Bigley has not made any allegation to the contrary.

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OFFICE OF THE ATTORNEY GENERAL
ANCHORAGE BRANCH
1031 W. FOURTH AVENUE, SUITE 200
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will not receive any emergency medication. Thus, his Original Application for Injunctive Relief and the underlying Emergency Motion for Injunctive Relief should be denied.

Moreover, the Alaska Psychiatric Institute (API) would object to the automatic entry of any stays of an Order Approving the Administration of Psychotropic Medication (order). API is an acute-care psychiatric hospital. It is not a home for the mentally ill. One of the purposes of civil commitment is that the commitment has, "a reasonable expectation of improving [the patient's] mental condition." AS 47.30.655(6). API practices an evidence-based medical approach to treating psychiatric illness. Housing someone at API is not treatment. The stays proposed by Bigley actually impede his freedom and forces API into the untenable position of housing him without providing treatment. Thus, any automatic stays of duly entered orders should be denied.[2] Should the court grant such an order and Mr. Bigley chooses to appeal it, the matter can be taken up at that time.

API also renews its objections to any pleadings submitted along with any of Mr. Bigley's pleadings that are not directly related to this case or that purport to encapsulate "testimony." Specifically, with regards to the pleadings filed on September 10, 2007, that include: Appendix pp. 52-73; and 111- 129. API also objects to Bigley's version of the "facts" which were included in his pre-trial brief and are part of the appendix. However, as this is clearly only one side's proposed version of what may possibly be entered into evidence, API is confident the court will be able to discriminate the true facts. API moved to strike the entire appendix and the "affidavits" to Bigley's pre-trial brief both in writing and at the hearing on September 5, 2007. There has yet not been any ruling made on the topic. The status of such pleadings and information is

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[2] API wishes to point out that any prospective order would have resulted after significant testimony. That fact, taken with the known litigious nature of Mr. Bigley, make it highly unlikely that any order written in this case—either granting or denying the medication petition would be written without due consideration and careful thought.

questionable and it is completely inappropriate to again include them in the pleadings filed today.

DATED: September 10, 2007

TALIS J. COLBERG
ATTORNEY GENERAL

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

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

Attorney for Respondent

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

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

NOTICE:
MOTION FOR TEMPORARY RESTRAINING ORDER and PRELIMINARY INJUNCTION MOOT

PLEASE TAKE NOTICE, that upon the agreement of the Alaska Psychiatric Institute "to not further emergency medicate Mr. Bigley pending Friday's commitment hearing," his Motion for Temporary Restraining Order and Preliminary Injunction is moot.

DATED: March 12, 2008.

Law Project for Psychiatric Rights

By: _____
James B. Gottstein
ABA # 7811100

I hereby certify the foregoing was hand delivered to Linda Beecher of the Alaska Public Defender Agency and Timothy Twomey of the Attorney General's Office and faxed to Marieann Vasser, Court Visitor, this 12th day of March, 2008.

_____
James B. Gottstein

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

574-24-605 C

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
AT _____

RECEIVED
MAR 20 2008

In the Matter of the Protective Proceeding of)

William Bigley, Ward or Protected Person

CASE NO. 3AN-04-545PR

PETITION FOR REVIEW OF GUARDIANSHIP/CONSERVATORSHIP (AS 13.26.125 / AS 13.26.310)

I am ☑ the ward or protected person ☐ the guardian ☐ the conservator
☐ a person interested in the ward's/protected person's welfare. Relationship:_____

I ask the court to

☐ review the guardianship/conservatorship because: Mary took my money

☐ appoint _____ as ☐ co-guardian ☐ co-conservator

☒ remove the current guardian/conservator and appoint _____ to be the new guardian/conservator because _____

☐ end the guardianship/conservatorship because the ward or protected person
☐ is no longer incapacitated ☐ no longer needs a conservator
☐ _____

☐ accept my resignation as guardian/conservator.

8/20/2008
Date

William Standley Bigley
Signature

Type or Print Name

Mailing Address City State ZIP

Daytime Phone

I certify that on _____, I ☐ mailed ☐ hand delivered a copy of this petition to:
☐ the ward/protected person
☐ the guardian: _____

Signature:_____

PG-190 (6/04)(cs) AS 13.26.125 & .310
PETITION FOR REVIEW OF GUARDIANSHIP/CONSERVATORSHIP

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

RECEIVED
MAR 26 2008
OPA CIVIL SECTION

In the Matter of the Guardianship of William Bigley, Respondent.	CASE NO. 3AN-04-545PR ORDER FOR APPOINTMENT UPON REVIEW

☒ It has been requested that the court review this case.

☒ It has come to the court's attention that a hearing to review the status of this case is necessary. A hearing is set for August 7, 2008 @ 10:00AM before Master John E. Duggan at 303 K Street Ctrm 26.

Therefore, the following are ordered:

☒ Office of Public Advocacy is appointed as the attorney for respondent.

☒ OPA/Betty Stanley (333-9480) is appointed as visitor and

- ☒ is authorized to receive all medical/psychiatric, financial, educational and vocational records including those from secondary sources, and any information pertinent to the court investigation necessary to formulate recommendations to the court.
- ☒ shall report to the court his/her findings regarding the status of the current guardianship, including recommendations as to whether or not the current guardian is fulfilling his/her statutory responsibilities and, if not, identifying other potential guardians, if appropriate.

☒ OPA ___ is appointed as expert.

03/26/08

Superior Court Master

I certify that on 03/26/08,
a copy of this order was sent to:
OPA,Stanley, Resp, Grd,
Clerk: ser

3AN-04-545PR

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
AT Anchorage

In the Matter of the Protective Proceeding of)

William Bigley ,
Ward or Protected Person)

CASE NO. 3AN-04-545PR

PETITION FOR REVIEW OF
GUARDIANSHIP/CONSERVATORSHIP
(AS 13.26.125 / AS 13.26.310)

I am ☑ the ward or protected person ☐ the guardian ☐ the conservator
☐ a person interested in the ward's/protected person's welfare. Relationship:_____

I ask the court to

☐ review the guardianship/conservatorship because: Kathy TOOK my money

☐ appoint _____ as ☐ co-guardian ☐ co-conservator

☒ remove the current guardian/conservator and appoint _____ to be the new guardian/conservator because _____

☐ end the guardianship/conservatorship because the ward or protected person
☐ is no longer incapacitated ☐ no longer needs a conservator
☐ _____

☐ accept my resignation as guardian/conservator.

8/20/2008
Date

William Standley Bigley
Signature

_____
Type or Print Name

_____
Mailing Address City State ZIP

_____
Daytime Phone

I certify that on _____,
I ☐ mailed ☐ hand delivered a copy of this petition to:
☐ the ward/protected person
☐ the guardian: _____

Signature:_____

PG-190 (6/04)(cs) AS 13.26.125 & .310
PETITION FOR REVIEW OF GUARDIANSHIP/CONSERVATORSHIP

FILED
STATE OF ALASKA
THIRD DISTRICT
2008 APR 16 AM 10:47
CLERK TRIAL COURTS
BY DEPUTY CLERK

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
AT Anchorage

In the Matter of the Necessity for the Hospitalization of:

William Bigley,
Respondent.
Date of Birth: 01/15/53

Case No. 08-00416PR

PETITION FOR INITIATION OF INVOLUNTARY COMMITMENT

Anchorage Community Mental Health Mobile Clinician Jamison McCoy, LCSW, petitioner alleges that the respondent is mentally ill and as a result of that condition is gravely disabled or presents a likelihood of causing serious harm to himself/herself or others.

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

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

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

Facts in support of this request are as follows:

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

2. The facts which make the respondent a person in need of (a screening investigation) (hospitalization for evaluation) are:
At risk of harm to others and self. Gravely disabled. Schizoaffective Disorder - Bipolar type - Off Medications. Currently incarcerated at CIPT for Disturbing the peace & Trespass. Arrested 4/10/08 - Released - Returned to Secure and Re-arrested the same day. While in custody continues to be paranoid, delusional, disoriented, irritable, disruptive, refusing medications, unable to regulate his own behaviors.

CONTINUED

Use black ink. Write only on the front of this form.
Attach it to the form it relates to at the time that form is filed.

ADDITIONAL INFORMATION

Case Number: _____
Case Name: William Bigley
Attachment to: Form Name: _____
Form Number: _____

I am the ☐ Plaintiff ☐ Defendant ☒ Petitioner ☐ Respondent in this case.

The following additional information is for paragraph number _____ on page _____ of the form named above:

Pt has history of assaults while decompesated. Refusing medications to stabalize symptoms when in the community - While not on medications, has a history of grandious, paranoid delusions, aggressive speech and behaviors that put him at RISK to assault others or be assaulted by others of the homeless community.

- Pt no longer in services with ACMHS due to threats to kill staff.
- Pt has over 70 mental Health admits
- Pt currently unable to verbalize release plan.
- Posturing threatenly
- accusing staff of implanting devices, stalking him and of trying to deprive him.
- Bunding on walls and tables this morning
- Pressured speech to include spittle flying from his mouth while demanding writer leave.

4-16-08
Date

J. M. Cole, LCSW
Signature

Jamison M Cole, LCSW 261-2800
Type or Print Name Daytime Telephone

4020 Folker St Anch AK 99503
Mailing Address City State ZIP

TF-941 (9/06)(cs)
ADDITIONAL INFORMATION FORM

DO NOT WRITE ON BACK

Case No. 3S-08-00416PR

3. Persons having personal knowledge of these facts are (include addresses):
MIKE MOD STAFF at Cook Inlet Pre Trial 269-0078

4-16-08
Date

Petitioner's Signature

Jamison M Cole, LCSW
Type or Print Name

4020 Folker ST A/A 99503
Petitioner's Address

261-2800
Petitioner's Phone

Verification

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

Subscribed and sworn to or affirmed before me at Anchorage, Alaska on 4/16/08 (date).

SEAL OF THE TRIAL COURTS OF THE STATE OF ALASKA THIRD JUDICIAL DISTRICT (SEAL)

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

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

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

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

Clerk: _____

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
AT ANCHORAGE

In the Matter of the Necessity for the Hospitalization of:	)	
Bigley, William, Respondent.	)	Case No. 3AN-08-00416pr
	)	EX PARTE ORDER (TEMPORARY CUSTODY FOR EMERGENCY EXAMINATION/ TREATMENT)

FINDING AND CONCLUSIONS

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

ORDER

Therefore, it is ordered that:

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

4-16-08
Date

Superior Court Judge

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

Clerk:

Recommended for Approval

Jennifer McBurney 4-11-08
Magistrate

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

AS 47.30.700, .710 & .715

ALASKA PSYCHIATRIC INSTITUTE
LEGAL STATUS RECORD

DO NOT WRITE ON THIS SHEET
THIS STATUS RECORD IS MAINTAINED AND UPDATED BY HEALTH INFORMATION MANAGEMENT SERVICES
COMMUNICATE INFORMATION REGARDING STATUS TO LEGAL TECHNICIAN

DATE	STATUS	TYPE OF DOCUMENT / STIPULATIONS	ORDER EXP
04/25/2008	POA	ADM via POA signed by a Peace Officer	
04/26/2008	JP-EXP	Pet. for Init. of Invol. Commit. filed by Leona Gillespie, ANP Faxed to Magistrate for Ex Parte Order	
04/26/2008	JP-EXP	Received ExParte Order recommended for approval by Magistrate Johnson, Anchorage	
04/28/2008	JP-EXP	CASE NO. 3AN 08 493 PR	
04/29/2008	JP-EXP	Pet for 30-day commit. and Pet. for Meds filed by Dr. Maile Due to Conflict of Interest - hearing must be held downtown in Superior Court. Probate Court to arrange.	
04/29/2008	JP-EXP	Received Notice of 30 Day Hearing and Notice of Meds Hearing - Hearing will be take place in the Superior Court at Anchorage in Courtroom 29, Boney Courthouse on April 30, 2008 at 0830 before Master McBurney	
05/01/2008	JP-EXP	Received Notice from the Attorney General's Office - 30 day commitment has been granted. Medication petition hearing will be held before a Superior Court Judge - date and time not known at this time	05/29/2008
05/09/2008	T-47	Rec'd Order for 30 day commit. dated 5-5-08 sgd by Sup. Ct. Judge Rindner, Anchorage NEW END DATE: 6-4-08	06/04/2008

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

IN THE MATTER OF:

Plaintiff,

vs.

WB: WILLIAM BIGLEY

Defendant.

Case No. 3AN-08-00493 PR CI

*** CONFIDENTIAL ***

VOLUME I

TRANSCRIPT OF MOTION HEARING

BEFORE THE HONORABLE SHARON GLEASON
Superior Court Judge

Anchorage, Alaska
May 12, 2008
10:17 A.M.

APPEARANCES:

FOR THE STATE: Timothy M. Twomey, Esq.
Assistant Attorney General
1031 West 4th Avenue, Suite 200
Anchorage, Alaska 99501

FOR THE DEFENDANT: James B. Gottstein, Esq.
Law Project for Psychiatric Rights
406 G Street, Suite 206
Anchorage, Alaska 99501

3AN6308-77
10:17:07
THE COURT: We are on record. It's in the matter of Mr. William Bigley.
I have here in the court Mr. Twomey from the State, correct?
MR. TWOMEY: Yes, Your Honor. Good morning.
THE COURT: Good morning. How are you?
MR. TWOMEY: Good, thanks.
THE COURT: And, Mr. Gottstein, you are going to be representing Mr. Bigley on this issue only; is that correct?
MR. GOTTSTEIN: Yes, Your Honor.
THE COURT: All right. And then I have the court visitor, as well.
And where is Mr. Bigley?
MR. GOTTSTEIN: He's downstairs. He should be up momentarily, Your Honor. We might be able to take up some preliminary matters, if you'd like. Or I would --
THE COURT: That's fine. We can go ahead and do that. What are the preliminary matters?
Let me tell you my preliminary matter. I have a 10:30 that we were unaware of that is about a 20-minute children's proceeding. So we are going to

have to take a short break, and then resume as soon as they are concluded. So --
MR. GOTTSTEIN: Well, maybe, Your Honor, this will take care of that.
First, I don't think we've met before. Nice to have met you.
THE COURT: I certainly recognize the name.
MR. GOTTSTEIN: First, I owe the court an apology. I was out of town from 1:00 a.m. Wednesday -- last Wednesday morning until 1:00 a.m. last night.
And when the fax came in on the expedited motion -- I know they were e-mailed to me, but I couldn't open that one up. So I didn't know about the motion for expedited consideration until I got the order.
THE COURT: All right.
MR. GOTTSTEIN: So I object to holding this hearing. And I think first I'll make a procedural objection, and then really get into the substance of that.
The procedural is that the -- the expedited motion was not properly made. And I was never given a chance -- you know, normally you have a motion for expedited consideration, and then an order granting --

you know, an order requiring a person to respond to expedited consideration, and then time to respond to the main motion, and that wasn't done. So I object on that basis.
But more importantly, Your Honor, if I could direct your attention to -- there's my limited entry of appearance. There is about 93 pages of attachments, which you know, I would be surprised if you've had the chance to read.
But I think it's fair to say that this has been before -- these points have been before the court. And also, Your Honor, they have been presented to -- in previous proceedings, at least the last three times.
And so the first one is that as far as I know, Mr. Bigley has not been committed. And therefore, this petition is premature. And that's clear under Myers and Wetherhorn and at page 31 of what's called the submission for -- and I've got copies of those two cases.
THE COURT: But I intended actually to pull them up and -- in any event, let's back up here. Because what I have is the master's proposed findings for a 30-day commitment order that Judge Rindner approved on May 5th.

MR. GOTTSTEIN: Okay. Well, I was not aware of that. I was not served with that.
THE COURT: And that looks like it was distributed on May 7 to all of the parties, so --
MR. GOTTSTEIN: I haven't received it.
THE COURT: Mr. Twomey, did you get a copy of that order?
MR. TWOMEY: I believe I did, Your Honor.
THE COURT: And that -- Judge Rindner adopted the master's recommended order of May 2nd. So the commitment order was entered, as I read the file, on May 5th, effective May 7.
Did the visitor get a copy of that order?
MS. VASSAR: I don't believe I did. But I am often not in that loop.
THE COURT: All right. Well, the service list -- and here again, this is from Judge Rindner's staff. But the service list shows that that was distributed AG, PD, and API.
So, Mr. Gottstein, you might not have received that, but -- because it was distributed to the PD's. But that's who it was served on last week, so --
MR. GOTTSTEIN: Okay. So --
THE COURT: Maybe that changes, then, your

perspective on -- on the procedural posture of the case.

MR. GOTTSTEIN: On that particular one. Although, do you mind telling me if the public -- I understood the public defenders were going to file objections to the master's --

THE COURT: There are no objections that have been filed. There were no objections filed that are in the file.

I always hesitate when I say no objections filed, which is to say that there are none in the file. I suppose it's possible some were filed across the street and didn't make it into the file, but there are none in the file.

MR. GOTTSTEIN: And if I could draw your attention, then, the next issue is that the (indiscernible) petition is defective. If I could draw your attention to page 32 of the submissions for representation hearing.

THE COURT: All right.

MR. GOTTSTEIN: All right. I am right there.

Okay. So as you know, Your Honor, Myers invalidated the statutory regime as being unconstitutional and required the additional requirements that the court find the force

(indiscernible) to be in the patient's best interests, and there is no less intrusive alternative, and then went ahead and defined what sorts of things that -- you know, that entailed, what sort of considerations.

And API has never changed the petition to reflect the Myers requirement, and therefore that petition is defective. I have no notice of what their grounds are for best interests. I -- there is no -- and none of this information is in there. So that's one aspect of it.

THE COURT: Well, as I read it, the case law says the state has to file the petition, and then the state has to meet its burden by clear and convincing evidence.

So I mean, there is nothing that I read in those cases, excuse me, that would indicate that certain -- certain allegations must be made in a petition in order for a case to go forward, but I could be missing something.

MR. GOTTSTEIN: Well, I think you are, Your Honor.

THE COURT: All right.

MR. GOTTSTEIN: Which is -- which is if you look at the court's file on the Meyer decision, the court required that there needs to be information

about the proposed medication, its purpose, the method of its administration, the recommended range of dosages, possible side effects and benefits, ways to treat side effects, and risks of other conditions, such as tardive dyskinesia.

THE COURT: And this is your client?

Good morning, Mr. Bigley.

MR. BIGLEY: Yes (indiscernible) at two years old (indiscernible).

THE COURT: Good morning.

MR. GOTTSTEIN: And, Your Honor, and I -- in order for me to adequately prepare, I need to know that information.

THE COURT: All right.

MR. GOTTSTEIN: And then finally, with respect to that, if you would look at -- I think it's the fifth page, at the --

THE COURT: Of your submission?

MR. GOTTSTEIN: Yeah.

THE COURT: All right.

MR. GOTTSTEIN: There is an e-mail exchange between Mr. Twomey and myself and API.

But the thrust of it is, Your Honor, is that I've asked since April 26th for a copy of his chart in order to be able to prepare for this, and I have not

been given it. And, Your Honor, I need some time to conduct discovery.

And frankly, Your Honor, API is really in defiance of the Alaska Supreme Court's mandate that a less -- that less-intrusive alternatives be made available. And so they're just trying to push this through.

But in any event, and I've tried many, many times to sit down with them to work out a less-intrusive alternative that doesn't involve the forced drugging of Mr. Bigley, to which he is entitled, and they refuse to sit down and talk.

And so I would like to have at a minimum -- well, a -- I think a pre-trial conference is really in order because there are really lots of issues. I intend to file some motions.

But one of them, and I think the most important one, is that -- that the court order a settlement conference. Because Mr. Bigley has been hauled in to API for 28 years and forcibly -- I think over 80 times, or about 80 times, forcibly drugged.

He immediately quits or usually quits, not always, when he gets out. Then he gets hauled in again. And it's kind of this fruitless thing that goes on.

And there is alternatives that can and should be put together for him, and I think we should have a settlement conference on that.

THE COURT: Okay. Thank you.

Mr. Twomey, what's the --

MR. TWOMEY: Well, Your Honor, we are here to proceed on our petition for administration of medicine pursuant to the statute, 47.38.39. We are here today to put on our evidence before the court so that the court can make the best-interest determination. I think that's the court's role in this proceeding today.

We would like to proceed and examine the issue of Mr. Bigley's capacity to give informed consent and whether the proposed medicine is in his best interest.

THE COURT: What is the status of the chart that Mr. Gottstein referred to? Do you have any information on that?

MR. TWOMEY: Well, Your Honor, I am a little uncertain. Because there was an order indicating that Mr. Gottstein was not to be representing Mr. Bigley until the conclusion of the commitment proceeding. That apparently has now been concluded, and Mr. Gottstein is assuming representation.

But up until this point, we were in a position of communicating with the public defender's office, not Mr. Gottstein.

THE COURT: All right. And so do you have the paper -- the chart, or what is the status there? Because I have an order that was signed by Master McBurney (phonetic) regarding representation, which is consistent with what you've indicated.

MR. TWOMEY: Yes, I have seen that, Your Honor.

MR. GOTTSTEIN: Your Honor, I was not served with that order, and I requested -- I specifically requested it.

THE COURT: Well, I am happy to give you a copy of it here, Mr. Gottstein. And to some extent -- all right.

How long for the state to put on your evidence? What is your estimation?

MR. TWOMEY: An hour, Your Honor.

THE COURT: And Ms. Vassar, how long?

MS. VASSAR: Twenty minutes.

THE COURT: All right. All right. I am going to do the following. I am going to take up the 10:30 matter.

I am going to have Mr. Twomey, if you would,

give Mr. Gottstein a copy of whatever you have in the way of the chart records. We will give you a copy of this order regarding representation.

I am going to allow the state to go forward, Ms. Vassar to go forward. If you seek time to respond and we can't conclude it, then I'll give him another day later this week.

But I do intend to go forward on the petition. I read the statute as either according or requiring this type of hearing to be held on an expeditious basis, so we are going to go forward.

But at the conclusion of the state's case and the visitor's, we'll see where we are as to scheduling time that might give you additional time to respond. But my intent is to go forward.

But Mr. Twomey can give you the records and we'll give you a copy of this order regarding representation.

MR. GOTTSTEIN: Your Honor, may I have -- I don't have any of the papers and their other --

THE COURT: What -- you are welcome to copy the entire file if you'd like.

MR. GOTTSTEIN: I know I don't have the recommendations.

THE COURT: The findings on the --

MR. GOTTSTEIN: Yeah.

THE COURT: And we can make a copy of that, as well.

MR. GOTTSTEIN: Your Honor, I am really not prepared to go forward at this time.

THE COURT: Well, and I am going to allow the state and Ms. Vassar to go forward with their case.

And if you need additional time to prepare a response, then we can do that on a later day. But my intent is to go forward on the hearing as requested.

MR. GOTTSTEIN: I haven't received a copy of Ms. Vassar's report.

THE COURT: Ms. Vassar, what is the status?

MS. VASSAR: My report is oral --

THE COURT: Okay.

MS. VASSAR: -- per statute. I can provide an earlier written report. That is what I planned to do this morning.

THE COURT: All right. We will go forward, but we will take a short break. Let's plan at 11:00, we will go back on record.

I think part of the confusion is the partial entry of -- or limited entry of appearance and making sure that all information gets to the various parties. But that's what we'll do.

And like I said, Mr. Gottstein, if you need additional time to present Mr. Bigley's response, we will make sure that we find that, probably on Wednesday of this week if you need additional time.
MR. GOTTSTEIN: Your Honor, I would just -- if you look at the Myers decision.
THE COURT: Right.
MR. GOTTSTEIN: And they -- the court is very clear that there is no reason to rush these proceedings because it's a very serious matter. As long as the drugs are not being administered, his liberty interests are preserved.
And to rush forward with this at this point when I have not had any of this, no opportunity --
THE COURT: Well, let me be clear. We are going to go forward with the state's case and the visitor's. And then you'll have an opportunity, if you need additional time, to respond later in the week.
But there is an entitlement, a requirement for a hearing. It should have been within May 8, and here we are at the 12th. So in any event --
MR. GOTTSTEIN: Your Honor, may I make one other point?
THE COURT: Absolutely, Mr. Gottstein.

MR. GOTTSTEIN: I'm sorry. Which is if you look at the Meyers' decision regarding best interests and less-intrusive alternative, they are very clear. There is no need to rush that. Okay.
The statute says with respect to the competency issue, that that is supposed to be held within 72 hours. So I guess if you look at it that way, it would be a three-step process, where -- and it seems to me the only thing that really should -- that the statute provides for 72 hours is the competency determination.
THE COURT: Well --
MR. GOTTSTEIN: And if -- if the court finds that he was either -- he is either competent or was competent at some previous time, then we don't need to get into the best interests and less intrusive alternative phase of it at all.
THE COURT: Hold on just a moment.
Mr. Twomey, do you have a response on that? I'm pulling up the statute.
MR. TWOMEY: Well, I really don't, Your Honor. We're here prepared to go forward.
THE COURT: Okay. Just a moment.
MR. TWOMEY: I don't think there is a three-step process. I think we're here with one

proceeding to examine whether or not Mr. Bigley has capacity to give informed consent.
THE COURT: And I disagree with your reading of the statute. As I read it, the 72 hours applies to this request -- this petition by the state with respect to medication.
But in any event, I -- I am fully cognizant of the additional requirements or the clarification of the requirements that our Alaska Supreme Court has set out. And I do take these types of proceedings and the type of requests that the state is asking quite seriously and intend to do so in this case.
So let's take a short break. We will get this paperwork to you, Mr. Gottstein, and then we will proceed. And then you get the chart, as well, whatever you --
MR. GOTTSTEIN: I will endeavor to do that, Your Honor.
THE COURT: All right. We'll go off record.
10:34:33
(Off record.)
11:04:00
THE COURT: All right. We are back on record here. And did you get a copy of those documents, Mr. Gottstein?

MR. GOTTSTEIN: Yes. Thank you, Your Honor. And if I could do just something for the record.
THE COURT: Absolutely.
MR. GOTTSTEIN: I think it's clear. But anyway, is that -- and I understand the steps that you have taken to kind of correct the problem. But the objection on notice of course includes that it's in violation of due process, which of course the hallmarks of due process are meaningful notice and a meaningful opportunity to respond.
THE COURT: Right. Absolutely. The objection is noted. Absolutely.
All right. Ready to call your first witness. Who all are you going to be calling as witnesses?
MR. TWOMEY: Dr. Larry Maile will be our first witness, and then Dr. Khari will be our second witness, Your Honor.
THE COURT: All right. So, Dr. Maile, if you could come all the way forward, please, sir.
(Oath administered.)
THE CLERK: Thank you. You may be seated.
Sir, for the record, can you state and spell your first and last name.
THE WITNESS: Lawrence J. Maile, L-A-W-R-E-N-C-E, M-A-I-L-E.

THE COURT: Thank you. Go ahead, please.
LAWRENCE MAILE, Ph.D.
called as a witness on behalf of the state, testified as follows on:
DIRECT EXAMINATION
BY MR. TWOMEY
Q Dr. Maile, where are you employed presently?
A At Alaska Psychiatric Institute.
Q And what is your position there?
A I am the director of the forensic evaluation unit and the clinical director.
Q And in connection with your duties at API, have you been familiar with patient William Bigley?
A I have. And currently, Mr. Bigley is (indiscernible) director of the unit that he is housed on. And I am familiar with Mr. Bigley, having treated him a number of times over his 77 admissions.
Q What is Mr. Bigley's current diagnosis?
A His diagnosis is schizophrenia, paranoid type.
Q Do you have an opinion as to whether or not Mr. Bigley has any insight into his own mental diagnosis, mental condition?
A Mr. Bigley has stated repeatedly that there is nothing wrong with him and that he's not mentally

ill. So I guess given that, I would say that he doesn't. At the very least, we have a difference of opinion.
THE COURT: So when you say repeatedly, is this in the near term or over the -- over the course of your involvement with him?
THE WITNESS: Both, Your Honor.
THE COURT: Thank you.
THE WITNESS: Most recently, in the last several days.
THE COURT: All right. Go ahead, please.
BY MR. TWOMEY
Q At the current time, does Mr. Bigley appreciate that he has a mental disorder or impairment?
A I have not asked him this specifically, but I guess given his comments, I would say no.
Q Has he denied the existence of his mental condition to you in the past?
A Yes, he has.
Q And how does he go about denying that?
A Well, he -- as I was getting to earlier, he's said several things: I don't have a mental illness. There is nothing wrong with me. He has stated various times that he thinks that we're crazy.

So it has taken a number of forms over the time that I have known Mr. Bigley.
Q Have you formed an opinion as to whether or not Mr. Bigley can understand what the predominant symptoms of his mental illness are?
A The predominant symptoms for Mr. Bigley, given his disorder, are probably -- the most prominent ones are delusions. He holds a number of beliefs that appear not to be true.
And as examples, that he's close personal friends with George Bush, who knows he is at API at this time and will take him out -- actually tomorrow I believe he stated.
Over the period of my having known Mr. Bigley, he's talked about Department of Corrections staff killing children and storing them in barrels. So many of the things that Mr. Bigley says on a day-to-day basis don't appear to be connected with my reality, if you will. So that would be his most prominent.
Given then your question, does he appreciate the most prominent symptoms, I would say no. He believes them to be true and to be real.
Q Do you believe that Mr. Bigley has the capacity to participate in his own treatment decisions

by means of rational thought process?
A I'd have to think about that a minute. Given that he doesn't believe that he's ill and that he is afflicted unfortunately with prominent delusions, I would say no, most of his decisions, his characterizations of people seem to be related to those.
As an example, one of our concerns for Mr. Bigley is that he doesn't eat and drink sufficiently and regularly, and that stems from his belief that we are poisoning his food. That's an example I guess of misjudgments on his part based on his symptoms. Those are the concerns that they would affect any impact on his rational decision-making regarding his treatment, as well.
Q Has Mr. Bigley been able to articulate to you any reasonable objections to the use of medications?
A Mr. Bigley has been very clear that he doesn't want any medication, and that he believes them to be poison, that we are poisoning him and that it will kill him.
Q Do those objections appear reasonable to you?
A They don't appear to be consistent with his prior treatment with medication. Obviously he has not died, and he seems to have improved. So I would say

they are inconsistent with my understanding of his experience of them.
THE COURT: When you say he seems to have improved, improved when he's had meds or just improved over the course of time?
THE WITNESS: Yes. He has improved as a result of treatment with medications in the past. If I were to characterize Mr. Bigley's course over the period of time I have known him, it has been a declining course overall.
THE COURT: Go ahead, please.
BY MR. TWOMEY
Q Do you believe that Mr. Bigley is capable at this point in time of understanding and discussing with you the method of administration of the medicines you are proposing?
A Mr. Twomey, it's not clear that Mr. Bigley can hold any kind of a rational conversation with me.
Q Same question --
A At least not in this admission.
Q Same question with regard to possible side effects and benefits of these drugs.
A No, sir.
Q Is Mr. Bigley able to review with you his medical history, including his history of having taken

medicine in the past?
A No. And I've actually asked my staff to kind of remind Bill of the times when he's been treated in the past. And uniformly, those are met with streams of profanity. So I would say that he is not able to participate in that.
Q Have you been able to provide Mr. Bigley with any explanation of how the proposed medication may interact with other drugs?
A No.
Q And why not?
A Well, primarily in the case of interactions with other medications, I would defer to the medical staff to do that. So for my part, I have not attempted that.
Q Okay. Have you been able to discuss with Mr. Bigley alternatives to treatment by medicine and what the risks of those alternatives would be?
A I have not discussed that specifically, although I have, and my staff has, suggested that Mr. Bigley would benefit from taking medications, and that he is at great risk out on the street without them.
Q What risks do you believe Mr. Bigley faces in the absence of receiving the medicines that API wishes

to prescribe?
A As I think this goes to the issue that I originally raised in my petition and in my prior testimony on his commitment, having known Mr. Bigley for I guess what would be about ten years, I'm not exactly sure. My experience with Mr. Bigley is that he's very different when he's been compliant with medications from when he's not.
And at such times when he's taking medications, as I said on the record previously, Mr. Bigley is a pleasant man. He is funny. He is an animated sort of individual. And he is one who is not threatening and not at risk to generate the harm from others by his perpetual threats to them.
The risk that Mr. Bigley faces without medication is that in terms of the longer term, he tends not to take care of himself. He doesn't eat, he doesn't drink, he doesn't seek appropriate medical care.
The issues in the shorter term are that Mr. Bigley --
THE COURT: Just a moment. Mr. Twomey, we have Mr. McKay (phonetic) here. This is supposed to be a closed proceeding, correct?
MR. GOTTSTEIN: Your Honor, I think it's

open.
THE COURT: It is an open proceeding? There is no objection there from any party? All right that's fine. Go ahead.
THE WITNESS: I'm sorry, Your Honor.
THE COURT: That's all right. You were in the middle of the talking about the impact of the medication. When he doesn't take the medication, he doesn't eat, is where my notes left off, Doctor.
THE WITNESS: I was probably not very effectively trying to draw a distinction between (indiscernible) or immediate in a little bit longer term.
THE COURT: No, you were.
A The not taking care of himself issues are the things that go to his -- what I characterized in my earlier testimony as his grave disability.
The issues of the danger to himself come in the more immediate sense and to others. He is threatening to people. And in fact, since the last proceedings, he's threatened to slit my throat if he gets out. Prior to the last proceedings, he threatened to find my staff and to kill them and their children.
Those kinds of responses, it's my concern

that I and my staff are going to handle those differently than someone might -- Mr. Bigley might encounter on the street. Those are the things that generate the immediate risk to him as a result of his condition, his irritability, his paranoia about people, and in all honesty, the way he treats people.

THE COURT: Go ahead, please.

BY MR. TWOMEY

Q Dr. Maile, have you formed an opinion as to whether or not Mr. Bigley is in fact competent to give informed consent?

A It is my professional opinion that he is not.

MR. GOTTSTEIN: Objection, Your Honor. And I think he hasn't really been qualified. And I don't know if that's -- I assume it's not a scientific opinion, based on science.

THE COURT: I think it was based on his work at API and knowledge of Mr. Bigley. That's what I took it as.

So to that extent, if you -- I mean, technically, yes, the witness has not been qualified. So if you wanted to --

MR. TWOMEY: We can qualify the witness, Your Honor, if that's necessary.

THE COURT: Just qualify the witness.

And if you had voir dire. But I hear he's a psychiatrist at API, correct?

THE WITNESS: Your Honor, I am a psychologist.

MR. TWOMEY: Is that correct?

THE COURT: Psychologist?

MR. GOTTSTEIN: Your Honor, if -- if we can agree that he's not testifying as to -- as to a scientific opinion, I think I can agree with that. But if it's scientific, then of course it comes under Coon.

THE COURT: I'm going to find that this witness can testify as to his opinion based on his work as a psychologist as to competency.

And I would -- the case that comes to my mind on this issue is the Samaniego decision which talked about psychological testimony and the applicability of the Coon Daubert standard.

So in any event, I will allow the witness to testify as to competency from his knowledge of the -- of Mr. Bigley and background as a psychologist. And then certainly in cross, you can explore the issue further.

MR. GOTTSTEIN: Your Honor, I think there's a -- and I'm sorry I didn't bring it with me, and I

should have. I think there's a case called Marron, M-A-R-R-O-N, where the Alaska Supreme Court discussed the difference between scientific evidence, which requires the Coon analysis, and opinion evidence based on experience, which doesn't, but still has to have the (indiscernible) of reliability.

THE COURT: In any event, I'm allowing the witness to testify as a psychologist. And if you wanted to explore it on cross, that's absolutely fine. But I am not excluding the evidence under Coon Daubert.

MR. TWOMEY: Your Honor, we will call another witness. So at this point, I have no further questions for Dr. Maile.

THE COURT: All right.

MR. TWOMEY: (Indiscernible) opposing counsel to cross.

THE COURT: Okay. Thank you.

Go ahead, please, Mr. Gottstein.

LAWRENCE MAILE, Ph.D.

testified as follows on:

CROSS EXAMINATION

BY MR. GOTTSTEIN

Q Dr. Maile, thank you. I believe that during your testimony during the commitment phase, you

testified that you were unaware of anybody having assaulted Mr. Bigley except while under your care; is that correct?

MR. TWOMEY: Objection, relevance, Your Honor.

THE COURT: I will allow that. Go ahead.

A I am not aware of him being assaulted outside of here -- outside of API, that is.

I am also not aware of him being assaulted in API, Mr. Gottstein, although we have intervened because of Mr. Bigley's threats to other patients. But he has not been assaulted.

BY MR. GOTTSTEIN

Q Didn't you testify that another patient attacked him in API?

A Mr. Gottstein, I testified that another patient very likely would have.

Q Didn't you testify that's how he got that bruise on there?

A What bruise?

Q On his cheek.

A Mr. Bigley had a cyst.

MR. BIGLEY: (Indiscernible.)

THE COURT: Oh, no, Mr. Bigley. That's all right. You don't need to do that, sir. But thank

you.
Go ahead.
A Mr. Bigley had a cyst on his cheek. That is not a bruise, as far as I know, unless it's associated with the removal of that cyst.
BY MR. GOTTSTEIN
Q So then in forming your opinion, you didn't use any of the validated competency to accept or decline medication instruments that have been developed, have you?
A No.
Q And you testified that when he was compliant with meds, you know, he was kind of easier to deal with. So he's voluntarily taken medications in the past, right?
A He has in the past, at various times.
Q Do you remember what -- what times? I mean, I remember a couple, but --
A I don't.
Q Do you -- and now, you mentioned that he had made threats to you. And I think in your testimony during the commitment phase, you testified that he -- he often makes those kind of threats, and people that know him know not to take them seriously, correct?
A No, Mr. Gottstein, that is not what I said.

I said that we must take them seriously, given the nature of the threats. Whether he will in fact follow through on them is an open question. But we must take them very seriously, especially given that he's threatened to kill the children of my staff people.
Q I'm sorry. But I think you testified that he never has acted on any of them, didn't you, to your knowledge?
A Not to those threats, not to my knowledge.
Q Now, are you aware of the study from the National Association of State Mental Health Directors that came out about a year ago that showed that since the advent of these new so-called atypical neuroleptics, that the average lifespan of people in the mental health system is now 25 years less than the general population?
A No, I am not.
Q But if -- if it's true, that these drugs dramatically shorten or substantially shorten people's lives, then wouldn't it be fair to characterize them as a poison?
A I think --
MR. TWOMEY: Argumentative, Your Honor.
THE COURT: Oh, I will overrule that. I will allow it. Go ahead.

A I would first want to see the study, Mr. Gottstein.
But it strikes me that there are a number of things that could well explain that, including the progression of the disease, difficulties in lifestyle, a number of things that could result in a foreshortened lifespan of individuals with schizophrenia, medication or not. That's --
BY MR. GOTTSTEIN
Q So you are unfamiliar with that study?
A I am unfamiliar with that one.
Q And unfamiliar with that the lowered lifespan has dramatically increased since the introduction of the new atypical drugs?
A I'm sorry; I didn't understand.
Q And so you are unaware that the lifespan of people being given these drugs has dramatically lowered since the introduction of these drugs?
A Interestingly, I have reviewed several studies that are on the Web site actually. And --
THE COURT: On what Web site?
THE WITNESS: On Mr. Gottstein's Web site.
A And as I look at them, there are some better and worse studies. There are those that discuss the side effects of different medications, their positive

potential impacts.
But I didn't see any that had a direct conclusion atypical antipsychotic medications lead to increased mortality or shortness of life.
They do discuss side effects, and there are some. They appear to be somewhat different than the typical antipsychotics, as near as I can tell.
BY MR. GOTTSTEIN
Q So I think it was -- so then you didn't review the Waddington study that is on the Web site from Ireland? I think that shows that the mortality rate doubled since the introduction of the atypicals.
A There are several interesting studies, I thought, looking at -- there is the study from Ireland, there was the one from Finland and one from Switzerland, I believe; is that correct? Those are the ones you have posted on your Web site?
Q Well, I have lots of studies on the Web site. I think the Switzerland and Finnish ones really are about alternatives, aren't they?
A They are about different sorts of medication and non-medication treatments.
THE COURT: Can you back up and tell me what atypicals are?
THE WITNESS: Yes, Your Honor. There are, if

you will, two sort of generations of anti-psychotic medications. I guess the easiest way to characterize them are the old ones and the new ones.

The old ones are those that were initially developed and started to be employed in the '50s and are still used.

The atypicals are the newer medications, different formulas that purport to be more specific in their action.

THE COURT: Thank you.

Go ahead, please, Mr. Gottstein.

BY MR. GOTTSTEIN

Q Okay. Just to kind of confirm, if -- if these drugs do in fact reduce life spans substantially then, wouldn't it be a fair characterization to call them poison?

A If, Mr. Gottstein, that were the only factor, and I could say clearly looking at the evidence, these medications and nothing else shortened people's lifespan, I would say that they would have to be employed very carefully.

I would also say, though, Mr. Gottstein, that if an individual has schizophrenia and one were, as an example, to kill oneself, that I would have to weigh the probability that an individual would take his own

life versus the need to treat them with something that might be invasive and of concern in terms of side effects.

One of those things -- those are medical decisions that must be weighed.

Q Well, first off, Mr. Bigley has never been a -- at least recently, a suicide (indiscernible), has he?

A He hasn't over the last several admissions, no.

Q And then I guess the point is, is that you feel it's your decision whether -- whether his -- you know, whether he should -- whether life-shortening drugs should be given rather than his --

A Mr. Gottstein, I think the decision rests with the court. I am in a position, having petitioned for this, to bring these concerns to the court. But the court must ultimately decide.

Q Okay. Now, if -- if Mr. Bigley knows by talking to you that what he says to you will be used against him in court, wouldn't it be a fair characterization for him to think that you were out to get him?

A I guess I'd have to think about that.

My practice, as you likely know,

Mr. Gottstein, is in the forensic arena primarily. And that characterization can be made of all of my clientele.

Ironically also, they all tend to speak to me. And those who were motivated to seek treatment in their own best interests tend to do so even though there may be potential legal consequences for them. So it's not my experience that the majority of my patients see me as out to get them.

Q So I'm not sure that you -- do you disagree with that statement? I mean, I don't mind that answer, but with -- if -- if he believes -- you know, Mr. Bigley has a lot of experience with coming into court and having people like yourself testify against him, right?

A Unfortunately, yes.

Q And so he's got a lot of experience with people like yourself taking what he says and using that against him, right?

A I'm certain he interprets it that way. Unfortunately, you know, I think if Mr. Bigley were exercising the good judgment that he shows when he has in fact been treated, he wouldn't be making the threats, which I am also going to come and report to the court and can't be in his best interests.

Q And in fact not only in this arena when -- that what he says to you can be used against him, actually when he doesn't talk to you, as you just testified, it can be used against him. And when -- you testified that he didn't talk to you as grounds for lack of competency, correct?

A I don't honestly remember that being my testimony, Mr. Gottstein.

Q You testified that he wouldn't talk to you, right?

A Mr. Bigley talks to me a great deal. Unfortunately, it's --

Q Well, I meant about the medications.

A He has not spoken extensively about them, other than to say he doesn't want them.

Q So now you testified that in the past, he's voluntarily taken them, correct?

A Yes, he has.

Q And then at some point after that, he's decided not to take them; is that correct?

A It appears to have been several points.

MR. GOTTSTEIN: Okay. I have no further questions.

THE COURT: Follow-up, Mr. Twomey?

MR. TWOMEY: Thank you, Your Honor.

LAWRENCE MAILE, Ph.D.
testified as follows on:
REDIRECT EXAMINATION
BY MR. TWOMEY
Q Dr. Maile, are you out to get Mr. Bigley?
A No, I am not. I guess if -- if I were to get my professional wish, if you will, for Mr. Bigley, it would be that he would receive medication and return as much as he is able to the Bill Bigley that I know from times when he is treated.
As I said, Your Honor, a friendly, pleasant guy. He is funny. He's easy to be around. That would be what I would wish to happen for Mr. Bigley.
Q You want him to get better?
A I do.
MR. TWOMEY: No further questions, Your Honor.
THE COURT: Did he have any side effects when these drugs were administered to him in the past?
THE WITNESS: Mr. Bigley has complained of several side effects over time.
One of the ones that he complained about most frequently was weight gain, which is a fairly common side effect of atypical anti-psychotic medication.

He's talked about being sleepy.
I can't honestly remember right offhand his other complaints. He has been very clear he doesn't like the side effects, though.
THE COURT: Okay. Follow-up at all, Mr. Gottstein? And you can follow up on that topic, as well, if you'd like, and I will accord counsel, as well. Go ahead.
MR. GOTTSTEIN: Yes. Thank you. So he's -- oh, I know what it was. I'm sorry, Your Honor. I'm a little sleep deprived at the moment.
THE COURT: That's all right.
LAWRENCE MAILE, Ph.D.
testified as follows on:
RECROSS EXAMINATION
BY MR. GOTTSTEIN
Q So doesn't he also have tardive dyskinesia?
A Does he carry that as a diagnosis? No. He has not been diagnosed with tardive dyskinesia.
Q So you are unaware of testimony in a previous case that he does have tardive dyskinesia?
A I am not aware of it, no.
Q And it -- and he's also complained of sexual dysfunction, hasn't he?

A I honestly don't remember.
Q So you are not aware of testimony in a previous case where -- I think it was Dr. Worrell testified to that effect?
A I am unaware of that.
Q Yeah. But isn't it true that sexual dysfunction is a side effect of these drugs?
A Yes, potentially, it is.
Q And as is tardive dyskinesia?
A Yes, sir.
MR. GOTTSTEIN: I have no further questions.
THE COURT: Follow-up at all on those?
MR. TWOMEY: No, Your Honor.
THE COURT: Okay. Thank you, sir. You are excused.
(Witness excused.)
THE COURT: Your next witness.
MR. TWOMEY: Dr. Khari, Your Honor.
THE COURT: Good morning.
(Oath administered.)
THE CLERK: Ma'am, for the record, could you state and spell your first and last name.
THE WITNESS: Kahnaz Khari, K-A-H-N-A-Z, the last name K-H-A-R-I.
THE COURT: Thank you. Go ahead, please.

DR. KAHNAZ KHARI
called as a witness on behalf of the State, testified as follows on:
DIRECT EXAMINATION
BY MR. TWOMEY
Q Good morning, Dr. Khari. Where are you employed presently?
A Alaska Psychiatric Institute.
Q And you are a medical doctor?
A Yes. I am a staff psychiatrist in two units, in the chronic unit and the forensic unit.
Q And you are board certified?
A Yes.
Q By what boards?
A By the American Psychiatry and Neurology department. I forgot.
Q Are you familiar with Mr. Bigley as a patient at API?
A Yes. But I just want to clarify that I was two weeks away. In this hospitalization, I actually had the first physical interaction this morning.
Q Okay. So you met with Mr. Bigley this morning prior to coming to court?
A I attempted it, but I was not successful.
Q Have you had an opportunity to review

Mr. Bigley's chart for this most recent admission?
A Yes. I was able to scan through and look at some of the pages that was of interest.
Q Is Mr. Bigley taking medication at this point in time?
A No, he is not.
Q What medication are you proposing for Mr. Bigley?
A I did look through some of the medication that Mr. Bigley has been taking during his hospitalization on 75th admission that he had in API.
On the various medication that he has been, the longest he has been on was Risperidone. And I am intending to use that medication because it is in the (indiscernible) form, like Risperidone Consta, which since Mr. Bigley has a history of non-compliance and he has taken that medication, he has responded, (indiscernible) to it and did not show any side effect.
So unless at some point when he takes the medication he is able to engage and I am able to sit with him to speak rationally, then discuss other medication, other options, to see if there is any other medication he would like me to look into.
Q Okay. So at this point, your plan is

Risperidone?
A Yes.
Q And how is that drug administered?
A That medication comes in actually three different format. In a tablet format, and in dissolvable form, and also in the injection form.
Q And how do you propose to administer the drug to Mr. Bigley should the court grant permission?
A Usually when we give the medication in the injection form. First we like to give them in the oral form to make sure the patient doesn't have any adverse reaction, mostly (indiscernible), but anaphylactic reaction.
But in his case, he is not -- he is not agreeing to take any medication. And he has taken that medication, did not show any severe adverse effect to the medication, so I am considering to go in the injection form.
Until that medication take that effect, I am also going to offer a medication from benzodiazepine family, like lorazepam or Clonopin, which is more of anti-anxiety medication to be able to -- he has responded well to that medication in past while he was under my care.
It decreases -- it decreases agitation,

labile mode, and his irritability, and also provided him some good sleep.
THE COURT: And I am going to point out here, Mr. Gottstein, maybe you could discuss with Mr. Bigley.
I know. When you talk, the problem is, Mr. Bigley, is that we are trying to record all of this.
And if you are unhappy with the decision or if the State is unhappy, then everybody has a right to appeal. And the problem is that we don't make a good recording when there is more than one person talking at once. It's just -- so it's an important thing that we only have one person talk at a time.
MR. BIGLEY: Sorry.
THE COURT: I understand that. I understand that. All right. That's all right.
Go ahead, please.
BY MR. TWOMEY
Q Dr. Khari, what dosages of medicine do you propose?
A Well, he's been taking that medication for -- on his last administration has been on 50-milligram IM. So I kind of like to look at it again more in detail, and then I could go on to the 37.5. The

option is only 25-milligram to the 37.5 on 50-milligram. And every two weeks.
So probably actually on my first dose, I might give him 25-milligram, and then on the next two weeks, increase it to 37.5, and then go to the higher dose.
Of course, I have to observe him as I give the medication to see how he is responding, because each time the patient does get the (indiscernible), the response would be different just based on his response gradually, decide what dosage should I move to.
Q Okay. So you are going to follow a plan then in terms of raising his dosage?
A Well, I am going to start with 25-milligram IM every -- the first one. But I don't -- knowing Mr. Bigley from past and also looking at the -- in reviewing his medication, I do not believe that would be a sufficient dose.
The maximum dose is 50-milligram IM every two weeks. So my ultimate goal would be a 50-milligram IM dose.
Q Okay. Why not just give him the 50-milligram injection at the outset?
A Well, actually, I could really go to

50-milligram. I personally lie more on the conservative side. I -- even though, as I say, he has a severe level of schizophrenia, he would respond well to it. But still I would like to -- I understand that he is totally against the medication.

So I would like to give him that benefit of -- start with 25-milligram, and hoping that he gets enough -- some level of improvement that his agitation and irritability goes down that perhaps I could have a reasonable, rational talk with him.

And by that, take the next step to -- part also to improve the (indiscernible) alliance that I create with my patient, to show him that I do want to hear with him -- I do want to hear him. I want to work with him and try to come off together, moving towards the direction to improve the quality of his life.

Q At this point in time, are you capable or are you able to have that sort of conversation with Mr. Bigley?

A Unfortunately, this morning, my intention was to go talk with him and try to evaluate and discuss the medication. He was very agitated. He was labile.

He start immediately. Without me even having the first chance to say any word, he became making

inappropriate comment. He was -- as I said, his behavior was escalating, so I decided it would be best for me at that time to separate myself for -- for safety of both.

Q What changes would you expect to observe in Mr. Bigley's symptomology after initiation of the treatment by medicine?

A From looking at -- knowing Mr. Bigley from past, as my colleague just on the last (indiscernible) express, that when Mr. Bigley is on medication, usually he is very likeable. It is very easy to engage with him. Even though on his baseline he may maintain his delusional thought content, but the intensity of it is a lot in lower level.

He is able to -- he is able to maintain his better -- better level of the engagement with other people. So I would expect him to be able to have some improvement his rational thought and have a better control, even though his delusional thought content may be present. But he is able to be in touch with reality more and be able to have some level of sensible discussion.

Q Are these medicines that you are proposing to administer to Mr. Bigley, are they painful?

A The injection is of course -- you know, I

think you do not find many individual that appreciate to get any form of injection, even when -- so from that aspect. So it is going to be intrusive and is going to have some impact on the muscles.

But however, I have observed that medication injection form given to many. It hasn't -- you know, it is not a pain that would -- it depends to the individual level of degree of how they perceive the injection.

Q What are the possible side effects of the medications that you are proposing?

A This medication is of a newer level of medication (indiscernible) anti-psychotic.

What I mean with the atypical anti-psychotic medication in comparison with the older anti-psychotic medication, their side effect is more favorable. Of course, it depends on how we look at the side effect.

When you look at the older anti-psychotic medication, you have a higher level of tardive dyskinesia, extreme (indiscernible) side effect.

With the newer medication, usually you do have them, but at a lower level. However, this medication in the higher dose does have some similarities with older anti-psychotic medication.

MR. GOTTSTEIN: Your Honor, objection.

THE COURT: Just a moment.

MR. GOTTSTEIN: I'm sorry. I was a little bit -- but I think she's testifying as to scientific evidence, and that she be required under Coon and Marron to provide that kind of -- that foundation and background in there.

THE COURT: I will sustain your objection as to foundation for the expertise on the side effects. So go ahead.

BY MR. TWOMEY

Q Okay. Dr. Khari, are you trained in the side effects of the medications that you are talking about here today?

A That is part of my training. And that is part of the side effect that has been shared is all based on evidence study that is done and on -- based on what has been observed on the patient.

Q Okay. How have you educated yourself about the side effects of these medications?

A Well, part of the education, then we go through the medical training. There is (indiscernible) training.

But most part of it, as you go continue on every medication from pharmaceutical company and from other study that is available when they do on each

individual medication, and as well also observing the patient while they take the medication in the hospital.
Q So you personally have observed patients having side effects from medication?
A Yes.
Q Okay. And how do you treat those side effects?
A Well, it depends what side effect we are talking about. To actually complete the first part of the question for this medication side effect, the major side effect of this medication --
MR. GOTTSTEIN: Objection, Your Honor.
THE COURT: No. I think it's -- an adequate foundation has been laid. But you can certainly explore it in cross, Mr. Gottstein.
Go ahead.
A The major side effect of this medication is (indiscernible) is not as significant to some other medication.
But it does have moderate weight gain. It does have some sedation side effect. It does have (indiscernible) hypertension. And in higher dose could have EPS and some level of tardive dyskinesia and hyperprolactinemia.

So those are the major side effect that become a concern. And I am so sorry. I forgot the second part of question.
Q I asked you how do you treat those side effects.
But first, before we get there, which of those side effects would be of concern to you in the case of Mr. Bigley? You have mentioned several possible side effects, including weight gain. Is weight gain a concern?
A As I said, every side effect that I mentioned is a concern for me for every individual patient that I treat.
But again, Mr. Bigley has taken this medication for a long period and the side effect has not been observed, even though he has expressed the side effect of weight gain and sedation.
So really, I have not observed any side effect at the present time to see that become a major concern for me. But part of the hospital setting, not just for Mr. Bigley, for every patient in every unit with every clinician that they continuously monitor. They do regular (indiscernible) test, which is especially for tardive dyskinesia, to make sure the patient is not experiencing those side effect.

So this is part of the training of all the staff in the hospital, from nursing staff to the rest of the team, to observe for those side effect.
Q Okay. So your plan in connection with Mr. Bigley's treatment would be to monitor him for the development of side effects?
A Yes.
Q How would you expect the proposed medicines to interact with any other medicines or street drugs or alcohol that Mr. Bigley might consume?
A Well, we never recommend our -- our patient to take mix medication with alcohol or the occasional substances. Of course, that is not recommended.
But however, mixing the medication with the illicit drugs of course is not -- he is not going to have the maximum full benefit of the medication.
It still in our population is not uncommon that unfortunately, the risk of -- or the level of use of the alcohol and substances is high, even though we recommend to our population -- to the patient it is still the (indiscernible). They may continue to use the drug. But (indiscernible) medication to be continued, because it allows them to be able to --
Of course, it depends what medication you are talking. With some medication could be very fatal,

when you mix for example benzodiazepine with alcohol. But however, the interaction of those medication, even though is not recommended, it doesn't have the fatality that benzodiazepine family of the medication have, or class of medication has.
Q Is the medication that you are seeking permission from the court to administer to Mr. Bigley, is it experimental in nature?
A No, it's not. This medication has been used for -- since -- I may be off on the date, but since '90s. It is not a new medication. It is not experimental medication, and is very common medication be used with a patient with the diagnosis of schizophrenia.
Q Does the standard of care of psychiatrists in this community require the administration of the medicine that you are advocating?
A Yes.
Q So the use of that medicine in Mr. Bigley's case would be within the standard of care in this community?
A Yes, it is.
Q What benefits would you expect to see in terms of the extent and duration of changes in Mr. Bigley's behavior should the court grant

permission?
A But every individual is respond to the medication differently.
I know you are asking about Mr. Bigley. And every time when the patient doesn't take their medication, unfortunately, the (indiscernible) -- the individual continue deteriorating. So the response may be different or may be longer this time than in a previous time.
So I cannot really give the exact date or time how he would respond, mainly because he has not been on medication for some time. But what I do know is that he has responded well on the medication. He did make some improvement with the medication, and I would expect that happen again.
Q Is it true that the longer that Mr. Bigley fails to receive this medication, the more harm he is experiencing?
MR. GOTTSTEIN: Objection, Your Honor. I don't think there's a -- I think she's got to lay a foundation for scientific evidence to respond to that.
THE COURT: The question was, is there a harm in not taking the medication?
MR. TWOMEY: That's right, Your Honor.
THE COURT: Okay. I will sustain as to

foundation. Go ahead. If you wanted to lay more on that topic.
MR. TWOMEY: Okay.
BY MR. TWOMEY
Q Do you have an opinion, Doctor, as to whether or not Mr. Bigley's mental condition is deteriorating at the present point in time in the absence of receiving medication?
A Yes. As -- as I have seen Mr. Bigley when he was on medication, he actually was functioning in the community in an assisted living facility. And he was able to have more rational interaction, and he wasn't labile. He was -- as I say, he was less tangential, less loose.
So I have seen him in a higher quality of living standard that he can have with the medication versus when he's not on medication.
Q Okay. Apart from your observation of his standard of living, are there other measurable changes that you could observe in connection with Mr. Bigley's mental condition?
A But his cognitive -- his thought process, you know, as I mentioned earlier, that his -- even though he may continue to have delusional thought content, but the delusion -- the intensity of it in the lower

intensity, he is not as labile, he is more redirectable, and he is -- he does not make the -- some of the threatening statement that he continues to make at the present time. And he is not as intrusive or inappropriate that he has shown while he was in the hospital last two weeks per report of the staff and the chart.
Q Is there a risk of -- to Mr. Bigley presented by not receiving the medication?
A Well, he will continue to deteriorate further. He could -- he could put himself and others in danger.
As again was earlier mentioned by Dr. Maile, my colleague, that when he is showing this behavior in hospital setting, all the staff are trained. They know how to interact and how to perceive the interaction.
But when he is in the community, he -- the community might not have the understanding where Mr. Bigley is coming from. So from that aspect, he really could put himself or others in unsafe position --
MR. GOTTSTEIN: Objection, Your Honor, speculation.
THE COURT: Well, I think we've been over

this, quite frankly, the issues that you've raised. So in any event, I'll sustain. I think she's covered this issue, in any event.
MR. TWOMEY: I just want to make sure, Your Honor, that we have explored all of the risks of non-treatment.
BY MR. TWOMEY
Q Are there any other risks of non-treatment that we haven't yet discussed?
A He might not be able to provide the care for himself, like not eating, not sleeping. And then -- and his psychotic thought content is going to get increased, so --
Q Doctor, do you believe it's in Mr. Bigley's best interest to receive the medicine that you are proposing?
A Yes.
Q Why is that?
A I would expect that his mental state would improve with the improvement of delusional thought content, his rational thought, his thought organization, and then his -- his affective mood.
MR. TWOMEY: I have nothing further.
THE COURT: Thank you.
MR. TWOMEY: Thank you, Your Honor.

THE COURT: Mr. Gottstein, go ahead, please.
MR. GOTTSTEIN: Thank you, Your Honor.
DR. KAHNAZ KHARI
testified as follows on:
CROSS EXAMINATION
BY MR. GOTTSTEIN
Q So one of the things that you testified to is that after -- you hope that -- I believe -- correct me if I mischaracterize your testimony. I certainly don't intend to.
But I think you said that if you are allowed to medicate him, that you would hope then to be able to discuss other medications with him later?
A Well, I -- yes. I do that with all of my patient. When they become more stable, I like to discuss about the medication they are taking, the benefit, the side effect and other options of the medication.
But again, looking at long standing of the period that he has been coming to the API, he has been the longest on that medication, and it seemed it did keep him to a level of stability that we would anticipate to see in him.
Q So then he was -- as I understand it, he was voluntarily taking medication in the past?

A Well, I would not say voluntarily. When he was -- as far as (indiscernible), he was not taking any medication voluntarily. But when he did have some court commitment, the medication was given to him.
Q So how far past in his chart have you reviewed his history?
A Well, as I said, I just came back to work today. So I just scanned with it. So the list of the medication, actually it was for several years back.
And then the last medication that he was on mostly was actually on an antipsychotic medication and mood stabilizer is (indiscernible). And I did not mention the (indiscernible) because I know Mr. Bigley is against medication, does not want to take the medication, doesn't have any insight to his mental illness, doesn't think in his medication.
And I thought having the medication simplified, and then having one medication probably would be -- would be the first best approach to go first.
Q So I don't know if you can tell, but isn't it true that from some relatively extended period of time, maybe even a year or so up until October of 2006, that he was voluntarily taking -- coming to API and getting his Risperidone shot every two weeks?

A But I am -- at that time when he was doing that, actually I wasn't working for Alaska Psychiatric Institute or was maybe the beginning of my work with this institution.
And I am -- yes, I understand that he was coming regularly and was taking that medication.
Q And then he wasn't under any court order to take medication at that time?
A As far as I know, he was not.
Q And then is it -- I don't know if you can review from the chart, but isn't it true then that once the hospital wanted to add and insisted on adding Depakote and Seroquel, that's when he -- that's when he then said he didn't want to take it anymore?
A I'm not sure. I don't know. But I do see that he was on the Seroquel and he was on Depakote. I do not know what faced in (indiscernible) aspect of -- as I said, I wasn't providing care for him at that time, so I don't know in what level he was agreeing to come to the hospital to take that injection, and in what situation he -- or in what point he changed his mind that he doesn't want any medication.
Q Okay. Are you familiar with what's known as the CATIE study?
A Yes.

Q And isn't it true that it found -- isn't it true that that study was designed to compare the first generation of neuroleptics versus the second generation of neuroleptics, called -- excuse me -- called the atypicals?
A Yes.
Q Okay. And then isn't it true that that study basically found there was no difference either with respect to efficacy or side effect profile?
A It is. But also I want to add that there is many studies available. And every study, we have to look at the whole picture of it.
But answer to your question, yes, that study at the end --
Q Can you --
A And they are still continuing that study, as far as I know.
Q Do you -- can you cite to me any of those other studies that you mention?
A Well, I don't have the list with me. But in part of our practice, of course, you know, on a daily basis, we try to read the studies or see the publication or what's available. Unfortunately, I don't have any of the names fresh in my mind right now.

Q And then isn't it true that the -- isn't it true that the CATIE study was funded by the National Institute of Mental Health?
A I believe so.
Q And isn't it true that was the largest study of its kind to compare the first -- called the first-generation neuroleptics versus the so-called atypical neuroleptics?
A It may have been.
Q And then isn't it true that that study found that 75 percent of the people taking -- actually both of those drugs -- quit taking them because they found them either ineffective or the side effects intolerable or both?
A I don't know what the percentage -- or exactly what the percentage, what you may have -- you know, if you are saying that is a statistic, then I would say I have to look at the evidence and then to say what the percentage.
But they did come from -- the conclusion of the study was that they did not find major differences between the two class.
Q Now, based on past experience, wouldn't you expect that after you started giving Mr. Bigley -- if you were allowed to forcibly drug him, that when he

got discharged, that he would quit?
A Well, this is what -- since I have known him or since I have been in (indiscernible), it appears that when he leaves the hospital, yes, he does not want to stay compliant with medication.
And that is why we recommend to go with the injection form. That is every two weeks. And it is that -- if he stops taking the medication, at least that medication is in his system for a period of time. At least that keeps him stable for some short period.
But even every day is better than no day to stay stable.
Q So you know, wouldn't it make sense to try and come up with a program that -- where he would -- if he -- since he refuses to take the medications when he leaves, to come up with a program to help him in the community that doesn't involve drugs?
A Well, when he's in hospital at this point, I think that the best thing we could do to keep him stable is to offer the medication.
However, I am aware that there is some program out that they are trying to work to have a patient with the mental illnesses with no medication. I think he already extensively involved with that program, as well, which it is very good and

encouraging.
However in this case, at this point, Mr. Bigley have a severe mental illness. He does not have any rational thought process. And I think he would benefit from the medication.
But I agree. Yes, in the community, we do need work to the community when the patient do not want to take the medication to see how we can work together in the combination of medication and other alternative to see if we can bring to work with this population.
But I think at this point in the (indiscernible), it is my understanding is what we could do now to stable him, probably he would benefit from the medication.
Q Now, you mentioned that the standard of care requires the use of medication. Is that a fair characterization of your testimony?
A Yes.
Q Okay. Now, does that mean that the standard of care requires you to force him to take the medication?
A Well, we are talking about Mr. Bill Bigley, I wanted to make that also clear. It depends. Every patient, to them, state of mind and how they are, how

severe is their pathology.
In the case of Mr. Bigley, he would -- you know, as we could -- he is continually showing the psychotic state. He is not organized. He is not rational. And it is a standard of care to be able to give the medication to bring some level of stability. And hopefully from that point, we could have more rational engagement and to see what other alternative or avenues could be looked into.
Q So it seems to me that when I think of standard of care, usually it would be that -- it would be the standard of care to recommend the use of the medication?
A Yes. I am sorry. I forgot the part that is forced medication. Yes, the standard of care is to recommend the medication, and let the individual decide.
But the level of the psychopathology that right now Mr. Bigley is experiencing, and we are in the court, and that if the medication is going to be forced is not the hospital's or the clinician's decision. It is the court decision.
Q So if -- if you recommend a medication to a patient -- well, first off, how many times have you testified in forced medication proceedings?

A I do not know the number. I have been working for API almost three years, so it is not uncommon that -- we actually -- the hospital has always the approach not to go to the court and try to do that and try to work with the patient.

But it is not uncommon when the patient that becomes so psychotic they don't have any insight into their mental illness and they do not want to take the medication, that put us in a position to come to the court and try to have the court to make that decision.

Q So can you give an estimate of how many forced drugging proceedings you have testified in?

A I am not good with numbers. I don't know. But I have been in court many times.

Q Would it be more than 50?

A I am not really sure. Perhaps the number -- I have been in court at least 50 times, so --

Q Would it be -- so it would be more than 25?

A Probably. Probably so.

Q Could it be as high as 100?

A I don't think so. But again, as I said, I don't keep the count of the numbers.

No, definitely not above 100, but probably near 20s or around these figures I feel more comfortable.

But then again, I really don't know.

Q So have you ever come to court and asked for authorization to administer psychotropic medication to a patient who has agreed to take them?

A No. Because if the patient agrees to take medication, why would I want to come to court?

Q Okay. So if -- how many times, when a patient doesn't want to take the medication, have you said okay?

A Again, I cannot give you the number. But as I said, every individual patient is different.

If the patient -- it is not uncommon that I've had patient that they did not want to take the medication. And I thought they would benefit from the medication, but however, I did not see them gravely disabled or danger to self or others. And I didn't think -- you know, I thought that they could -- they have enough support in the community and they could manage to maintain themself in the community.

And I just -- I totally agreed. I (indiscernible) them. I asked them when they get discharged to follow up with outpatient provider. And it is not uncommon that I have done that.

Q Okay. So in other words, if you think that someone would benefit from -- well, from medication

and they don't want to, but you don't think that they're a danger to self or gravely disabled, you would recommend discharge?

A Well, do I recommend -- I don't recommend. Do I recommend discharge?

Q Yes.

A Yes. I have had cases that the patient came to the hospital, still did not want to take the medication. We discussed, did not show the criteria for hospitalization, didn't show the level of the dangerousness or significant concern, and was discharged with recommendation to take medication. But they did not want to take it, and they were discharged.

Q Okay. So now how many people who then you have had that have been committed but didn't want to take the medications did you accept that?

A As I say, I am not good with numbers. I don't remember the numbers. But I have had cases that I went to the court that the patient did not want to take the medication. And I think I thought they would benefit from the medication, and I went to the court and court granted it, and I administered the medication.

Q So I don't want to put words in your mouth.

And there is a little bit of a language thing here.

So what I understand your testimony to be is that if the person is committed and they don't want to take medication, that you'll go to court and ask for court authorization?

A If I believe that they definitely need medication, they must take medication and the patient does not agree or doesn't think they should take medication.

Q Okay. So basically what happens is if they agree to take the medication, you -- you will accept that. If they are committed and don't agree to take it, that you will come to court and ask for medication?

A But that is part of the statute, that if the patient doesn't want to take the medication, and then I feel like that they would benefit from it, and if they don't take it they may put themself -- as I say, they may put themself in danger, or others, or not able to provide care for themself, then I have to come to the court and then try to express my concern to the court.

Q So would it be a fair characterization that there just aren't patients at API that really are allowed not to take medication?

A No. We do have patient that are in the hospital, and they don't take medication.
Q For long periods of time or just prior to the discharge?
A No. Actually, they may not take medication throughout their whole hospitalization.
Q How many would you say that is?
A Again, Mr. Gottstein, unfortunately, I am not good with numbers. I cannot give you numbers.
But I am just saying that there are what I -- I guess what I am trying to understand, you are mentioning -- trying to categorize the patient that are in API, as far as yes, there are patient -- you are put in three categories from the outset.
Are they patient in a hospital that -- or has it been cases in the hospital that the patient came, did not want to take the medication, hospital thought they would benefit from the medication, and they say they didn't take the medication during the hospitalization, they got discharged, which I said yes.
And the other category was you mentioned that do the patient come there, they do not want to take the medication, and the hospital feels -- the clinician feels like they should take their

medication, they take them to the court and court grant the medication. I say yes.
And some is in between. They come to the hospital. They want -- they think they are sick. They want medication. Hospital gives them medication, and they do not go to the court. This is the three category I understand you are asking. And I am saying that all those three categories does exist, and we do treat our patient with those categories. And every individual is different.
Q Okay. And what I'm trying to get at is -- and I am not trying to put words in your mouth or anything. I just want to understand.
But -- so my -- what my sense of it is, if they are in the hospital and they agree to take the medication, they get it.
If they are committed in the hospital, at least -- at least your patients, and don't want to take the medication, you come to court and ask for court authorization?
A Yes.
Q Okay.
THE COURT: Mr. Gottstein, is this a good place to take a break here?
MR. GOTTSTEIN: You know, I think that --

yeah, I think it probably is. I'm not sure if I'm done or not, but --
THE COURT: All right. And then you can review your notes. And then we'll have any redirect and Ms. Vassar's report shortly. We're going to take a short break.
And, Mr. Gottstein, if you can impress again on your client the importance of making a good record here as best you could, I appreciate it.
We'll take a short break.
THE CLERK: The court will be in recess.
12:14:10
(Off record.)
12:32:50
THE COURT: We are back on record here. And, Mr. Gottstein, I see your client is gone. But are you ready to proceed?
MR. GOTTSTEIN: I think we can, Your Honor.
THE COURT: All right. Then go ahead, please.
MR. GOTTSTEIN: Although I much prefer to have him here. But I understand we need to keep moving.
BY MR. GOTTSTEIN
Q Dr. Khari, who would know at the hospital how

many unmedicated patients there are?
A Well, I am sure the -- that I -- I am not sure the exact person. But probably by contacting Mr. Atter (phonetic) or Dr. Hopson, they may direct you better to which person would have that answer.
Q So you think Dr. Hopson would probably know?
A He -- if he doesn't know, we know which person would have -- would know. Or if we don't have that, I'm sure it shouldn't be difficult somehow to come up with some number, I suppose.
So in answer to your question, no, I don't know. Perhaps Mr. Atter or Dr. Hopson could have a better answer for you on that.
MR. GOTTSTEIN: Okay. Thank you. I have no further questions.
THE COURT: Redirect?
MR. TWOMEY: No, Your Honor.
THE COURT: All right. Thank you. You can be excused.
(Witness excused.)
THE COURT: And then we have a report from the visitor, correct?
MS. VASSAR: Yes.
THE COURT: Or did you have other witnesses?
MR. TWOMEY: I don't, Your Honor.

THE COURT: Go ahead, then.
MS. VASSAR: Thank you, Your Honor.
I did have the opportunity to meet with Mr. Bigley this morning. And he was extremely agitated. And we didn't get very far in the interviewing process.
I do have a capacity assessment, a list of questions that I -- that I ask the respondent. And we didn't get very far in that at all.
It starts out really simple, like what's your name, to which he responded: You know who I am. I am the president of the United States.
And what's the date? And he said: Does it matter?
Do you know the name of this place? Who cares, was his response.
And that's about as far as we got into the actual formal assessment tool.
But my observations were he was very agitated. He was banging on the table. He got up at one point and was standing over me, and then shoved a chair across the room. Not very far across the room, but shoved the chair.
He told me that the room was bugged. And I really didn't -- it just -- and then he just starts on

about a lot of his delusional content. The president knows he's there, the president is going to get him out, but he's the president. But he knows Bush.
And it just was escalating to a point where I -- despite trying to ask him questions, I didn't -- I didn't get -- that's about as far as I got in the process. And then he -- I -- they took him out.
He did want to know -- I told him that he had the hearing today. And he is always very interested in coming to court. And he wanted to know who it was going to be before, and what the room number was, and that sort of thing.
But other than that, I couldn't keep him on track long enough to really get into the questions that would be pertinent to this hearing.
I did speak with a psychiatric nursing assistant who was with him on the unit and brought him in and out of the room. And he said that his behavior was consistent with what he had seen recently. He has been very agitated, escalating.
I also spoke with Dr. Khari --
MR. GOTTSTEIN: Objection, hearsay.
THE COURT: It's coming in. I would think that as a visitor, that hearsay statements would come in. And I'm equating it to a custody investigator,

like the court's appointed expert in that capacity. So I will allow it in.
Go ahead.
MS. VASSAR: I also spoke with Dr. Khari, who told me that he's had to spend a great deal of time in the quiet room. He's been so agitated, he is also agitating to the other patients.
When he came to the hospital on April 25th --
MR. GOTTSTEIN: Objection, Your Honor. That's a continuing objection.
THE COURT: The hearsay objection is continuing, and so noted.
And did you want to weigh in on the hearsay objection?
MR. TWOMEY: Well, Your Honor, I am looking at the statute 47.38.39 --
THE COURT: I have it right here.
MR. TWOMEY: -- (d)(2). And it seems plain that the visitor is to talk about oral statements of the patient and conversations with relatives and friends. So it appears that the statute contemplates such hearsay statements be considered by the court.
THE COURT: Go ahead, Mr. Gottstein.
MR. GOTTSTEIN: Your Honor, I think that is actually directed to prior statements regarding his

desire to take or decline the medication.
THE COURT: I would agree with you, Mr. Gottstein, that that subsection is looking at whether there have been expressed wishes regarding medication stated in the past.
MR. GOTTSTEIN: He didn't say anything.
THE COURT: Nonetheless, I will allow in the hearsay. Because what I see is that the visitor is -- her responsibility is to assist the court in investigating the issue of whether -- on these issues. And it's in that regard, akin to the other types of experts we have where hearsay comes in for that purpose. So --
MR. GOTTSTEIN: Your Honor, I really don't understand how that's relevant to his capacity or prior expressions of --
THE COURT: Well, on the relevance, I will overrule you, as well.
So go ahead.
MS. VASSAR: He was admitted to the facility on April 25th. And he was originally in the Susitna unit, which is a lower level of supervision, I guess you could say.
But he had to be removed from there to the Taku unit because he was so disruptive. And --

THE COURT: And when did that change occur?
THE WITNESS: On the 26th. He was only there a day before they moved him to Taku.
MR. GOTTSTEIN: Your Honor, I really object to that. Because it's going to the -- I think it's highly prejudicial and it's not -- no real probative value on the issue of competence.
There's been no -- my experience, Your Honor, is that reasons are stated for these sorts of things and end up upon exploration that they're really not true. And I -- I really object to her description of that as certainly not relevant. And the hearsay --
THE COURT: The reason for the change in the unit? Is that what you're objecting to?
MR. GOTTSTEIN: Yeah. Well, the testimony about -- yes.
THE COURT: Well, I will allow the testimony that Mr. Bigley was moved to a unit that was more restrictive, and let's move on.
MS. VASSAR: I found no evidence of an advanced directive. I was not able to talk with other family members. I received notice of this hearing late on Friday, and I wasn't able to talk with other family members. He hasn't really had any outpatient providers to speak of, of late. He has been in and

out of the hospital.
THE COURT: When did that -- that guardian --
MS. VASSAR: I did not speak to the guardian on this admission. I have spoken with the guardian on very recent admissions. I know the guardian is not aware of any advanced directives, but the guardian does support the use of medication.
I have spoken in the past with the guardian that he had prior to the guardian that he now has at OPA, Mr. Steve Young. And he was the -- he was his guardian when Mr. Bigley was compliant with taking medication on an outpatient basis from API. He would go every two weeks and receive the Risperdal Consta.
And during that time, he lived in the community in an apartment of his own. And he was able to shop. He -- Mr. Young would accompany him on shopping trips. And that went on for a couple of years, where he voluntarily would get himself to API either with a taxi or he knew the bus schedule to get there and get his medication.
THE COURT: What timeframe was that approximately?
MS. VASSAR: I'm thinking it was about 2003, 2004. It's been a while. But in that time. Possibly up to 2005, in 2005.

But somewhere in there, there was a couple-year period of compliance where he did pretty well. I'm trying to think of -- and he has -- Mr. Bigley, not this time because he was so agitated, but he has mentioned side effects to me.
He has mentioned erectile dysfunction which has come up. And my understanding is when he was compliant with coming to API -- and I just learned this recently -- that he also had a prescription for Viagra during that time and did pretty well with that. So although he had that complaint, it was addressed.
And he has also -- he's also complained to me about the somnolence, you know, sleepy.
He's complained to me about the injections, that he feels like they've altered the appearance of his buttocks, and that's of concern to him.
And that's mainly what I've gotten from him over the years that I've known him is the chief complaint -- and he doesn't mention it so much now -- is erectile dysfunction, the feeling sleepy, not feeling as on top of his game.
THE COURT: All right. Anything else to add here?
MS. VASSAR: I don't know of any other -- any other side effects that he's mentioned --

THE COURT: Okay.
MS. VASSAR: -- or that have been verified by the hospital. As far as I know, I have never seen a diagnosis of tardive dyskinesia.
And the other thing, to Bill's credit, is I've never seen a diagnosis of alcohol or street drugs. So he doesn't have that complication when he's out in the community.
THE COURT: All right. Anything else that the state sought to add today?
MR. TWOMEY: No, Your Honor. I believe we're satisfied with the evidence we've presented.
MR. GOTTSTEIN: Your Honor, may I cross examine?
THE COURT: Well, I was going to ask, is the practice generally to allow questions of the visitor?
MR. TWOMEY: Well, I believe the statute permits that.
THE COURT: Permits that? And then I didn't swear in Ms. --
MS. VASSAR: I'm sort of always sworn in. But I'm certainly happy to be sworn in.
THE COURT: All right. And why don't I do that and reaffirm all the testimony. It doesn't need to be restated. And then Mr. Gottstein can ask some

questions.
Go ahead, please, and stand. And you can remain where you are.
(Oath administered.)
THE CLERK: For the record, can you please state and spell your first and last name.
MS. VASSAR: Marie Ann, M-A-R-I-E, A-N-N. My last name is Vassar, V-A-S-S-A-R.
THE COURT: All right. I guess it's an indication that I am not doing these hearings on a regular basis. They are usually across the street or at API.
In any event, Mr. Gottstein, go right ahead.

MARIE ANN VASSAR
testified as follows on:

CROSS EXAMINATION

BY MR. GOTTSTEIN

Q Are you aware that Dr. Doug Smith treated Mr. Bigley for many years in -- I think it was either Sitka or Ketchikan?

A I am not aware of it.

Q So then you didn't inquire as to him about any expressions regarding the drugs while he was under his care?

A No, I didn't. I understand Mr. Bigley's

lived in Anchorage for many, many years now. He was last in Sitka many years ago.
MR. GOTTSTEIN: I have no further questions, Your Honor.
THE COURT: All right. Follow-up at all on that?
MR. TWOMEY: No, thank you, Your Honor.
THE COURT: Thank you, Ms. Vassar.
(Witness excused.)
THE COURT: So the State's concluded its evidence.
Mr. Gottstein, as I indicated, if you sought to come back another day and present evidence, you can do so. And I will find time either tomorrow or Wednesday on the calendar.
MR. GOTTSTEIN: Your Honor, I'd like to make a motion at this point to dismiss the petition.
THE COURT: All right.
MR. GOTTSTEIN: I think --
THE COURT: On the break, I printed out Myers once again here and Wetherhorn. So I have them right here. Go ahead.
MR. GOTTSTEIN: I think that there are two bases for that.
One is that they basically admitted -- two

admissions. Admitted that he's voluntarily taken the medication, and then quit.
And under the statute, if -- he can only be administered medication if he gives informed consent or by court order. So by definition, he either gave informed consent, in other words was competent to accept the medication at the time that he accepted it, or it was an assault.
THE COURT: But aren't I looking at today as opposed to in the past?
MR. GOTTSTEIN: No. Because if there is -- so there is a complete logical inconsistency with what the hospital is doing, is that he is required -- in order for them to administer drugs to him voluntarily, he's got to be competent.
So if they give -- he's competent, competent while he's taking it. And so then as soon as he decides he doesn't want to take it, all of a sudden, he is incompetent?
And in the case of the -- and that's basically the testimony that was given, is -- and so he has to have been competent at the time that he declined. So that's one.
The other ground --
THE COURT: So are you saying that today he's

competent or --
MR. GOTTSTEIN: No. If at any time in the past -- the statute says if at any time in the past he's -- you know, while competent, he's declined to take the medication and expressed his view about it, that the court has to honor that.
THE COURT: All right.
MR. GOTTSTEIN: And then the other ground, Your Honor, is that Dr. Khari essentially admitted that there is a less-intrusive alternative that wasn't pursued.
THE COURT: And that would be, in your mind, what?
MR. GOTTSTEIN: Well, she testified that it would be -- it would be good to work with him to develop a program in the community that honored his choice not to take medications. And I've been trying for quite some time to really get that.
And that's why, Your Honor, actually, my preference would be to hold this proceeding in abeyance pending a settlement conference to work something out on that. Because I think that they really admitted that there is a less-intrusive alternative.
And what they have done in the past is they

simply discharged him into the street without any kind of support, which they know inevitably will lead to problems.

THE COURT: So where -- and I understood that testimony in the prospective, that it would be a positive thing in our community to have such an alternative. But is there one existing now?

MR. GOTTSTEIN: Well, yes, I believe one could very easily be put together.

THE COURT: But currently there is no facility that -- I mean, I don't know.

MR. GOTTSTEIN: Yeah. API could -- I'd move for one, and it'd be in the paper -- you know, the -- I think in the attachments to my limited entry of appearance.

But yes, what Mr. Bigley needs. And there is actually testimony, although it was mine, about what really he needs in the community. And in fact, there is the affidavit of Paul Cornils, too. But really, the -- a couple of things.

One is that Mr. Bigley has a lot to say. And you know, it would be really helpful for him to have someone to say it to.

And then to have someone in the community with him while -- for substantial periods of time to

just, you know, help him with -- to keep from getting into trouble in all kinds of areas.

And I think that as I put in my -- that submission, that the -- you know, having invoked the awesome state power to lock him up and then move to forcibly drug him, that that really -- his right to a less-intrusive alternative springs into being and the state is obligated to provide that. Because the state may not provide their service in an unconstitutional way.

THE COURT: Thank you, Mr. Gottstein.

What are the state's responses on those two points?

MR. TWOMEY: Yes, Your Honor. We are here today dealing with Mr. Bigley's mental condition as it exists today. Mr. Bigley may or may not have been experiencing a greater level of competency in the past.

In the past when he was competent, he was compliant with his medicines. He was taking those voluntarily. He is not now. And the court is faced with this issue now in determining as of today, is he competent to make a decision concerning his medicines. We believe our evidence --

THE COURT: Can I ask you a very fundamental

question?

MR. TWOMEY: Yes.

THE COURT: If you look at the Myers case, it lists at the second stage -- and this is after a person's been -- after a commitment order has been entered. And now it's talking about the type of petition the state has here, the medication one.

It says: At the second stage, the state must prove two propositions. And these then are two separate requirements, as I understand it. There is no "and" there, but should there be between 1 and 2? That the committed patient is currently unable to give or withhold informed consent, and that the patient never previously made a statement? Is that your reading of it?

MR. TWOMEY: Yes, that is my reading of it, Your Honor.

THE COURT: All right. And so just so I understand how the law would work here, is -- what if somebody is mentally healthy, and at age 21 says I never, ever, ever in my life want psychotropic meds, no matter what?

MR. TWOMEY: I think the court needs to give that deference. And we've he had the court advisor in this case indicate that she has not found any such

evidence. And the facts are contrary, Your Honor.

THE COURT: You know, and I understand that from the facts here. But if a person made that statement, then is your reading of Alaska law that if at age 35 they developed a mental illness, that the state would be precluded from administering -- administering meds -- psychotropic medication? Is that your reading of the Myers case?

MR. TWOMEY: It is, Your Honor.

THE COURT: Okay. Thank you. Go ahead.

MR. TWOMEY: So --

THE COURT: Just to follow up, what if they made that statement at age 21, and then at 30, they said, you know, maybe that would be an okay way to address this type of situation? So you had conflicting statements made over the course of the person's adult life, but at one point they had made a statement --

MR. TWOMEY: I think you'd have to look at the most recent statement made while competent, Your Honor.

THE COURT: Okay. Thank you. Go ahead. I kind of got you on a side track.

MR. TWOMEY: Well, just two points. One is we're dealing with Mr. Bigley's condition today and

the issue of whether he's competent today, not whether he was competent in the past to accept medicines that were being provided to him.

And we are also dealing with the situation as it exists today with respect to alternatives to treatment.

Dr. Khari's testimony as I understood it was that there is no presently available alternative to treatment by medicine, and that treatment by medicine is within the standard of care and is required in this case. It would be nice to develop a program and to work with Mr. Bigley.

But Dr. Khari's testimony was that she is hopeful that that will occur once she is able to engage with this patient and after he receives his medicine and his condition likely will improve.

So we are not faced with a situation where there is an alternative presently available to treat Mr. Bigley's condition.

THE COURT: But as I understood Mr. Gottstein's argument, he was saying that the -- that the fact that Mr. Bigley stopped going to API and voluntarily receiving medication was in effect a statement made while competent, or that the action was in effect the statement that expressed a desire to

refuse future treatment. Do you understand? That's how I understood his argument.

MR. TWOMEY: I guess I hear the argument. I don't necessarily agree with it. I don't know why Mr. Bigley stopped taking his medicine, what motivated him at that point in time. I don't think that that's an unequivocal statement that he doesn't want to take medicine.

THE COURT: All right. Thank you.

MR. TWOMEY: Thank you, Your Honor.

THE COURT: Mr. Gottstein, any further response on the motions?

MR. GOTTSTEIN: I think -- yeah. I don't really need to belabor the point about the previous statement.

THE COURT: Did I interpret your argument correctly --

MR. GOTTSTEIN: Yeah.

THE COURT: -- that the conduct was in effect a statement?

MR. GOTTSTEIN: Yes, Your Honor. And really, when you look at the big picture of it, as I think Dr. Khari really clearly testified, is that it's not truly a legitimate competency process that goes on. If people accept the medication, they say fine, and if

they decline it, they automatically say that they are -- well, you know, except in one case. Now, I don't think that latter thing is so important here with -- with respect to Mr. Bigley.

But I do think that -- and the other -- and the other point here, really the big picture point, is that Mr. Bigley has a right to a less-intrusive alternative. And as long as the hospital is always allowed to force someone to take medication, there is -- there is no -- then they -- then his right to a less-intrusive alternative is not being honored.

And I should have mentioned that there -- it is possible for them to provide a less-intrusive alternative. And it's in the paperwork that I filed. Mr. Cornils' affidavit talks about some of it.

And I can file kind of, you know, proper, you know, evidentiary forms of that. And I would intend to if we go beyond that.

And also, the -- there are a number of staff members at the hospital who like Mr. Bigley and could really help him out in the community. And they could -- and there are other people that could pretty easily be found to do that.

And really, I think that's why I'd ask for the settlement conference. Because I think we --

rather than have this all-or-nothing situation where he's not getting really what he needs and he's not really -- and he's -- you know, and his rights, and he's being forced to be drugged, and back and forth and all this, that we ought to collectively get together and try and work something out that has a reasonable prospect for success.

And that's why I would really like to hold this in abeyance pending a settlement conference on that.

THE COURT: And who in your mind would be the participants in that type of a settlement conference?

MR. GOTTSTEIN: Well, I think -- I think Dr. Hopson is the medical director.

THE COURT: All right. Thank you.

MR. GOTTSTEIN: And you know, I think maybe the -- the guardian probably.

THE COURT: So, Mr. Gottstein, I am not going to be ruling on these motions today because I do want to look again at the paperwork that you submitted and the case law. But do you need -- do you plan to present additional evidence, assuming I decline the motions?

MR. GOTTSTEIN: Yes, Your Honor.

THE COURT: All right. And can you give me a

time estimation of how much, and who you would intend to call and how long we should set aside on the calendar?

MR. GOTTSTEIN: There is I think some written testimony which I think will, you know, speed the process that I can --

THE COURT: That's in the submission?

MR. GOTTSTEIN: Yeah. And I don't know. Do you want me to file formal certified copies or -- I mean, I probably should.

THE COURT: All right. So you've got the written submission. And I'll ask the state's counsel just a moment on that. But the written submission.

MR. GOTTSTEIN: Then I would probably -- I think I would have some additional written testimony. And then I think then make those people available for cross examination.

Many -- a couple of them are telephonic, so I would move the opportunity to do that telephonically. And then I would probably -- I think probably an hour and a half would be enough. I hate to -- not counting cross, it's so hard to say. But I would say an hour and a half for any, you know, supplemental oral testimony.

THE COURT: All right. And so it's your

proposal to submit affidavits and then make those people available to Mr. Twomey to cross? Or I'm not sure I understand.

MR. GOTTSTEIN: Yes.

THE COURT: Okay. And who all in the way of affidavits?

MR. GOTTSTEIN: Well, and it may not be an affidavit. You know, I got this order on Friday.

THE COURT: No. I understand.

MR. GOTTSTEIN: So part of it depends on availability. One --

THE COURT: Not if we did this.

MR. GOTTSTEIN: Okay. I -- and then I guess I would want to -- did you say -- you didn't say you denied the motions?

THE COURT: No, no, no. I'm going to take them under advisement, that -- but assuming the following, that I do deny the motions at least without -- prior to hearing your case, then we'd be looking at 10:00 a.m. on this Wednesday.

And you could get in your affidavits at some point that both sides could agree on tomorrow.

And then would that be acceptable to the state? Do you understand what I'm proposing?

MR. TWOMEY: Well, I am. But I am a little

unclear as to what affidavits and how many witnesses, and so forth.

THE COURT: Well, if you had -- (indiscernible). But first, are you available 10 to 12 on Wednesday to conclude this hearing?

MR. TWOMEY: Yes, Your Honor.

THE COURT: All right. And what I'd do is give you a decision on record on the motions at the outset of the hearing. But assuming -- and I don't know at this point. But assuming those are denied, then we'd go forward with the hearing. So that would be our plan of action.

MS. VASSAR: Your Honor, would my presence be necessary?

THE COURT: You could waive your presence. That's fine. That's fine.

MR. GOTTSTEIN: So, Your Honor, I understood you to ask who my witnesses might be?

THE COURT: Well, just some type of ballpark. I realize if you haven't had time to prepare all of your witnesses. If you had a timeframe tomorrow when you could let Mr. Twomey know who you plan to call, that would be helpful.

MR. GOTTSTEIN: Okay. I've actually got some pretty (indiscernible) oral argument tomorrow morning,

so this is going to -- but yeah, I could certainly do that.

THE COURT: So afternoon sounds like a better timeframe for you on getting the information to Mr. Twomey on who you plan to call?

MR. GOTTSTEIN: Right. And --

You can tomorrow maybe. It's not our turn yet.

THE COURT: Well, you can sort that out tomorrow. And actually, the key is not even letting -- the witnesses are less important. It's if you plan on submitting affidavits, you need to get those in tomorrow so that --

MR. GOTTSTEIN: Yeah, yeah.

THE COURT: -- they can be cross examined on Wednesday.

MR. GOTTSTEIN: Is it possible to do it later in the week?

THE COURT: The week gets worse for me is the problem.

MR. GOTTSTEIN: Your Honor, there is some prior testimony in some cases that -- would it be acceptable for me to present that or --

THE COURT: Is it already transcribed?

MR. GOTTSTEIN: Yeah. I mean, some of it. I

mean, there is the one --
THE COURT: Which issue? Does it go to the less-restrictive alternative issue, or which issue does it go toward?
MR. GOTTSTEIN: Well, I'd have to think about some of it. I'd love to get a transcript of (indiscernible). In fact, if we could facilitate me getting a CD of that, it would be good.
One is the side effects.
The other is Mr. Bigley's prior psychiatrist who has treated him, treated him for a long time, and his testimony about his -- that kind of -- basically that what happened, you know, where he's at, at the end of treatment.
THE COURT: All right. So 10 to 12 on Wednesday. And if you had transcripts, basically, I need the submissions. If you can't get them in tomorrow because of your other commitments, then we need them Wednesday. But I need to give the state the opportunity to respond to them, so you need to get them in.
MR. GOTTSTEIN: Right. And, Your Honor, I think as you know, that this compressed schedule really is improper and so --
THE COURT: And you've gone on and made that

record.
MR. GOTTSTEIN: And I've made that point. I know. So I certainly -- I will do the best that I can in trying to figure out how to, you know, do that to the best of my ability.
And I really -- I really need a copy of his chart.
THE COURT: And I read it as within 72 hours after the filing of the petition for the medication, the court is to hold the hearing. And we are many days past that. But that's okay.
MR. GOTTSTEIN: Yes, Your Honor. But I think, if I may, that you really -- it's important to look at what Myers says about the -- the constitutional right of the respondent to have the court take, you know, a proper amount of time to determine that.
THE COURT: Right. And I --
MR. GOTTSTEIN: And I think that has to apply to -- that has to at least supersede that 72-hour thing. And I think -- and that's why I suggested that it's -- that in the way to read those two things in accord is to find that that 72 hours only applies to the competency determination. And so --
THE COURT: Right. Well, I read it

differently. But that's all right.
What we're going to do is conclude this. 10:00 a.m. on Wednesday. And the evidence that you seek to present, you can do so. And if there are people that you are planning to have testify only by affidavit as your direct, then you need to get those to the state tomorrow.
But otherwise, have them here in person, and then there will be an opportunity to cross examine.
MR. GOTTSTEIN: But one, Your Honor, would be Dr. -- I'm talking to Peter Breggin. He's in New York. So I would like (indiscernible) for telephonic.
THE COURT: So -- oh, that's -- telephonic, is there any objection to telephonic?
MR. TWOMEY: No, Your Honor.
THE COURT: All right.
MR. GOTTSTEIN: And I really need a copy of his chart.
THE COURT: Oh, you didn't get the chart?
MR. TWOMEY: Your Honor, we showed him the chart during break, and I indicated we would make an effort to produce a copy for him today.
THE COURT: Could you get that over this afternoon?
MR. TWOMEY: Yes.

MR. GOTTSTEIN: Sorry. I missed that.
THE COURT: It's okay. So the chart will go over this afternoon. And we'll take up with the respondent's case Wednesday morning at 10:00 a.m.
MR. GOTTSTEIN: Thank you, Your Honor.
THE COURT: All right. Anything further?
MR. GOTTSTEIN: No, Your Honor.
THE COURT: Thank you for coming. All right. We will go off record at this time.
(Off record.)
1:08:52

TRANSCRIBER'S CERTIFICATE

I, Jeanette Blalock, hereby certify that the foregoing pages numbered 1 through 101 are a true, accurate, and complete transcript of proceedings in Case No. 3AN-08-00493 PR, In the Matter of WB: William Bigley, Motion Hearing held May 12, 2008, transcribed by me from a copy of the electronic sound recording, to the best of my knowledge and ability.

_____ _____

Date Jeanette Blalock, Transcriber

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

IN THE MATTER OF:

Plaintiff,

vs.

WB: WILLIAM BIGLEY

Defendant.

Case No. 3AN-08-00493 PR CI

*** CONFIDENTIAL ***

VOLUME II

TRANSCRIPT OF MOTION HEARING

BEFORE THE HONORABLE SHARON GLEASON
Superior Court Judge

Anchorage, Alaska
May 14, 2008
10:17 A.M.

APPEARANCES:

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Assistant Attorney General
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FOR THE DEFENDANT: James B. Gottstein, Esq.
Law Project for Psychiatric Rights
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3AN6308-79
10:17:01
THE COURT: Okay. We are back on record in a case involving Mr. Bigley, who is present here in the courtroom. And we have Mr. Twomey and Mr. Gottstein.
And I received paperwork from you, Mr. Gottstein, yesterday. And in it, it indicated you had not yet received the chart. Has that been remedied, or what is the status there?
MR. GOTTSTEIN: Your Honor, I received -- it was there when I got back from my supreme court oral argument, so yesterday.
THE COURT: All right. And I see a rather lengthy witness list. And I am concerned about the timeframe. So -- and it looks like three are simply to have available for cross examination of the materials you submitted, which I have reviewed; is that correct?
MR. GOTTSTEIN: Yes, Your Honor. I really only have three witnesses I plan to call.
THE COURT: Dr. Jackson, Dr. Hopson, and Camry Altaffer (phonetic)?
MR. GOTTSTEIN: Altaffer.
THE COURT: Altaffer. All right.
Mr. Twomey, are you ready to proceed?

MR. TWOMEY: Yes, Your Honor.
THE COURT: All right. And who would you seek to call first, Mr. Gottstein?
MR. GOTTSTEIN: Dr. Jackson. And her number is area code 910/208-3278.
THE COURT: All right. Thank you.
So did I indicate until noon today we could go, or did I -- is that what I had indicated? Or did I make any indication?
I have to go to an event at noon or there about. So we'll see where we are time-wise. I know it's an important issue for your client, Mr. Gottstein. If we need to find more time in the next couple of days, we can do so. So let's see what progress we can make up until noon.
MR. GOTTSTEIN: You indicated noon.
THE COURT: I did. All right. That was my recollection, but I didn't see it in the log notes. All right.
We are a little late getting started, which was not really my fault, but my reality, anyway.
MR. GOTTSTEIN: Your Honor, I gave the clerk exhibits for this morning.
THE COURT: I have them right here. A through F; is that correct?

MR. GOTTSTEIN: Yes, ma'am. And I gave them to Mr. Twomey.
THE COURT: Mr. Twomey, you have a copy, as well?
MR. TWOMEY: Yes. I received them this morning, Your Honor.
THE COURT: Do I have Grace Jackson on the phone?
THE WITNESS: Yes.
THE COURT: All right. Good morning, Ms. Jackson. My name is Judge Gleason. We have you on a speakerphone here in a courtroom in Anchorage, Alaska.
You have been called as a witness on behalf of the respondent, William Bigley. It is a matter here where I have the lawyer from the state and Mr. Gottstein present.
I am going to be recording your testimony here in just a moment. I will administer an oath to you. But any questions first?
THE WITNESS: No.
THE COURT: All right. If you'd raise your right hand, please.
(Oath administered.)
THE COURT: If you would then please state

and spell your full name.
THE WITNESS: Grace Elizabeth Jackson. That's G-R-A-C-E, Elizabeth, E-L-I-Z-A-B-E-T-H, Jackson, J-A-C-K-S-O-N.
THE COURT: All right. Thank you.
Go ahead, please, Mr. Gottstein.

DR. GRACE JACKSON

called on behalf of the respondent, testified telephonically as follows on:

DIRECT EXAMINATION

BY MR. GOTTSTEIN

Q Thank you, Dr. Jackson. First off, did you send me a copy of your curriculum vitae?
A Yes, I did.
Q And it's 11 pages?
A I believe that is correct, yes.
MR. GOTTSTEIN: I'd move to -- it's Exhibit A. I would move to admit.
THE COURT: Any objection there?
MR. TWOMEY: No, Your Honor.
THE COURT: All right. A will be admitted.
(Exhibit A admitted.)
MR. GOTTSTEIN: Should I give this to the clerk at this point?
THE COURT: That's fine. You can hold on to

it, and we'll get it later, if that's easier for you.
BY MR. GOTTSTEIN
Q Okay. And if I might just take care of the other part of it, too. Did you also send me essentially an analysis of the neuroleptics, neurotoxicity of -- oops, I didn't number it -- 19 pages.
A Yes, that's correct.
Q And is that your work?
A Yes, that is my work.
Q And this analysis is true to the best of your knowledge?
A That's correct.
MR. GOTTSTEIN: I would move to admit that, Your Honor.
THE COURT: That is Exhibit E?
MR. GOTTSTEIN: E.
THE COURT: All right. Any objection to E, Mr. Twomey?
MR. TWOMEY: No, Your Honor.
THE COURT: All right. E will be admitted.
(Exhibit E admitted.)
BY MR. GOTTSTEIN
Q Thank you, Dr. Jackson. Could you briefly describe to the court your experience, training --

training, education and experience?
A Certainly. I attended medical school at the University of Colorado between 1992 and 1996.
Following that, I entered and successfully completed residency in psychiatry, which was performed actually within the U.S. Navy. And that residency was performed -- well, the internship was in 1996 through '97, the residency 1997 through 2000.
Subsequent to completing that residency program, I served as an active duty psychiatrist in the U.S. military. I actually transitioned out of the military in the spring of 2002, and I have been actually in self-employed status since 2002 working at a variety of different positions in order to have some flexibility for research, lecturing, writing, and clinical work, and also forensic consultation.
Q Could you describe -- so have you published papers?
A Yes. I have published papers in peer-review journals. I have contributed chapters to other books which have been edited by other mental health professionals, both in this country and overseas.
And I am also the author of my own book, which I published in the year 2005.
Q And what was the name of that book?

A That book is called Rethinking Psychiatric Drugs, a Guide for Informed Consent.
Q And have you testified as an expert -- testified or consulted as an expert in psychopharmacology cases?
A Yes. I have served as a consultant in a number of cases involving psychiatric rights similar to this case.
Also involving disputes over the use of medications versus alternative treatments in regards to child treatments. I've served as a consultant to families or their doctors in other states in order to assist in the preparation of different treatment plans.
And I've also been involved as an expert witness in consulting on product liability cases.
Q Were you qualified as an expert in psychiatric and psychopharmacology in what's known as the Myers case in Alaska here in 2003?
A Yes, I was.
Q And did Dr. Moser testify I think something like that you -- that you knew more about the actions of these drugs on the brain than any clinician he knew in the United States?
MR. TWOMEY: Objection, hearsay, Your Honor.

THE WITNESS: I'm sorry. I'm getting a lot of beeps on my phone. Can you hear me all right?
THE COURT: Yes.
But, Mr. Gottstein, your response to the hearsay objection?
MR. GOTTSTEIN: It's actually in the testimony that was filed, I believe.
THE COURT: Well, then the testimony speaks for itself.
MR. GOTTSTEIN: Okay.
THE COURT: So you can go forward.
MR. GOTTSTEIN: I would move Dr. Jackson as an expert in psychiatry and psychopharmacology.
THE COURT: Any objection there, Mr. Twomey, or voir dire?
MR. TWOMEY: No, Your Honor.
THE COURT: All right. Then I will find the doctor so qualified in those two fields.
Go ahead, please, Mr. Gottstein.
BY MR. GOTTSTEIN
Q Dr. Jackson, in preparation for this case, have you reviewed the -- what's known as the -- well, the affidavit of Robert Whitaker?
A Yes, I have.
Q And what is your opinion on that affidavit?

A I believed it was very truthful. I thought it was a very accurate presentation of the history of this specific class of medications which we are discussing in this case, the antipsychotic medications.

And also a very succinct but accurate description of some of the problems that have emerged, not only in the conduct of the research, but also in terms of the actual lived experience of patients. So I felt it was a very accurate and very clear presentation of the information as I understand it myself.

Q Now, would it be fair to say that this information is not generally shared by most clinicians in the United States?

A Oh, I think that would be a very fair -- very fair statement.

Q And why would you say that is?

A Well, I think we have a short time here. It's really a broad subject. But quite succinctly what has happened is that the educational process throughout medicine, not just psychiatry, and also the continuing medical education process, even when physicians have completed the first steps of their training, have actually presented a very biased

depiction of the history, or actually omitting the history of many medications.

So a lot of this is a reflection of the educational process, both in the first stages of medical school and residency, and then what is occurring in the medical literature even now.

Q Let me stop you right there just for a minute. So were you trained in this way?

A Yeah. I was -- absolutely. I was trained in the traditional sense that basically serious -- especially severe -- quote, severe mental illness or mental illnesses are diseases of the brain which require chemical treatments, i.e., medication treatments, and that in most cases, these medications must be used on a very chronic or even permanent basis.

Q And did something happen to cause you to change your mind or question that information?

A Lots of things happened. Probably one of the most important things is that I was fortunate enough to be trained -- or be training in a location that exposed me to some additional information.

In other words, some of the history, and also some of the alternative work which could be done that might be effective. So that was one part, is I did

begin to have an exposure to a different perspective.

But the most -- probably the most important thing for me was the lived reality of my patients, just opening my eyes and really paying attention to see whether or not people were improving.

Q I'm sorry; I missed that a little bit. Could you go into that a little bit further, what you found?

A Sure. Well, what really happened is that internship -- I should probably just back up and say that I regard -- in retrospect, I look at the educational process as really an indoctrination.

And I think it's rather unique or heroic when people can begin to examine things more critically. And I was just lucky enough to have an exposure to some individuals who allowed me to do that.

But more specifically, I began to see that in clinic after clinic, whatever setting I was moving through, I was seeing the patients were in fact not improving, that in most cases, in fact, patients were getting sicker and sicker.

And there are two ways to react to that. One could either blame that on the underlying illness and say that we just don't have treatments yet that are effective, or one could even begin to pay attention and ask a broader question or more pointed question,

gee, is it possible that there's something about the way we are approaching these phenomena that is in fact getting in the way of recovery?

And once I began to ask that question, I basically had a 180-degree turnabout in terms of how I had to practice ethically and according to science.

Q And did that result in a -- I think you kind of testified to this -- in a change in direction more towards researching this issue?

A Oh, absolutely. Well, basically, it resulted in two things. It resulted in a great deal of conflict between myself and most conventional settings. It's why I'm an independent practitioner and not a person enjoying an academic appointment or an appointment in a facility.

So it really made -- I had to make a firm decision, was I going to be truthful to science or was I going to go after a $200,000 a year job with nice perks and the respect of my colleagues?

So it was very clear to me that in order to honor the dictum first do no harm, I had to really stay truthful to the science. And that's really what necessitated my breakaway. So that's why I'm really an independent person who does my own research and tried to just help where -- you know, where the help

is actually needed or asked for.
Q Thank you. And so then, just to kind of fill in then this, it's Exhibit C, your neurotoxicity analysis, that would be some of your, you know, more recent work, is that correct, or current state of your research into this issue?
A Yeah. Fairly current.
I am trying to finish a second book this year. And what has really happened over the past two years is that I try to do clinical work to keep myself current with that.
But I also step aside. And probably every single day, I am working on the most current research in the field in order to, you know, lecture and to also write this second book.
What really happened about four years ago is I began to appreciate the fact that most physicians -- and this isn't just a criticism of psychiatry, by any means. But most of us ignore something which is called target organ toxicity. We don't pay attention to how the treatments we're using might actually be adversely affecting the very target we are trying to fix or help improve or repair.
So in my case, about two years ago, I started to just begin focusing on the most current research

that looked at the brain-damaging effects of different kinds of interventions. And that is really what I've been focusing on.
So the document that you have there is a reflection of some of that research. I should say that it's not completely up to date, because some of the research I've been doing more recently even demonstrates that these drugs are more toxic than what I have written in this report.
Q Okay. Thank you. I want to get to that -- get to that also a little bit more. But I'm also -- are there other reasons why clinicians are not really understanding this -- this state of affairs?
A Sure. Well, I think there are so many things that happened.
I'll just take my example. I went to medical school in 1992, graduated in '96, and did my residency until 2000. This was a very pivotal time in what was occurring within the mental health field and also within the United States culturally. And if I just picked, like, maybe four key things.
One is the government decided to name this decade the decade of the brain. In doing so, it sort of attached a governmental license or the (indiscernible) of sanctioning regarding these

phenomena as brain diseases.
The second thing that happened was the birth of something called evidence-based medicine. This was -- actually sort of became official through the Journal of the American Medical Association and other major journals to really elevate an importance, not the actual day-to-day observations that a doctor would be making and not the actual science of what causes illness, but clinical trials that are aimed at just improving or changing symptoms.
The third thing that happened was something that is called direct consumer advertising in 1997, which again was trying to market these drugs and make them more popular or appealing to the public.
And the fourth big thing that has really changed is something called the preemption doctrine. And also, the Daubert litigation.
Daubert was a supreme court decision in 1993 that has really made it quite difficult for toxic tort litigation to occur, so that the implications of that for doctors -- and they don't realize this. It's very much behind the scenes -- is that the pharmaceutical industry began publishing as many papers that they could as fast as possible in the journals in order to meet the Daubert standard of something called weight

of evidence or preponderance of the evidence.
So essentially what happened in the 1990s is that the journals, more than ever before in history, became a tool of marketing, a marketing arm for the drug companies. And drug companies shifted in terms of previous research in the United States.
Most of the research had previously been funded by the government and conducted in academic centers. In the 1990s, that was pretty much over, and most of the funding is now coming from the pharmaceutical industry. So that's really in a nutshell what happened in the 1990s when I was training.
Now, where are we now? What that means is that the journals that most doctors are relying upon for their continuing information continued to be dominated by pharmaceutical industry funded studies and by papers which are being written, if not entirely by the drug companies, then by authors who have part of their finances paid for by the drug companies.
And while I don't believe that it's necessarily going to buy us the information in an article, I think trials have to be funded by someone. Unfortunately what has happened is that there have been too many episodes of the suppressed information,

so that doctors cannot get the whole truth.
Q Well, I want to follow up on that. What do you mean by suppressed information?
A Well, one of the things that has happened repeatedly, and again, most doctors don't realize this, is that the pharmaceutical industry has not been forthcoming in terms of surrendering all of the information to the Food and Drug Administration that they were by law I believe, or at least under ethics, required to do.
For instance, in January of this year, the New England Journal of Medicine published a very important article that had been done. Actually, one of the key authors was a former reviewer at the Food and Drug Administration, who is now back in private practice, or somewhere.
And he and his co-authors had actually had access and reviewed the clinical trial database on the antidepressant medications. And they found that 31 percent of the trials were never published. So 31 percent of that information was never reported in the journals so that doctors could see it.
Okay. Well, you might say who cares. The point of it is that within that 31 percent, had they been published, the overall risk benefit understanding

of this category of medications would have been changed. Instead of favoring these drug treatments, it would have altered the whole face of the journals, and potentially the use of these medications would have become more limited.
Because that 31 percent of the information was showing that the medications were, A, not terribly effective or not more effective than placebo at all, and, B, it really began to reveal the full scope of the hazard. So by not publishing all this information, there is a false view of efficacy and safety.
I should say the same thing has happened with Vioxx. The same thing has happened with the cholesterol-lowering drugs. This is an epidemic right now, which is a real crisis in the integrity of medicine. It's not just psychiatry.
Q Does the same thing happen with respect to the neuroleptics?
A Absolutely, the same thing has happened with respect to the neuroleptics. I think you're a perfect example of someone who has tried to work to bring some of this hidden material to the forefront, because I still think there are concerns among professionals, and I hope among the public, that the Food and Drug

Administration still may not have seen all of the actual data that has been generated in the actual trials. So it is a continuing problem and a continuing concern.
And yes, I believe that most people -- I'll give you an example. When I was working in the VA clinic a couple summers ago in Oregon, I attended a dinner lecture where a speaker for a specific antipsychotic medication slipped out some information that I thought was extremely important. He said that the FDA and the public still has not seen information on Abilify, Aripiprazole, another antipsychotic.
And he alluded to the fact that there was a severe problem with cardiac toxicity, but he would not go any further. He was speaking on behalf of another company. But he said that it would be possible to contact him and perhaps he could share that information.
Well, my point is, why are the rest of the doctors not getting this information that Abilify is eight times more toxic to the heart than the other antipsychotics? I sort of filed that away in the background of my head and said, boy, you know, I'd like to have this information.
But the point is, doctors are not getting the

information. And that's a real problem both for them and it's a problem for their patients.
Q Is it fair to say that you've really devoted your life to -- or your work at this point to ferreting out this sort of information and making it available?
A Right. As best I can. And you know, it's -- it's really sort of a Catch 22. I would love to have the respect of my peers. I would love to be at Harvard teaching. You know, I would love to be an academic able to teach medical students.
But unfortunately, the system is so skewed still in the direction of the pharmaceutical companies and their products that I can't, you know, even get a foot in the door.
So yes, I am full-time researcher trying to do my best to understand this material accurately, and fairly, and objectively, and then to actually act responsibly in response to that knowledge.
Q So in reviewing this information, is it important to carefully look at the data and analyze what's actually presented?
A It's extremely important to look at the methodology. I don't think -- unless a person is actually working at the Food and Drug Administration

or one of the actual clinical trial researchers, you know, actually producing the data that you would actually -- that a person like myself would have access to the raw data.

But what I can analyze and ask questions about is to go to people who have either performed these studies, or when I read the published studies, which is usually what I have access to, to really use good critical thinking in terms of analyzing the methods that have been used.

And you might -- I'm not sure if we're going to have time to discuss methodology, but this is one of the key things that any physician really has to pay attention to.

It's not just the fact that there might be 10 or 20 studies that say a particular medication is either good, bad, or indifferent. It's actually important to -- you know, before even looking at that conclusion, to address how the study was performed so that one can make a well-informed and an appropriate judgment as to whether or not the conclusion should even be considered.

Q And so without going too much into it, could you describe a couple of methodological concerns that you have with respect to the second generation of

neuroleptic studies of which Risperdal is a member?

A Certainly. One of the things that has happened is that the database or the research (indiscernible), which is actually used to approve medications in this country, psychiatric medications, and then used to continue to argue in their favor, especially in product liability litigation or in a lot of cases. That data set is very limited in terms of generalizability.

What most people don't realize is that when a drug is being approved, the people performing the research want to pick the healthiest or the least sick or the least damaged patients, so that they can try and produce good outcomes. So that is one of the main concerns that all of us doctors have about clinical trials is that we recognize the fact that the generalizability is limited.

What do I mean by that? Well, they usually want to pick people who don't have additional illnesses, such as diabetes, heart disease, lung problems, liver disease.

Well, that's going to rule out a large number of people who are actually existing in the real world, because once they've been on many of these medications, they are guaranteed to have some of these

problems.

Number two is they eliminate the use of additional drugs, meaning additional medication. Well, that eliminates another huge portion of the United States population, because most of the people who are being seen in mental health settings are actually receiving more than one, and in some cases, you know, as many as 10 or even 20 medications for various conditions.

So it makes it very difficult to extrapolate to the real-world setting the information that they get or they find in a clinical trial.

Another problem is the length of a clinical trial. A clinical trial usually is cut off at six weeks. That's it. And the drug companies understand and actually choose the six-week cut off for a very good reason. They know that generally speaking, they can't continue to produce favorable results after six weeks.

And then another big problem with these methodologies is the fact that they really are enrolling people who have previously been receiving medications.

So what does that mean and why does that alter or bias the results? Well, one of the problems

in the antipsychotic medication literature, as in the antidepressant literature, is the fact that patients are brought into the study and they have previously been taking a medication, in some cases right up to the day that they enter the study.

And then the first seven to ten days in most of these trials involve taking the patients off of those previous or pre-existing medications. So seven to ten days, the person is abruptly cut off from their previous drug.

Now the real stage of the trial begins. So that first seven- to ten-day window is something that is called a washout. And sometimes what they'll do is they'll give everybody a sugar pill in those first seven to ten days and call it a placebo washout.

Now, the use of the term washout has two meanings. Washout meaning whatever other drugs the person may have been taking before, those are supposed to wash out of the system. And the second part -- and the second meaning of washout is that if someone begins to improve too much in those seven to ten days, they are removed from the study.

Q So may I interrupt you?

A Sure.

Q Are you saying that when people are withdrawn

from the drugs they were taking previously and they improve when they get taken off the drugs, then they are eliminated from the study?

A That's right. They take them out of the study. Because they only want to have people remaining in the study who are going to continue to look -- you know, either continue to look bad on the placebo if they continue to stay -- if they are randomized to the placebo part of the trial.

Or if they are then switched back on to an active medication, something chemically active instead of a sugar pill, their withdrawal symptoms, having been cut off of a previous drug, will hopefully respond to having another drug that was similar to the previous drug, you know, put back into their system.

So you understand completely, they remove people -- and this is important in terms of this case. Because for instance, in the Zyprexa trials, a full 20 percent of the people improved so much in the first seven to ten days when they were taken off their previous drugs that they kicked all those people out of the trial.

If they had retained them in the trial, they could not have gotten results that made Zyprexa look like it was any better than a sugar pill. It would

have biased the results in favor of the sugar pill.

Q So now, did you -- did you analyze the studies that the FDA used in --

THE COURT: And I am going to cut off here and say what would be helpful to me, Mr. Gottstein, is as I understand it, API is proposing Risperdal here, correct?

MR. GOTTSTEIN: Yes.

THE COURT: And so if we focused exclusively on that, I think given our time constraint and the proposal, I think that would be the most helpful for me.

MR. GOTTSTEIN: Well, Your Honor, one of the problems is that we didn't know until Monday that -- you know, that it was Risperdal.

THE COURT: But now that we do, if we could focus on that, I think that would help.

BY MR. GOTTSTEIN

Q Well, are all these -- are all these things that you mentioned also applicable to the Risperdal studies?

A As far as I know. And I have no reason to believe from what I've read in the literature -- I haven't had time to read the FDA review on Risperidone as I have done with olanzapine. But based on the

trials that I have seen in the regular journals, I have no reason to believe that anything other than this procedure has been used repeatedly.

In other words, the placebo washout and actually switching people or removing people who improve too much, it's sort of a standard protocol that you have a certain score in terms of symptoms. And if people don't meet that cutoff, in other words, they begin to improve too quickly, they don't get to stay in the study.

So I have no reason to believe that Risperidone was any different than Zyprexa in terms of this method of eliminating people who -- and you know, favoring or biasing the result of the study.

Q In the interest of moving forward, is it fair to say there are other methodological problems with these studies?

A Oh, absolutely. What many of these studies will do is to allow certain concomitant treatments. In other words, certain additional medicines during the study so that you can't really be sure that the results they are claiming are the result of the actual interventional drug. For instance, Risperdal instead of a benzodiazepine or an antihistamine.

Another thing is the way that the data

themselves get reported. And one of the things that is frequently done is to use something called LOCF, or last observation carried forward. So what that means is if you were to enter a study for instance, and they started you on Risperdal, and you start to have a severe side effect, let's say Parkinsonian symptoms, and you dropped out of the study at two weeks, but the study is supposed to end at six weeks, they will carry forward your score to the six-week mark.

Now, this will sometimes -- people will actually drop out when they have a higher score and they'll carry that forward, as well. But the use of LOCF statistics, especially when they carry forward people who are dropping out on placebo, those are people who are dropping out because they are in withdrawal. They have been cut off from a previous drug.

And so they carry forward an end result, which is not a reflection of the underlying illness, let's say, but a reflection of this introductory bias, the placebo washout.

So the fact they report all of these LOCF data, meaning the fact that they are just carrying forward the results or the statistics from people who drop out of the study early, biases the results in

favor of the drug, when in fact it's not an accurate reflection of what's really going on in the study.

And that happens quite often, and that certainly happened in the Risperdal/Risperidone literature.

Q So just to kind of finish up this part, would it just generally be fair to say that it would be pretty difficult for a practicing psychiatrist in clinical practice to have this information that you are providing to the court?

A Oh, it would be almost impossible. It's -- it would be something you would really have to devote your study to.

And actually, you know, not only would it be difficult for the ordinary doctor to know this is going on, but he or she would read what is published in the regular journals and see that the results are promising, like 70 to 80 percent response rates, meaning a good response with patient satisfaction, et cetera.

And then he or she would be in the real-world setting, and maybe be lucky see 30 or 40 percent of the patients able to even tolerate the drug. So it not only is something that would be hard for doctors to know, but what they're actually being exposed to is

so far removed from reality that they are very unlikely to understand what is going on in the real world.

Q Okay. So what is going on in the real world? What is the impact of drug -- well, specifically Risperdal on patients?

A Well, the real effects in the real world are -- are really in two categories. And as a doctor, you know, I am sort of thinking in terms of safety first. I sort of think of, boy, what do I really have to look out for here if somebody comes into my office and they are receiving this medication or I am asked to begin it?

So one of the things that, you know, we are really talking about is safety. Are people dying on these drugs? Do people die from taking Risperidone? Yes. People are actually experiencing shorter life spans.

Initially it was felt that the life spans for people on medications like Risperidone were perhaps shortened maybe ten or 15 years. And I think that's even been elevated in the most recent government studies to more like 20- or 25-year shorter life spans. So instead of a male -- and we're usually talking about, you know, males with mental illness,

would probably be living, you know, if they were lucky, 72, 74 years of age for men in the United States these days. And we are really talking about something which drops the lifespan down into the 60s.

So at the worst what is going on is that we are actually contributing to morbidity, actually shortening people's life spans. And that's -- and that is either through an acute event like a stroke or a heart attack or something called a pulmonary embolism, or we are talking about more chronic illnesses that eventually take their tolls, things like diabetes and heart failure.

So at the very worst, what is going on in the United States is an epidemic of early suffering or mortality that was not present before these medications were being used, you know, by such a prevalence -- in such high numbers.

The second thing that is going on is that we are arguably worsening the long-term prognosis of people, and in directions that were not previously seen or talked about. And I think my affidavit speaks to this. And also Mr. Whitaker's affidavit speaks to the history and the actual historical outcomes when individuals were being offered something other than just the medication or the priority on medication.

And so that is the other big thing in terms of what's going on.

What's going on is that people are suffering in great numbers, and that people are dying early, and that people are having what might have previously been a transient, that is a limited episode, converted into a chronic and more disabling form of experience.

Q Is -- are these drugs brain damaging?

A Well, I try and not sound like I am, you know, really off -- off my rocker. Because people probably wouldn't like it if I actually used a term for what's happening.

But I sort of say we have unfortunately contributed to a population of CBI patients, meaning chemically brain injured.

I was in the military, so I am very used to TBI patients, traumatic brain injury from, you know, concussions and explosions and what's going on in Iraq and Afghanistan.

But what is the elephant in the room that people aren't addressing in psychiatry and neurology is this population of CBI, chemically brain injured.

So yes, I actually would say that what we have created, and I think Mr. Bigley is an example of this, is that we are creating dementia on a very large

scale.
Q And that's -- isn't -- that's a lot of what you referred to as your affidavit, but Exhibit E here, your neurotoxicity paper addresses, isn't it?
A Yes, that's correct. That's really the tragedy of me being born at the time I happened to be born and having to actually live through this and watch this still happening.
But that is, in a nutshell, these are not antipsychotics and they are not neuroleptics. They are prodementics. Or they are medications that are actually contributing to an epidemic of dementia.
I think the states will probably be bankrupted by this in about 20 years. But we are a little bit away from that so far.
Q So is that associated with cognitive declines?
A Oh, this is associated with cognitive decline, it's associated with behavioral decline, where people really have a hard time, you know, modulating self-control and actually modulating their anger and modulating their emotional expression. So cognitive and behavioral.
Q Now, are there physical negatives associated with these drugs, not just -- you mentioned brain --

damage to the brain, but --
THE COURT: And here again, I have to say, it's more helpful for me to hear specifically about the drug that the state's proposing in this case.
BY MR. GOTTSTEIN
Q Is what you're -- Dr. Jackson, is your testimony -- does it apply to Risperidone?
A Certainly. One of the things that's been interesting about Risperidone is that it was the first, quote, unquote, new or -- well, I should back up and say it's actually the second of the newer, quote, unquote, atypicals. The first one was approved in the United States in 1989.
But Risperidone is usually referred to as the first of the new drugs. That's a little bit incorrect. But Risperidone was approved by the Food and Drug Administration in 1993, and really entered use in 1994.
What's been clear in the published studies since its entry into the market is that it is probably the closest to some of the older drugs. 6-milligram and above doses, it replicates Haldol. So even the notion that this is a newer and safer medication has been completely borne out by neuroscience research, that that was a hopeful expectation that has really

not been satisfied.
One of the interesting things about Risperidone compared to some of the other drugs, also, is that it seems to have an association with tumors of the pituitary, prolactinomas. And as prolactin levels stay elevated, men experience sexual side effects, breast enlargement.
But there's also been a long risk, not only in terms of the bones, osteoporosis, but whether or not the prolactin itself could, you know, have any other effect say on the heart or be a reflection of heart damage.
So Risperidone is sort of unique in terms of this connection to brain tumors or the pituitary tumor. So that is one thing.
The other thing that Risperidone, like the other newer medication, is known for is diabetes. So that is one of the main concerns. Not that diabetes can't be treated or can't be regulated in some way, but because of the fact diabetes itself presents risk for further damage to the brain.
And I think it's only in the past, say, three or four years that researchers in the Netherlands have been publishing a series of papers that really demonstrates some of the early dementia changes that

occur in people with diabetes, even if their sugars have been fairly well controlled.
So diabetes itself is tipping into more than just an endocrine disease, but it is becoming a neurological disorder as well.
Risperidone, like the other antipsychotics new and old, but especially these newer medicines, like Seroquel, which is another one, and Risperidone all present risks for other damages to the endocrine system, like the thyroid gland.
And when you actually disrupt thyroid hormone, you also contribute to further damage to the brain in terms of dementia and cognitive abilities. So Risperidone does that, as well.
The other thing with all these medicines, there is the risk for strokes and for heart attacks, and also for leg clots and pulmonary edema. So the risk for sudden death is always there. And that's certainly one of the big concerns with Risperidone.
So diabetes, thyroid disease, heart disease, sudden death, you know, osteoporosis, breast enlargement, sexual changes, and the fact that many of these other problems in the body, again, have an indirect but a potentially very significant effect on the brain function itself. So those are concerns.

Risperidone in animal studies, because we really haven't been doing this yet in humans, also has been shown to increase the levels of a protein called apolipoprotein D, like delta. And this in some studies has been connected with an increased deposition of something called amyloid, amyloid protein or amyloid plaques. And this is one of the main causes or markers of Alzheimers dementia.

So we have some good evidence from the animal studies to understand why it is that patients who already have Alzheimers dementia or people with dementia who have been placed on medicines like Risperidone deteriorate faster and have a progression of their underlying dementia in terms of the actual brain tissue changes themselves.

So Risperidone unfortunately seems to be a medicine that I predict probably in about four or five years, you will see the neurologist will say, hey, people are getting Alzheimers on this medication, or changes that are precursor to Alzheimer's. I am predicting that in about four or five years, that that may be something that we begin to see.

There is already a black box warning on these drugs, including Risperidone, that these drugs are not to be used in elderly people who already have

dementia. But what you're not being told is that these are medications that are actually causing dementia in people who don't already have it.

Q Okay. Now, you refer to them sometimes as antipsychotics. Would you call -- does Risperidone have an antipsychotic property?

A Well, I think what these medications do is that they -- they actually will stop annoying behaviors. And they can make a person so confused or sedated, they can actually inhibit so much brain activity, either electrically or chemically, that the symptoms which some people call psychotic or schizophrenic seem to be at bay. So from that standpoint, people, you know, have called them antipsychotics.

But there is nothing specific about the effects of any class of medication in psychiatry, either a medication is slowing down brain function and brain process or it is speeding them up and enhancing certain brain functioning and processes.

So this whole class of medication which had been historically referred to as neuroleptics or antipsychotics, are in fact medications that are chemical lobotomizers. And I tried to mention some of that history in my affidavit.

The use of the term antipsychotic was really an historic euphemism, once it became unacceptable to mention what these drugs were really doing.

And in fact, what was very important is that in the '60s, and probably throughout the 1960s, doctors were being encouraged it actually give high enough doses of these drugs to cause brain damage, to actually cause Parkinsonian symptoms. And they were trained to believe that until you produced Parkinsonian symptoms in a patient, the drugs were not yet at the level that would actually improve the psychosis itself.

And that has since been borne out as something that was a complete fallacy and a huge mistake. So one thing --

Q If I can stop you.

A Sure.

Q Did you -- and we kind of want to move a little bit faster, if we can. If you can try and really focus on the exact question I ask.

A Sure.

Q But did you -- you reviewed some of Mr. Bigley's history for this, didn't you?

A Yes, I did.

Q And was that that kind of dosing given to

Mr. Bigley during that period?

A Yes. You had shared with me some of the -- some of the records. And I have to say it was limited due to our time constraints.

But the very first hospitalization was -- I just about fell out of the chair when I saw what had happened. I think at one point he was receiving 60, that's 60, 20 milligrams of Haldol three times a day is I think what I read in the record.

The dose of Haldol that is now recognized as, quote, blocking enough dopamine receptors to produce antipsychotic effects, meaning the dose that would typically be thought to be helpful, is 5 milligrams. He was receiving 60 milligrams. So he was receiving a dose that was guaranteed to actually cause Parkinson's disease, and that dose has been shown.

So the short answer to your question is I looked at the doses. And in my opinion, that was really the beginning of, you know, a long demise.

Q Did -- do you recall if those records indicated that Mr. Bigley's symptoms continued in spite of doses that induced Parkinsonism?

A Right. That's why I think the doctor -- well, I know it did, because the doctors themselves were surprised, which made me appreciate the fact that

I was reading a record from 1980 and another record from 1981.

Backing up 27 years ago, 28 years ago, the doctors apparently had been trained in this -- still in the philosophy of care that you administer until you get these side effects. And once you see those side effects, you know the psychosis will be eradicated.

And so when the doctor wrote the note, his delusions continue in their severity and same intensity despite the fact he now has Parkinson side effects, I'm reading to myself, oh, this is fascinating. This is what they used to teach doctors is that they had to give doses to produce Parkinson's in order to heal the psychosis.

But of course, they eventually learned that that did not heal the psychosis. In fact, for many people, including Mr. Bigley, it seemed to make things worse.

Q So is that -- does Risperdal cause psychosis in some people?

A Sure. All of these medications cause psychosis in people. Because of the fact that as you damage the brain and you leave unresolved the initial cause of a person's psychosis, you are really not

treating the initial problems.

I know that Mr. Whitaker has also explained some of this in his affidavit. But the thinking had always been that as you block certain receptors in the brain, research demonstrates that the body reacts to that. And as much as you may try to block something, the brain tries to increase or up-regulate some of those receptors.

And so some patients appear to become more sensitive to those changes. And as their brain responds or adapts to the presence of the drug, it can sometimes go the opposite direction and make the initial symptoms worse. That is called supersensitivity psychosis.

Q So is it fair to say that drugs like -- including Risperdal cause psychosis when it's given and also when it's withdrawn?

A It can be both, either. And it's also fair to say that what many people go on to demonstrate is something which is called tardive, that's T-A-R-D-I-V-E, in many different formations, or many different varieties.

For instance, there have been papers written on the subject of tardive psychosis. And what that means is it's a delayed onset. Tardive basically

means delayed onset. So for tardive psychosis, the implication is that you might start off thinking that you have things licked and that you've really delivered something that seemed to improve things.

Q So --

A But then as -- yeah, as time wears on, things actually are being induced or stirred up by the drug itself.

Q So as I understand it, the withdrawal psychosis symptoms are caused by changes in the brain as a result of the drug such as Risperdal; is that correct?

A Right. I should preface.

Q Okay. And --

A Yeah.

Q And then over time, is it possible if someone is off the drugs for a fairly lengthy period of time that the brain will then re-adjust and the symptoms will go away?

A They are not only possible, but actually been demonstrated in many cases. The key here is to understand how to actually assist people who are trying to come off of medications if they're still taking them, and how to deliver effective intervention so that they're not left with no help or no treatment

at all.

Q So is it fair to say that when someone comes off these drugs, that they -- they ought to be given a fair -- that their initial condition would worsen and they ought to be given, you know, a fairly lengthy period of time to see where they can get to off the drugs?

A I think that's fair. I think there are two phases to drug withdrawal. There is an immediate phase which reflects changes as the drug is actually leaving the brain. And that can take some time. And also changes in the brain receptors, you know, the ones that I mentioned previously that seem to increase in number as the drug is being taken and given. But that is sort of an immediate phase of withdrawal.

There is a longer-term phase of withdrawal in terms of what the brain has experienced in terms of rewiring or anatomic structural damage. And so that long-term phase of withdrawal means that someone might appear to be better for a while, and then five or six months later might have some setbacks.

And many people unfortunately are still not trained enough to understand the fact that the recovery process, the rehabilitation or repair of the brain actually can require many months. So I think it

would be fair to say that withdrawal takes some time.
Q Okay. I'm going to try to move it to another topic here.
THE COURT: And, Mr. Gottstein, just to give you a head's up, we've been close to an hour here. So what's your timeframe?
MR. GOTTSTEIN: Well, I -- I'm really concerned about that, too, and especially we've got -- I think this is important, obviously, and I know Your Honor does, too.
One of my big concerns is I've got people standing by for cross examination.
THE COURT: So maybe we need to finish up. I have really tried to indicate several times that hearing about medications generally is not as helpful as hearing about what is -- what the state's proposal is in this particular case.
MR. GOTTSTEIN: Well, and I understand, Your Honor, that she is actually saying all of this applies to Risperdal.
BY MR. GOTTSTEIN
Q But one of the things that the state's proposed is -- or the hospital has proposed is to include a benzodiazepine, I think Ativan, was it, and Clonopin I think. What can you say about that

combination?
A Well, I don't think the combination is anything that really eliminates or speaks to the problems I've already identified. It certainly is not going to prevent Risperidone's effects in terms of causing, you know, or enhancing dementia that's already there. It's not going to prevent diabetes. It will prevent the other problems.
So while I think it's better to use perhaps benzodiazepine briefly for someone who is having certain kinds of problems, its addition in this case, in no way avoids the concerns or the problems of Risperidone by itself.
Q Okay. Now, you indicated before that you reviewed I think the -- was it the submission for representation hearing and attachments to that?
A I have to go back to the documents. I reviewed the affidavits I believe by --
Q Was one of those Paul Cornils?
A Yes. Mr. Cornils is the one that I have read, and the affidavit by -- is it Bassman or Bassman?
Q Bassman, Dr. Bassman.
A Dr. Bassman. And also have read Mr. Whitaker's affidavit and portions of the record,

yes.
Q Now, do you have any comments about Mr. Cornils' affidavit?
A Well, I thought the plan that Mr. Cornils had outlined was an exceedingly thorough, and one that I was, to be quite honest, envious of. If I were in the situation of API or a provider at that facility, I would want to have many of Mr. Cornils' and plans like this.
So I thought this looked like a very solid and a very reasonable proposal, you know, as a first step.
Q Okay. And from what you can tell, how much of -- what do you think is seen in Mr. Bigley's behavior is a result of brain damage from the drugs?
A Gosh, I think at this point it becomes very difficult to separate out in my opinion what would be appropriate outrage at what had happened even 28 years ago and what's biological. I think it's -- it's reasonable to address both psychological contributions and the biological. So I can't give you an exact answer to that.
Q Okay. Now, do you think that it's wise to continue with this neuroleptic medication for -- at this point?

A I think it would be very unwise for a lot of reasons.
Q Okay. And finally, this I think will be my last question. What would you say about if -- about Mr. Bigley saying, quote, you just wanted to throw me in a cage, lock me up like an animal, take all my money, and try to poison me, end quote?
A Well, if one just heard that without understanding the context or this person's history, one might think that sounds a bit outrageous or a bit extreme. But having read even the few notes from this person's medical history, I would say that sadly enough, that's exactly what has been happening to this man for 28 years.
MR. GOTTSTEIN: I have no further questions, Your Honor.
THE COURT: Thank you.
Mr. Twomey, go ahead, please.
MR. TWOMEY: Yes. Thank you, Your Honor.
DR. GRACE JACKSON
testified telephonically as follows on:
CROSS EXAMINATION
BY MR. TWOMEY
Q Dr. Jackson, have you ever practiced medicine in the State of Alaska?

A No, I have not.
Q Are you familiar with the standard of care for physicians practicing psychiatry in Anchorage, Alaska?
A Actually, I sort of don't know how to respond to the words standard of care. That is a legal term. But maybe if you explain what you mean by that, I could answer your question more clearly.
Q Are you critical of psychiatrists based on the fact that they prescribe neuroleptics?
A I'm not critical of psychiatrists per se. I am critical of the lack of attention or consideration of informed consent and science.
Q Would you agree that psychotropic medication is widely accepted within the psychiatric community as an effective treatment for psychosis, particularly schizophrenia?
A Oh, I would agree that it has wide acceptance. But I would disagree with the imputation or the inference that it is, you know, effective.
Q And that's despite the fact that the Food and Drug Administration has approved these medicines?
A No. It's based on the fact that the Food and Drug Administration, by its own admission, doesn't receive all the information that they need to even

weigh on the safety or effectiveness of these drugs.
Q So you are critical of the process, is that correct, in terms of approving these drugs?
A Oh, I am critical of the process of approving, and I am critical of the process of oversight after they are approved, and I am critical of the way in which they are used.
Q Have you ever met Mr. Bigley?
A No, I have not.
Q Have you reviewed his entire medical history?
A No. I have reviewed some select portions of it.
Q Are you being paid for your testimony today?
A Yes. I will be paid for my testimony.
Q What do you charge?
A Usually I charge $2,000 for a full day of court hearings, or $1,000 for a half a day. And Mr. Gottstein or the Law Project for Psychiatric Rights had agreed to compensate me according to my usual wage or rate of $1,000 for a half a day.
Q How much time have you spent reviewing and preparing for today's testimony?
A Probably about ten hours. Those are not being reimbursed, by the way. I am only being paid for my testimony today.

Q What is your understanding of what it is that the state is proposing to do with regard to Mr. Bigley at this point?
A Well, my understanding of the situation is that the state was going to be doing business as usual. And that is to continue sort of the in and out cycle of hospitalizations, revamping previous or new treatment plans, and then discharging, and then sort of repeating that process over again as it might become necessary.
Q And what do you base that understanding upon?
A I have looked at the records. I have also reviewed -- let me see if I can cite the right document for you, because I want to be sure I understand how it's been referenced.
Mr. Gottstein had sent me a copy of the motion for less-intrusive alternatives. And basically, I am basing my understanding of the state's proposal on that motion.
Q Does Mr. Bigley suffer from dementia?
A I really can't diagnose Mr. Bigley from being in North Carolina, not having reviewed his full medical records and not having met with him.
But I can say that from what I know already of his previous treatments and from what I have seen

in the records that have been made available to me, I would say it would not be unreasonable to suggest that he is chemically brain injured at this point.
And there are elements which would support an argument for dysmentia, if not dementia. There are two different ways of using that term. But I would hesitate -- to answer your question, Mr. Twomey, I would not want to apply a diagnosis in a haphazard fashion on a patient I have not met.
Q Does Mr. Bigley have diabetes at this point in time?
A There is nothing I have seen in the records that were given to me that showed diabetes. But on the other hand, I should say there is nothing that demonstrates he has been tested for the same.
Q Would you agree with me that many drugs have side effects, yet it is still appropriate for physicians to prescribe such medicines?
A Oh, I -- sure, I would agree that many, many medications have side effects. And their use really is dependent upon an accurate and fully informed consent. Unfortunately, that is lacking in the case of most psychiatric drugs.
Q Is it your opinion that Risperidone should not be prescribed in any case?

A I would have to think about that. You sort of catch me off guard. There may be some uses that we have not fully thought through.

For instance, I would have to review the literature on cancer and see if Risperidone has some possible uses in cancer.

But for the current indication of attempting to assist a person with psychotic symptoms, let's say, I would be concerned about its use as really taking people further away from the intended result.

Q Have you ever prescribed Risperidone in your practice?

A Certainly I did when I was in my medical school -- in medical training, and while I was in the service.

And if I have been -- in studying since that time, the Department of Corrections or in the Veteran's Administration system, where people were previously on that drug, I do not endanger people by abruptly stopping therapies or treatments.

But I have not started any patients on Risperidone since I came to the realization of what these medications are doing and what the alternatives are.

Q And what did you come --

A (Indiscernible.)

Q I'm sorry. When did you come to the realization --

A The first awareness was in 2001. But I really crystallized that view, so about 2001, and then 2002.

Q Okay. So am I correct in understanding that since that date, you have not started any of your patients on Risperidone?

A That's correct.

Q Okay. But you have continued patients on Risperidone; is that correct?

A Certainly. I would not endanger people by abruptly stopping treatments that other doctors have begun.

Q Okay. What dangers are presented by what you say, abruptly stopping treatment?

A Well, if a person is not going to have care from a doctor who will be able to monitor the interruption or cessation of therapy, some patients can have problems. So that would be the main one, is to be able to have continued oversight, to not just cut people off and not be able to see how they're doing as the medication is actually leaving their system.

Q Are you able to quantify in Mr. Bigley's case any of the risks presented by Risperidone at this point in time?

A I'm sorry; your question was quantify?

Q Yes. In terms of likelihood or percentage.

A Oh, likelihood or percent. Gosh, you know, that is an interesting question. I don't think I've ever been asked that before. I don't typically quantify for anyone percentages of what might happen.

But I'll tell you, there is one exception, and that is in terms of what's been published on the possibility of tardive, T-A-R-D-I-V-E -- tardive dyskinesia. And to address that, I should probably mention that one of the studies that I have found very important, you know, since it was published in 2006 is a study that found that Risperidone and the other drugs like it actually had a 5 percent prevalence of tardive dyskinesia. This was just in the first years of their use.

And for people who have been on the medications for longer than just starting them, you know, for just being on them brand-new, say like within the first month, 20 percent of the patients on drugs like Risperidone had already developed tardive dyskinesia.

So I usually tell people that you know there is, you know, a real risk, not just an imaginary risk, that the new drug, including Risperidone, is a medicine that can cause tardive dyskinesia, even in the first years of use. And I think it's really important for patients to know that that is a real risk.

So as high as 5 to 20 percent of the patients on Risperidone will develop tardive dyskinesia symptoms in the first years of use.

Q Is that a risk that is commonly understood in the psychiatric community?

A No, not at all. Most doctors ignore this. They don't really pay attention to it.

That's why this paper was so important when it was published. It was published by Jose DeLeon in 2006 in Kentucky. And it was based on doing a cross-sectional survey of inpatients and outpatients over 500 patients that were participating in another study.

And fortunately, these authors are the people doing the study. Once they were finding that so many people on the new drugs, even people who had just started the new drug, were having tardive dyskinesia, they took the time to write it up and publish it.

It's not commonly known, but it should be.
Q Does Mr. Bigley suffer from tardive dyskinesia?
A I don't know. I haven't evaluated him in person to know if he has those symptoms. I haven't seen them mentioned in the records that were shown to me. I have seen references to Parkinsonian symptoms before. And Parkinsonian symptoms, even if they are historical, are believed to place people at greater risk for developing or having tardive dyskinesia, as well.
Q Are you able to quantify the risk of tardive dyskinesia in Mr. Bigley's case at this point?
A Oh, I would -- quite realistically, I would say that he should have tardive dyskinesia. It is astounding to me that he doesn't already have it.
And I would say that there is a high likelihood that Mr. Bigley will have it within the next five to ten years if he's placed back on Risperidone.
There is also a high likelihood he is simply just going to die in the next five years if he is placed on Risperidone. I don't think that's really unreasonable or irrational to make that comment based on what he's had before.

Q Exhibit E, your analysis of neuroleptic toxicity, has that been peer reviewed?
A Oh, that document itself has not been peer reviewed, but all the studies that I have cited have been peer reviewed and appear in mainstream or major journals.
MR. GOTTSTEIN: I have nothing further for you. Thank you.
THE COURT: Mr. Gottstein.
MR. GOTTSTEIN: Yes.
DR. GRACE JACKSON
testified telephonically as follows on:
REDIRECT EXAMINATION
BY MR. GOTTSTEIN
Q Dr. Jackson, I would like to just briefly go through maybe what you reviewed. Did you review the -- I think it was called submission for representation hearing and exhibits to that, including the affidavit of -- affidavits of Mr. Whitaker, Dr. Bassman, Paul Cornils, and then the medical records attached to that?
A I don't believe I know -- I can tell you what I've looked at. I don't believe I've looked at everything you might be citing because it was a very large document, that I communicated to you I was

having problems opening.
I have looked at and reviewed the affidavit of Dr. Bassman, the affidavit of Mr. Cornils. I have reviewed the motion for less-intrusive alternative. I have reviewed Mr. Whitaker's affidavit.
And I have also reviewed portions of the medical history. And I can tell you exactly which ones I have seen. I have seen hospital records from the initial hospitalization dated -- date of admission was April 15. That's 4/15/1980, the discharge summary.
I have then reviewed the admission -- or I'm sorry, the discharge note, discharge summary from a hospitalization which was in February of 1981 through May of 1981.
And I believe the last portion of the records that I had been sent would be the hospital record -- this was February of 2007, API hospitalization No. 68.
And then again, I think the last thing that I had seen was a medical progress note which was signed by a Dr. Lucy Curtis dated March 16, 2007, and an API contact of March 19, 2007 with regard to blood tests for Depakote.
And that is the extent of the records that I have seen. Oh, I have also seen the log -- log sheet

from Monday, May 12th, 2008.
Q Okay. Thank you. Now, you testified that -- that it would be preferable I think to gradually withdraw someone from Risperidone because of problems with abrupt withdrawal; is that correct?
A Right. I think a lot of that depends on context. It's hard to make a general statement. It depends on the previous dose and if there is an emergency situation.
Q Now, what about if someone refuses to take it?
A If someone refuses to take it, again, I think it depends on the context. I think if someone is refusing to take it, there is no reason to start it over again for the sake of doing a withdrawal. It really depends on the context.
Q Okay. With respect to tardive dyskinesia, is this 5 -- 5 percent, is that considered cumulative for example, that 5 percent per year? So the second year would tend to be 10 percent, third year 15 percent? Is that your understanding?
A Well, I believe the idea of cumulative risk really came out of a Yale study, and was mostly speaking about the older antipsychotic medicines. Nobody that I know of has yet published data on

cumulative incidents or the cumulative, you know, risk for the newer medications.

And the study that I had just briefly mentioned, Jose DeLeon study that was published two years ago, was unfortunately not able to really give us an incidence or cumulative incidence. It was more a cross-sectional shotgun, people who had never been on the drugs who were just newly started.

And 5 percent of those people who were just beginning these new drugs developed tardive dyskinesia early in the course of their exposure. In that study, 20 percent of those who had already been on the atypicals for just a short period of time had TD.

Q Thank you. And then Mr. Twomey asked you about your analysis not being peer reviewed. That was true of your analysis of olanzapine in 2003 in the Myers case, isn't it?

A That's correct, that analysis (indiscernible).

Q And that is your analysis of olanzapine, which is Zyprexa? Has that been borne out by subsequent studies and revelations?

A It's actually been borne out in terms of the attachment of black box warnings that pretty much were pertinent to my testimony.

MR. GOTTSTEIN: Okay. I have no further questions.

THE COURT: Follow-up at all on those topics, Mr. Twomey?

MR. TWOMEY: I have nothing further, Your Honor.

THE COURT: All right. Thank you very much, Dr. Jackson. You can be excused at this time.

THE WITNESS: Thank you, Your Honor.

THE COURT: Okay. Bye bye.

THE WITNESS: Bye bye, now.

(Witness excused.)

THE COURT: Your next witness is Dr. Hopson.

MR. GOTTSTEIN: Your Honor, I've -- Dr. Bassman and Mr. Whitaker both had to adjust their schedules to be available for a cross examination. I'm wondering if maybe we could do their cross examination now.

THE COURT: Do you have questions for either Dr. Bassman -- it was Dr. Bassman or who else? That's fine. Go ahead.

MR. BIGLEY: I'm truly sorry, okay.

THE COURT: That's all right. Go ahead.

MR. GOTTSTEIN: Bill -- he would like to be excused.

THE COURT: He can be excused. That's fine. That's fine, Mr. Bigley. You can be excused. You're all right.

All right. So, Dr. Bassman, do you have cross examination?

MR. TWOMEY: Well, I may not, Your Honor, depending on whether we can have a stipulation that Dr. Bassman is not familiar with the standard of care here in Anchorage.

THE COURT: Any disagreement with that?

MR. GOTTSTEIN: I think you should explore that with Dr. Bassman.

THE COURT: All right. I cannot go after 12:00 today. I just have to go on record in that regard.

MR. TWOMEY: Your Honor, my preference would be to --

MR. GOTTSTEIN: I don't think that that's relevant to his testimony.

THE COURT: Well, you can certainly explore the issue on cross. The standard of care in Alaska, I think --

MR. GOTTSTEIN: I would stipulate to that.

THE COURT: All right. That Dr. Bassman is not familiar with the standard of care as to what

issue specifically?

MR. TWOMEY: As to the administration of Risperidone by psychiatrists in the State of Alaska.

THE COURT: I am showing Dr. Bassman as a Ph.D., correct?

MR. GOTTSTEIN: And his testimony was really on less-intrusive alternatives.

THE COURT: So Dr. Bassman is not testifying about medication administration at all? I mean, I'd have to go back and look at his affidavit.

MR. GOTTSTEIN: There's some in there. But it's mainly about --

THE COURT: But he is a psychologist, not a psychiatrist?

MR. GOTTSTEIN: Correct.

THE COURT: So your proposed stipulation, just to state it again, Mr. Twomey?

MR. TWOMEY: Well, one moment, Your Honor. I want to take a look at Dr. Bassman -- or Ronald Bassman's affidavit. If I could have a stipulation that Ronald Bassman is not a medical doctor, but he is --

THE COURT: That's fine.

MR. TWOMEY: That his affidavit goes only to the issue of a less-restrictive alternatives.

MR. GOTTSTEIN: Less intrusive, I think.
MR. TWOMEY: Less-intrusive alternative.
THE COURT: All right. Is that the entirety of your proposed stipulation?
MR. TWOMEY: Yes, Your Honor.
THE COURT: All right. That Dr. Bassman is not a medical doctor, and his affidavit is intended to focus exclusively on the less-intrusive alternative. Am I stating it correctly, your position, Mr. Twomey?
MR. TWOMEY: Yes, Your Honor.
THE COURT: All right. Mr. Gottstein, is that stipulation acceptable?
MR. GOTTSTEIN: That's fine.
THE COURT: All right. So that then with that stipulation, Mr. Twomey, you are not seeking to have Dr. Bassman for cross; am I correct?
MR. TWOMEY: That's correct, Your Honor.
THE COURT: That brings us then next, Mr. Gottstein, there was another individual you indicated.
MR. GOTTSTEIN: Yes. Mr. Whitaker.
MR. TWOMEY: If we could have a stipulation, Your Honor, that Mr. Whitaker is a journalist and not a medical doctor.
THE COURT: Any disagreement with that

proposed stipulation?
MR. GOTTSTEIN: Well, I can stipulate that he is not a medical doctor. But he is also an expert in the study in analyzing clinical trials. He actually had a business that did that, that was so well thought of that it was purchased. So he's an expert in the analysis of clinical studies.
THE COURT: The state's proposing the stipulation that Dr. Whitaker is a journalist.
MR. GOTTSTEIN: It's Mr. Whitaker.
THE COURT: I'm sorry, Mr. Whitaker. And I see that as the first phrase of paragraph 1, that he is a journalist. So there is no dispute there; is that correct?
MR. GOTTSTEIN: Correct.
THE COURT: And what is the balance of the stipulation that, Mr. Gottstein, you were proposing?
MR. GOTTSTEIN: Well, I think the affidavit speaks for itself. But I would just -- and it talks about his history of and expertise in analyzing clinical studies.
THE COURT: From the perspective of a journalist; is that agreeable?
MR. GOTTSTEIN: But he also had a business of analyzing clinical studies, and people paid money to

get that -- those analyses.
THE COURT: Is that discussed in the --
MR. GOTTSTEIN: I think that it is. 1D.
THE COURT: 1D. On what page is that?
MR. GOTTSTEIN: It's the first page.
THE COURT: Oh, I see. So --
MR. TWOMEY: Well, Your Honor, I'll stipulate that he owned a company from 1994 to 1998 when he sold the company. And --
THE COURT: It reported on the clinical development of new drugs?
MR. TWOMEY: Yes.
THE COURT: All right. Is that agreeable? That's what the individual said in that affidavit.
MR. GOTTSTEIN: Yeah. And I certainly would stipulate to that. Also he is an expert on this -- on the analysis of clinical studies.
MR. TWOMEY: Well, the analysis of clinical studies is not at issue in this case, Your Honor. I propose that we stipulate that Mr. Whitaker has no direct testimony pertaining to Mr. Bigley or the treatment proposed for Mr. Bigley in this case.
THE COURT: How about -- does the affidavit simply speak for itself? I mean, I haven't heard anything yet that's not in the affidavit. You

certainly have the right to cross if there are topics you wanted to explore. But is it --
MR. GOTTSTEIN: (Indiscernible.)
THE COURT: Well, no. But --
MR. TWOMEY: I am not really particularly interested in cross examining this witness on issues that don't relate to Mr. Bigley.
THE COURT: Is there any reference at all in this to Mr. Bigley? As I understand it, there is none.
MR. GOTTSTEIN: No.
THE COURT: All right. So, Mr. Twomey, can the affidavit stand as written?
MR. TWOMEY: Yes.
THE COURT: No stipulation from either side? It's simply he is the journalist as indicated in his affidavit. All right. Very good.
Then that brings us to -- Mr. Twomey, do you seek to cross examine Mr. Cornils on his affidavit?
MR. TWOMEY: Yes, Your Honor.
THE COURT: All right. And then who else is available right now?
MR. GOTTSTEIN: We've got Dr. Hopson and Ms. Altaffer here.
THE COURT: All right. Well, what can we

accomplish in the remaining 20 minutes most effectively here?
MR. TWOMEY: Your Honor, I'd like to proceed with Dr. Hopson's testimony. He is the medical director of API and has made arrangements to be here again today.
THE COURT: Any objection there, Mr. Gottstein?
MR. GOTTSTEIN: No. That's fine.
THE COURT: All right. Let's hear then from Dr. Hopson.
(Oath administered.)
THE CLERK: Sir, for the record, could you please state and spell your first and last name.
THE WITNESS: Yes. It's Raymond Duane Hopson. It's R-A-Y-M-O-N-D, D-U-A-N-E, H-O-P-S-O-N.
THE COURT: Thank you. Go ahead, please, Mr. Gottstein.

DR. RAYMOND HOPSON

called as a witness on behalf of respondent, testified as follows on:

DIRECT EXAMINATION

BY MR. GOTTSTEIN
Q Thank you, Dr. Hopson. I asked Mr. Twomey if we could stipulate to the admission, to speed things,

of Exhibits B, C, D, and F. Do you have any objections to that?
MR. TWOMEY: No objection.
THE COURT: There is no objection, Mr. Twomey.
MR. TWOMEY: No objection, Your Honor.
THE COURT: All right. To B, C, D, and F, then, those will be admitted, as well as A and E, which were previously admitted.
(Exhibits B, C, D, and F admitted.)
THE COURT: Go ahead then.
BY MR. GOTTSTEIN
Q Okay. Dr. Hopson, let me give you those Exhibits, if I may. Well, actually, I'm not going to give you B. Well, I'll give it to you just in case you want to refer to it.
MR. GOTTSTEIN: I'm sorry, Your Honor.
THE COURT: That's all right.
BY MR. GOTTSTEIN
Q Dr. Hopson, you -- you were in the courtroom on Monday when Dr. Khari testified, weren't you?
A Yes, I was.
Q Okay. And so you heard Dr. Khari's testimony about people who -- that people who are committed -- committed but not medicated, and she didn't know how

many people that was. Do you know how many that was?
MR. TWOMEY: Objection, relevance, Your Honor.
THE COURT: I'll allow it.
Go ahead, Dr. Hopson.
A At any one particular time I do not. It changes from day to day. We have roughly four to five admissions per day.
I did -- after that came up, I did ask our data analysis to do a scan for the last five years of the number of involuntary court commitments that we've had, and it shows a progressive decline from roughly 6.5 per month to 4 per month currently. So we have a downward decline in our number of involuntary commitment -- medication administration commitments.
BY MR. GOTTSTEIN
Q But isn't that that most of those people have accepted the medication without going to court; isn't that true?
A No. You wouldn't go to court if they were accepting them voluntarily.
Q That's my point. So the question is, how many committed patients, people who have been committed, are not being given neuroleptic medications?

A I wouldn't have a specific number on that. Again, it would vary from day to day. But I know there are some for sure.
Q Some, so that's more than one?
A Sure.
Q But you don't know how many?
A No.
Q Okay. I want to refer you to, if I can find my copy here, to Exhibit -- Exhibit C. Are you familiar with that document?
A I have never seen it before.
Q Are you familiar with the circumstances surrounding that discharge?
A No, I am not. I would have to review that.
Q Do you recall that Mr. Bigley was involuntarily committed in September, right around actually Labor Day, September of 2007?
MR. TWOMEY: Objection, relevance, Your Honor.
THE COURT: What is the relevance?
MR. GOTTSTEIN: It's to a less-intrusive alternative. I'd show that rather than deal with -- that they just discharged him after they had him committed when they couldn't drug him.
MR. TWOMEY: Your Honor, we are dealing with

the present commitment and the petition that is now pending for administration of medication, not what may have happened in September of last year.

THE COURT: Well, how does this tie into today, Mr. Gottstein?

MR. GOTTSTEIN: Well, there is a pattern of -- under the supreme court's opinion in Myers, Mr. Bigley is entitled to a less-intrusive alternative.

And the hospital absolutely refuses to consider doing that. And so they go into court and say that he is so -- so gravely disabled that he has to be locked up.

And then when they can't drug him, they all of a sudden -- he's not so disabled and they discharge him. In that case, it was after --

THE COURT: Well, why don't we ask about the hospital's plans, if this petition for administration of drugs today were to be denied.

Did you understand my question, Dr. Hopson? What would be API's plan for Mr. Bigley -- and I have no opinion sitting here today. I haven't heard all the evidence on how I am going to rule on this petition. But if I were to deny that, what do you see as the appropriate course of care for Mr. Bigley?

THE WITNESS: Well, unfortunately, you know, Mr. Bigley is in a very difficult -- this is his 75th admission.

And he -- he does have a pattern of coming into the hospital, and then because he either doesn't accept treatment or we're not granted the act through statute to treat him, he eventually gets released from the hospital, because we are an acute care facility.

And once a patient is no longer of imminent danger to self or others, we have to release them if they ask to be released. And since we're not able to commit him, that's what we do.

And on the streets of Anchorage, Mr. Bigley is very well known. He is incorrigible. He has been arrested multiple times. He has been --

THE COURT: My question was -- let me go back and say right now there is an order in place that allows the state -- for API to have Mr. Bigley remain at API.

THE WITNESS: Right.

THE COURT: But there is a separate petition that's pending on the involuntary medication. So my question is, assuming that the order on the commitment is in place, and it is, then -- and the petition for the meds were denied, then what do you see as the

appropriate course of conduct for Mr. Bigley?

And that's really what your question is, am I correct? Well, you can follow up on your own --

MR. GOTTSTEIN: Yeah. That's an excellent -- a better question than I was going to ask probably. Thank you.

THE WITNESS: Well, the plan would be to -- he is on a commitment. We would keep Mr. Bigley and work with his guardian to try to once again secure housing for him, which is a challenge at this point.

THE COURT: So do you see that there is any services that API could provide other -- in the absence of providing medication?

THE WITNESS: Well, certainly within the hospital, you know, we have the safety and the security in the milieu. And to a degree, that does help some patients.

There is research to show that psychosocial treatments are no more effective than placebo in some patients. In Mr. Bigley's case, it tends to agitate him more to be in the hospital because we are a non-smoking facility.

And the best I have ever seen Mr. Bigley, if I may comment, was a couple of years ago when he was agreeing to take some medication, and he was --

because of that, he was able to have suitable housing. And he was happy. He was not on the streets, and he was doing well at that time.

THE COURT: Thank you. Go ahead, please.

BY MR. GOTTSTEIN

Q So can you cite the studies that you are saying that psychosocial rehabilitation is no more effective than placebo?

A Yes. It's by Hogarty and Ulrich, which I believe are researchers that you have cited on your Web site, as well.

Q What year?

A 1998, May through August.

Q In what publication?

A Journal of Psychiatric Research. They report that relapse rates are reduced by 50 percent with medication as a standard of care, and that psychosocial treatment without medication is as ineffective as placebo.

THE COURT: What's the definition of psychosocial treatment?

THE WITNESS: That would be the treatment you would receive just for being in the hospital without any medication, the structure, the milieu.

THE COURT: Okay. Thank you. Go ahead,

please.
BY MR. GOTTSTEIN
Q So you testified that he is agitated -- gets agitated by being in the hospital; is that correct?
A Yes.
Q And he doesn't like being locked up?
A I don't think anyone does.
Q And he has been pretty successful out on pass, hasn't he?
A Well, I think that depends. His behavior on pass, you know, it's certainly as demonstrated here. He is still really agitated in the open environment.
Q But there is testimony recently that he was given a pass and he came back even without escort; isn't that true?
A Right. There have been times when we have allowed him to do some therapeutic passes. Those therapeutic passes -- also it must be said that because we are an acute care facility -- are for part of discharge planning and not part of just the treatment, you know, the --
THE COURT: Could you give me an example?
THE WITNESS: Yes. As we are working on someone's final discharge plan, we usually will allow a couple of therapeutic passes, maybe with their case

manager or with a family member to go visit an assisted-living home, that sort of thing.
But it would not be just part of their daily process to live at the hospital and go out on a daily pass.
BY MR. GOTTSTEIN
Q But there's no reason why that couldn't be true, is there?
A Absolutely. That is not our mission. We are the state's acute care hospital. And if we started housing patients and just letting them go out on pass all day, we would be full of patients like that, and we wouldn't be able to fulfill our mission totally. That's what the assisted-living homes and structured case management is for.
Q And that works for many people, right, structured living and assisted-living homes, correct?
A It does.
Q But it doesn't work for Mr. Bigley, does it?
A It has when he's been on medication, yes.
THE COURT: And is it a prerequisite for most or all assisted-living homes that the individuals have adequate medication?
THE WITNESS: It's not a prerequisite. And in fact, he's been in multiple homes where he has not

been on medication. He just deteriorates without it.
BY MR. GOTTSTEIN
Q But you would agree that Mr. Bigley's situation is pretty unique, wouldn't you?
A Well, he certainly is a -- he has chronic schizophrenia. He's had it for many years. And individuals -- he's been through multiple medications I'm sure through the years. And because of that, I think it does make his situation unique, absolutely.
Q And in Mr. Bigley's case, isn't it true that this issue of losing his housing really tends to cause -- you know, cause a problem with him being in the community?
A Yes, I think it does.
Q And you'd think even though it's not the hospital's mission, that it probably would be -- kind of make things be on more of an even kilter if he could come to API when he didn't have other housing?
A Well, there again, I think Mr. Bigley is brought to the hospital when he deteriorates to the degree that he is frightening other people, people in the banks, people in downtown offices, when he gets thrown out of his housing. You know, those are the times that he's brought to the hospital for evaluation and treatment recommendations.

Q Yeah. And he would be much happier if he was let out during the day and --
A There again, that would not be -- the implication there is Mr. Bigley could come to the hospital and sleep at night and be let out during the day, to be on a daily pass every day. And that would not at all be in the mission of the hospital.
THE COURT: So if you had -- which clearly you don't. But if you had unlimited resources here, how would you approach this problem?
THE WITNESS: Well --
THE COURT: I mean, setting aside API, just generally, what do you see as the best outcome for Mr. Bigley?
THE WITNESS: Well, the ideal thing, which many states do have, is very intensive case management that, you know, funds someone to work with him on an outpatient basis.
And I know that's where Mr. Cornils has come into the picture. And you know, if that could ever be established, if he was willing to work with Mr. Bigley and vice versa, that would be ideal.
In that case, you know, it might be that Mr. Bigley wouldn't have to come to the hospital ever if he were doing well in an outpatient setting.

THE COURT: And is that type of resource available in our community?
THE WITNESS: Well, I know that Mr. Cornils has worked with him. I don't know at this point where that relationship is. I haven't spoken with Mr. Cornils.
THE COURT: All right. Thank you. Go ahead, please.
BY MR. GOTTSTEIN
Q Okay. I think actually I want to leave that topic.
If the hospital was authorized to administer the drugs with -- you know, when he didn't want to, and he refused to take them, how would it be administered?
A If -- you're saying that if a court order for involuntary administration of medications was granted by the court?
Q Right.
A Well, our process says we would offer him some oral medication. And if he refused, then we would medicate him with some intramuscular, IM medication.
Q And that is an injection?
A Yes.

Q And if he -- if he refused to do that, would he be held down and injected?
A There are cases where that happens. It's done in a very -- you know, staff are trained in particular ways to do that where it's safe, doesn't harm the patient.
But quite frequently, my experience says when you get down to that point, even with the most agitated patient, they will agree to take the injection. So you don't have to lay hands on. We never want to lay hands on patients.
Q Okay. Now, normally, if a patient agrees to take the medication, then of course you will -- then that's pretty much the end of the question, right, and they are given the medication; is that correct?
A If that's what the doctor recommends.
Q Yes. But what happens if they change their mind after they take it and they don't like it?
A It happens all the time. The doctor will decide, you know, perhaps they're doing well. Not all of our patients take medications. Not all of the patients leave on medication.
Q And what if then it's decided -- the doctor decides, well, the person really should be on the medication?

A If they felt they were of imminent risk to themselves or a danger to themselves or others and unsafe to leave the hospital, if the patient was wanting to leave the hospital, they would consider petitioning the court.
Q That I think is a separate issue. I am talking about in terms of the medication. If they -- if they initially agreed to take the medication, then decided that they didn't like it, and the doctor thought, well, they really needed to do that, wouldn't then a petition for involuntary administration of medication --
A Not automatically, no. The patient, if they were doing well enough, they could be considered just to stay in the hospital, if they were there voluntarily or if they were on a commitment. It doesn't always continue to the medication administration.
Q But it does sometimes?
A On occasion. I said currently four times per month.
Q Okay. Of people that initially agreed to take the medication?
A Of our involuntary -- we petition the court approximately four times per month currently out of

the roughly 120 admissions per month that we get.
THE COURT: So have you had -- do you do petitions only for commitment but without petitioning for the involuntary medication?
THE WITNESS: Yes, we do.
THE COURT: Go ahead, please.
BY MR. GOTTSTEIN
Q Okay. I would like to refer you to Exhibit F.
A Okay.
Q So -- and it's I think now 5507. I have highlighted it, it says: Declined a.m. meds. Do you see that there?
A Uh-huh.
Q So if he had -- and these were neuroleptics, weren't they?
A No. He is not prescribed any neuroleptic medication, because we know that is the issue here and he doesn't want them.
He has a stomach medication that is prescribed for him. And sometimes he will take it and sometimes he won't. But we certainly offer it to him.
MR. GOTTSTEIN: Okay. I have no further questions.
THE COURT: Mr. Twomey.

MR. TWOMEY: Yes. Thank you, Your Honor.

DR. RAYMOND HOPSON

testified as follows on:

CROSS EXAMINATION

BY MR. TWOMEY

Q Dr. Hopson, have you had an opportunity to listen this morning to Dr. Grace Jackson's testimony?

A Yes.

Q Is there anything that you would like to comment upon, having heard her testimony as it relates to Mr. Bigley's case?

A Well, certainly. I certainly respect her knowledge and her research. I think it's pretty clear, and she kind of skirted around that. To me it seemed like that she certainly is not in the mainstream of clinical practice, that she's a researcher, and she certainly has devoted a lot of time and energy to the research that she does.

But as far as the mainstream, the standard of practice based on evidence-based medicine, you know, you evaluate patients. And a physician is --

MR. GOTTSTEIN: Your Honor, I think this really requires -- he's getting into scientific evidence and would require a Daubert --

THE COURT: Well, he was -- you were saying

that you disagreed with Dr. Jackson's analysis; is that correct?

THE WITNESS: To summarize it quickly for you, I would disagree with it because, you know, the standard of care certainly -- the --

THE COURT: And let me just respond to Mr. Gottstein's objection, which is to say, can he respond from the perspective of the standard of care as a psychiatrist here in Anchorage as opposed to a research analyst? I am hearing that -- you are the clinical director of API?

THE WITNESS: The medical director.

THE COURT: Medical director.

MR. GOTTSTEIN: Well, I think if we're limiting it to the standard of care in Anchorage, yes.

But in terms of refuting Dr. Jackson, I think we have to go through the whole Daubert, and I should be entitled to, you know, get his -- you know, what he cites and all that.

THE COURT: Why don't you just give us your perspective as the medical director. Go ahead.

THE WITNESS: Well, certainly, there are patients that we don't medicate.

And I think each physician is obligated to consider the best for their patient. And half of the

United States uses algorithms, which are specific guidelines that you approach the treatment of schizophrenia. And those recommendations are for antipsychotic medications if the symptoms are interfering with their daily functioning.

So to not treat someone with the severity of the illness that Mr. Bigley has, I think we would be remiss in doing that. For years, I --

THE COURT: When you say when to not treat, do you mean to not use medication to treat --

THE WITNESS: Yes. Yes. In my private practice for years before my current position, I had multiple patients that I did not treat that were schizophrenic that managed -- that had enough support and safety in their environment to function well. And I think that's wonderful.

But I think in this particular case, and each patient I think must be taken on a case-by-case basis, that we have to look at what's going to be the best for them.

THE COURT: All right. Thank you. It's 12:03.

I'll just say it's high school graduation week, and I need to get going here very shortly.

So with that said, where were we in the

middle of questions?

MR. GOTTSTEIN: Well, I think I --

DR. RAYMOND HOPSON,

testified as follows on:

REDIRECT EXAMINATION

BY MR. GOTTSTEIN

Q Isn't it true that these algorithms have really come into disrepute because they were corrupted by pharmaceutical money?

A It's my understanding the Texas Medication Algorithm Project is currently followed in 26 states in the United States.

Q So you are unfamiliar with Allen Jones' report on how the pharmaceutical companies really corrupted that process?

A I am unfamiliar with that. I would say that, you know, I think there are going to be individuals, like the doctor that testified earlier, that are going to have their viewpoints on it.

But a large number of clinicians obviously around the United States continue to support these types of algorithms.

Q And you are unfamiliar with actual payments being made to the people that were -- served on those panels to make those recommendations?

A Yes.
MR. GOTTSTEIN: Okay. No further questions.
THE COURT: Okay. Any redirect? We're done.
MR. TWOMEY: I'm not sure where we were, Your Honor. I think I was questioning.
THE COURT: I think you might have been.
MR. GOTTSTEIN: Oh, I thought -- I thought we were on cross.
THE COURT: Oh, no. The clerk agrees with you there, Mr. Twomey. Go right ahead. I think I was, and that's what got us a little off track there. So go right ahead.

DR. RAYMOND HOPSON,
testified as follows on:

RECROSS EXAMINATION
BY MR. TWOMEY

Q Dr. Hopson, have you had an opportunity to review the affidavit of Robert Whitaker?
A Yes.
Q All right. Do you have any comments upon the conclusions set forth in his affidavit?
A I would have to see his direct conclusions again. It's been a few weeks. However, I would disagree with them.
MR. GOTTSTEIN: Objection, Your Honor, in

terms of this would not be based on again the Daubert objection.
THE COURT: Well, he's indicated he's not -- I guess I don't find Dr. Hopson's testimony in this particular point that helpful when he indicated he hadn't reviewed this in a few weeks. So if there is specific points you wanted to bring up, and then we can see.
But I have to leave here. So what we can do is continue this tomorrow. I want to give each side an opportunity.
I also don't want to have the doctor inconvenienced any more than necessary. So what is your thought on how to proceed?
MR. TWOMEY: How much more time do you have available?
THE COURT: Negative five minutes.
MR. TWOMEY: Well, then I guess we will have to come back tomorrow.
THE COURT: I can do 10:00 a.m. tomorrow. Is that convenient for both sides? And we can take up Dr. Hopson then. I apologize for that. But let's do 10:00 a.m. tomorrow.
And then you'll have an opportunity if you'd like to look at the affidavit again, knowing that

that's the next question.
Anything further today, Mr. Twomey?
MR. TWOMEY: No, Your Honor.
THE COURT: All right. And 10 to 12, will that complete -- that is an extra two hours, Mr. Gottstein. I am going to assume that is more than sufficient. Am I reasonable in that assumption?
MR. GOTTSTEIN: I think it should be.
THE COURT: Well, I guess it has to be, is what I am indicating.
MR. GOTTSTEIN: Oh, okay. Yeah.
You said you wanted to cross examine Mr. Cornils?
MR. TWOMEY: Yes, Your Honor. Or yes.
THE COURT: All right. So he will be available, as well, tomorrow.
So 10:00 a.m. tomorrow. We can go off record. Thank you all. We'll see you tomorrow. Thank you.
(Off record.)
12:06:22

TRANSCRIBER'S CERTIFICATE

I, Jeanette Blalock, hereby certify that the foregoing pages numbered 103 through 194 are a true, accurate, and complete transcript of proceedings in Case No. 3AN-08-00493 PR, In the Matter of WB: William Bigley, Motion Hearing held May 14, 2008, transcribed by me from a copy of the electronic sound recording, to the best of my knowledge and ability.

_____ _____
Date Jeanette Blalock, Transcriber

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

IN THE MATTER OF:)
)
Plaintiff,)
)
vs.)
)
WB: WILLIAM BIGLEY)
)
Defendant.)
)

Case No. 3AN-08-00493 PR CI

*** CONFIDENTIAL ***

VOLUME III

TRANSCRIPT OF MOTION HEARING

BEFORE THE HONORABLE SHARON GLEASON
Superior Court Judge

Anchorage, Alaska
May 15, 2008
10:07 A.M.

APPEARANCES:

FOR THE STATE: Timothy M. Twomey, Esq.
Assistant Attorney General
1031 West 4th Avenue, Suite 200
Anchorage, Alaska 99501

FOR THE DEFENDANT: James B. Gottstein, Esq.
Law Project for Psychiatric Rights
406 G Street, Suite 206
Anchorage, Alaska 99501

3AN-6308-80
10:07:02
THE COURT: Good morning, everyone. Please be seated.
MR. TWOMEY: Good morning, Your Honor.
THE COURT: We are back on record with respect to Mr. Bigley. Counsel are here, Mr. Bigley is present, and Mr. Gottstein is standing.
MR. GOTTSTEIN: Thank you, Your Honor. Just a couple of things.
I gave Mr. Twomey a copy of some rebuttal exhibits, and if I could give them to you --
THE COURT: All right.
MR. GOTTSTEIN: -- I'd appreciate it.
THE COURT: I guess -- all right. Aren't we still on your witnesses?
MR. GOTTSTEIN: Well, I think that's going to come up. I think that actually most of Dr. Hopson's testimony yesterday was really rebuttal testimony. It was beyond the scope.
And in light of the time, I think that really we ought to stick to that. I plan on making that objection.
THE COURT: Well, why don't we hear the rest of Dr. Hopson's testimony.

You can make objections as warranted, and then we'll take up your rebuttal issues.
MR. GOTTSTEIN: And one other thing, is there's been some confusion.
He was behind me yesterday, but I understand Mr. Bigley got upset at various times at the testimony yesterday.
And I just would like to make it clear to his escorts that he can, if he wants --
THE COURT: He can certainly come and go.
MR. GOTTSTEIN: -- to, that he can leave and take a break.
THE COURT: You can certainly come and go, Mr. Bigley. If you feel you don't want to stay in the courtroom, that is absolutely your right.
All right. Are we ready to proceed with Dr. Hopson?
MR. GOTTSTEIN: Yes, Your Honor.
THE COURT: All right. And, Doctor, I will remind you, you are still under oath from yesterday's proceedings. Go ahead and have a seat, if you would, please.
And whenever you're ready, Mr. Twomey.
MR. TWOMEY: All right. Thank you, Your Honor.

DR. RAYMOND HOPSON
previously sworn, testified as follows on:
RECROSS EXAMINATION
BY MR. TWOMEY
Q Dr. Hopson, directing your attention to some of the conclusions set forth by Robert Whitaker, specifically that antipsychotics increase the likelihood that the person will become chronically ill --
MR. GOTTSTEIN: Objection, Your Honor, beyond the scope.
THE COURT: Please let Mr. Twomey finish his question --
MR. GOTTSTEIN: Oh, I'm sorry.
THE COURT: -- before you object.
Go ahead, Mr. Twomey.
BY MR. TWOMEY
Q Specifically the statement that antipsychotics increase the likelihood that a person will become chronically ill, do you have a response to that?
THE COURT: And hold on just a moment, Dr. Hopson.
MR. GOTTSTEIN: Objection, Your Honor.
THE COURT: Now, and your objection is.

MR. GOTTSTEIN: It's beyond the scope.
And I didn't object yesterday. I thought we could just do it. But I know there's a real time constraint.
It seems to me what we ought to do is just finish up the cross. Then if he wants to call in for rebuttal, he can.
But then he wanted to cross at least one other of my witnesses that submitted written testimony. It seems that should be done. I understand, Your Honor wants to finish today, and I very much would like to, as well.
THE COURT: All right. So the objection to this particular question is that it's beyond the scope of your direct.
Mr. Twomey.
MR. TWOMEY: Well, Your Honor, Dr. Hopson is here, and I'd like the opportunity to address this issue now rather than to call him back.
THE COURT: Any objection to rebuttal evidence on this, then?
MR. GOTTSTEIN: Your Honor --
THE COURT: No, no. I am asking Mr. Twomey, and then I'll hear from you, Mr. Gottstein.
MR. GOTTSTEIN: I'm sorry. I thought you

were asking me.
THE COURT: Go ahead.
MR. TWOMEY: What was your question, Your Honor?
THE COURT: My question is, it's beyond the scope. But if you go down this road, then any objection to Mr. Gottstein presenting some rebuttal on this?
MR. TWOMEY: No, Your Honor.
THE COURT: All right. Mr. Gottstein, would that address your concern?
MR. GOTTSTEIN: Well, one of the problems that I have is that I don't have any expert report from Dr. Hopson or anything. And he kind of sprung a study on me yesterday. And so I would be concerned about that.
I would really prefer just to finish up my case, and then -- which really it's going to be mainly redirect on what Mr. Twomey did. And then I think he should cross Mr. Cornils and see where we are. And I may or may not end up calling Mrs. Altaffer (phonetic). And then he can put on his rebuttal case.
THE COURT: All right. So why is the approach -- just from an efficiency standpoint with the doctor here, why is the approach that Mr. Twomey's

proposing unacceptable, other than it's technically not in compliance with the format for the presentation of evidence?
MR. GOTTSTEIN: The main one is the issue of time, I guess, Your Honor.
THE COURT: All right.
MR. GOTTSTEIN: Other than -- but I do object to the -- you know, the order and form, as well.
THE COURT: Well, and that objection is noted.
But in the interest of time, I will allow the questioning now, and then allow the rebuttal. We are a bit out of order, but I think it is the most efficient use of everybody's time here of the various professionals involved.
So go ahead, Mr. Twomey.
BY MR. TWOMEY
Q All right. Dr. Hopson, do you have a comment that you'd like to make in response to the conclusion that antipsychotics increase the likelihood that a person will become chronically ill?
MR. GOTTSTEIN: Objection, Your Honor.
THE COURT: Please let him make the whole question or I can't rule on it.
MR. GOTTSTEIN: I'm sorry.

THE COURT: Would you restate the question?
A comment on antipsychotics --
BY MR. TWOMEY
Q Directing your attention, Dr. Hopson, to the first of Robert Whitaker's conclusions that antipsychotics increase the likelihood that a person will become chronically ill, do you agree with that statement?
THE COURT: All right.
MR. GOTTSTEIN: Objection, Your Honor. Yesterday I think we concluded with Dr. Hopson being allowed to testify as to the standard of care in Anchorage.
And this is getting into scientific evidence. And I think that I am entitled to have -- you know, having an expert report on that and going through the Coon Daubert analysis.
And Dr. Hopson testified yesterday that, you know, he's had that affidavit for two weeks. And there's no reason why I couldn't have had that.
And that's the objection, Your Honor.
THE COURT: Well, it's overruled.
And the reason why is that there's case law from our supreme court that recognizes that people in the position of Dr. Hopson, that are responsible for

providing care to individuals, are kind of hybrid experts, if you will, as opposed to hired experts, that they are more in the nature of treating providers.
And so from that perspective, as a treating provider, I will allow Dr. Hopson to testify, and not from the perspective of a pure expert, if you will.
MR. TWOMEY: And Your, Honor, I intend to narrow the focus of these questions.
THE COURT: That might be helpful.
Anyway, Mr. Gottstein --
MR. GOTTSTEIN: If I understand your ruling, Your Honor, and I am not sure what case you are referring to, but in terms of Coon, Daubert and Marron, which I have the cite for that if you haven't seen it, is the distinction between scientific evidence and experiential-based evidence. And I understand your ruling to be on -- that this is based on his experience. And I --
THE COURT: No, that's incorrect. I was responding to your concern about the lack of an expert report. It's a separate issue from the Daubert standard.
On the issue of the expert report, the case law in the supreme court of our state is clear that

the provisions under the civil -- under the civil rules for provision of expert reports do not apply to individuals that are so-called hybrid experts, meaning that they are responsible for providing care as opposed to hired to provide testimony.

And it is from that perspective that the lack of an expert report is not a basis for exclusion of this testimony.

Secondly, on the Daubert issue, I am going to stand by the supreme court's decision in the Samaniego case that discussed some of the flexibility to be accorded in this area with regard to testimony.

So that is my ruling. That is my clarification. And I think we can go forward.

MR. GOTTSTEIN: May I, for the record, just address the Samaniego case?

THE COURT: Later on you can. But my ruling stands, and we are going to hear Mr. Twomey's question.

Go ahead.

BY MR. TWOMEY

Q Do you have my question in mind, Doctor?

A Yes. Well, one thing, I think it's important. There is a lot of data that indicates that individuals with schizophrenia have two times the

mortality rate of the general population, in general, just by virtue of them having schizophrenia specifically.

And that is due to a number of things. They have difficulty getting themselves to appointments. They have a higher risk of cardiovascular disease due to their smoking. They have very poor diet, poor exercise regimens, so they have an increased likelihood of obesity and diabetes. That is well-documented.

So I think it's difficult to say that it's -- all of this increase in mortality is due to antipsychotics. The illness itself bears that out.

Q As a treating physician involved with Mr. Bigley's care, do you believe that the use of antipsychotics in his case would increase the likelihood that he would become chronically ill?

A No, I don't have any evidence to support that.

Q Okay.

THE COURT: What testing has there been, do you know, with regard to some of the health conditions that were testified to yesterday with regard to diabetes or any of those potential risks with respect to Mr. Bigley?

THE WITNESS: Yes. Whenever Mr. Bigley is admitted, as with all patients, they get a complete metabolic profile, complete blood count that includes blood sugars.

We monitor their weight. Certainly obesity is not an issue with him, but we would be monitoring his blood lipids and his blood sugars, which to date he does not carry a diagnosis, I do not believe, of diabetes or hyperlipidemia.

THE COURT: Thank you. Go ahead, please, Mr. Twomey.

BY MR. TWOMEY

Q Do you have -- well, do you agree with the second conclusion set forth in Robert Whitaker's article that long-term recovery rates are much higher for unmedicated patients than for those who are maintained on antipsychotic drugs?

A Well, as I mentioned yesterday, I think that -- I did note the study that reports that psychosocial treatment without medication is as ineffective as placebo.

Other individuals have reported that 75 percent of patients on placebo relapsed, as compared to 33 percent on active meds.

THE COURT: Now we are getting into -- more

in the nature of expert testimony as opposed to testimony related to Dr. Hopson's opinions with respect to Mr. Bigley and prognosis there.

MR. TWOMEY: Well, I'll ask another question, then.

THE COURT: All right. Thank you. Go ahead, Mr. Twomey.

BY MR. TWOMEY

Q Dr. Hopson, do you believe that with respect to Mr. Bigley, that he would have a higher probability of recovery without medication?

A No, I do not.

Q And why? Why do you have that belief?

A Well, again, I mentioned yesterday that I've seen Mr. Bigley, when he was taking medications, was able to live in stable housing where meals were prepared. His whole quality of life I think was higher at that time.

And without that, I think he is intermittently homeless. His dietary intake is questionable. And I think all of that ultimately affects his overall health.

Q Okay. Do you believe that if Mr. Bigley receives the antipsychotic medication that API is requesting permission to prescribe in this case, that

it will hasten Mr. Bigley's health --
A No, I do not.
Q Why do you hold that belief, that opinion?
A Well, again, you know, our concern all along, in addition to his medical well-being, is his personal safety.
And you know, I think being as agitated as he intermittently is, and gets in the face of people, we have significant concerns that he could be assaulted. Homeless individuals I know are assaulted more frequently, particularly when they're psychotic, from personal experience.
I worked with the homeless mentally ill in Dallas, Texas for 14 years, and am well-acquainted with the risk of being psychotic on the streets.
Q Now, do you hold the belief that all psychotic patients should receive medicine as their form of treatment?
A No.
Q And -- but with regard to Mr. Bigley, you believe that medicine is appropriate?
A Right. I -- particularly because of the chronicity of his illness and his course of illness, his response to previous medication is very -- you would approach his care very differently than you

would a first -- new onset psychosis. You might not even consider medication in that case.
Q Okay. So how is Mr. Bigley different from someone who is a new onset patient?
A Well, he's been hospitalized. He is currently in his 75th admission at API. That in and of itself speaks to the fact that this is a chronic mentally ill individual.
His record indicates he has had multiple trials of medications. And I think we do have some evidence in his history to indicate when he was on medication, he was in a stable living environment and doing better.
Q Okay. Now, with Mr. Bigley, there is a history of him not adhering to the medication that is recommended for him once he's discharged from the hospital; is that correct?
A That is correct.
Q Does that history of non-adherence affect your treatment recommendations in any way?
A It does. It's well known and accepted that non-adherence to a treatment regimen increases your chance of readmission, relapse. That speaks for itself.
In the --

MR. GOTTSTEIN: Objection, Your Honor. I think that's getting into scientific --
THE COURT: Well, it was said in the context of why -- the impact of Mr. Bigley's history of non-adherence. So I'll take it from that perspective, as to the opinion with respect to Mr. Bigley only.
So from that limited perspective, go ahead, Mr. -- I think, Dr. Hopson, you were in the middle of your answer. Go ahead.
A I think in his particular case, you know, the approach, and Dr. Khari I believe testified to this the other day, the recommendation would be to use a depo medication with him. And that is a medication that lasts for, you know, two weeks in the body. And that way, it reduces the need for his direct interaction with caregivers for that.
It also improves adherence because they don't have to remember to take an oral medication every day. And that is very in line with recommendations for someone who has a chronic mental illness.
BY MR. TWOMEY
Q Okay. What recommendations are you referring to?
A Well, for instance, I mentioned yesterday the Texas Medication Algorithm Project. It's a

well-accepted standard of care throughout half of the United States currently.
And for an individual with chronic mental illness, it does place them at stage 5 of that algorithm, which is for depo medication.
Q Okay. And the Risperdal Consta that Dr. Khari has recommend administered to Mr. Bigley, that's a depo medication?
A Yes.
Q Okay. So it is a long-acting medication that stays in the fat cells?
A Two weeks, yes.
THE COURT: What is the standard of care in the other half of the country?
And you can object here if I'm going outside the scope of -- if I'm --
MR. GOTTSTEIN: I wouldn't object to your question, Your Honor.
THE COURT: You have every right to, Mr. Gottstein.
But as I understood your answer, it's half of the United States. What is the approach in the other half?
THE WITNESS: Well, they may be following the TMAP. Because it really is widely accepted as a

standard.
However, they may have not adopted or require strict adherence to its stages in its state mental health facilities.
THE COURT: Go ahead.
BY MR. TWOMEY
Q Now, Dr. Hopson, you are the medical director of API?
A Yes.
Q Okay. Can you describe for the court the -- the -- the mission of API from your perspective as medical director?
A Sure. We are the state's only state mental health facility. We are an acute care facility due to the lack of beds throughout the state. We have 80 total beds. 50 of them are acute adult inpatient beds.
We take referrals from all over the state. Our average length of stay is 12 days. That is held in distinction and different from many state facilities in the Lower 48 that have long lengths of stay and perhaps can accommodate I guess less acute treatment regimens.
But our mission, our funding and all is focused clearly at acute care.

THE COURT: What about the other 30 beds?
THE WITNESS: Ten of them are adolescent, ages 13 to 17. Ten are forensic, and ten are long-term difficult to reach -- or difficult to treat patients, TBI patients.
THE COURT: What does it mean, forensic?
THE WITNESS: They are in department -- custody of Department of Corrections, and they are sent to us for competency.
THE COURT: All right. Thank you.
BY MR. TWOMEY
Q What is your definition of acute care?
A Acute care means an individual is of imminent -- imminent risk of harm to self or others or gravely disabled, basically. And so those are the criteria for which patients are admitted to us.
All of our patients are admitted to us involuntarily. They are brought to us on peace officer application warrants or on ex partes. So they are involuntarily.
THE COURT: Are all 80 beds generally full all the time?
THE WITNESS: They are certain times of the year. This week we have been. We've had a waiting list several days this week.

BY MR. TWOMEY
Q Do you have a response to the proposal that has been suggested on behalf of Mr. Bigley that API provide housing facilities for him and that he be allowed to come and go basically on his own schedule?
A I think it would be impossible. First of all, it doesn't fit our mission. It doesn't -- it ties up a bed that is not in line with our mission.
And it sets a precedence for us to be providing a different level of care than we're accustomed to doing.
Q Do you think that providing such an arrangement would be in Mr. Bigley's best interest?
A No, I do not.
Q Why not?
A I think the best thing for an individual is to be in the least restrictive, which would be in an outpatient setting, in a more normalized housing environment rather than living in a hospital.
Q And do you have an opinion as to how that can be accomplished in Mr. Bigley's case at the present time?
A With very intensive case management. If he were functioning at a level where he could participate in the assisted-living home or apartment or boarding

hotel, or wherever his guardian might work with him on placement.
Q Based on your experience with Mr. Bigley, do you have any opinion as to the probability of success of that arrangement without the administration of medication to Mr. Bigley?
A We have tried it multiple times. And he does not last but just sometimes a couple of days, sometimes a couple of weeks.
THE COURT: You have tried without medication?
THE WITNESS: Yes. In multiple care facilities, boarding houses, boarding hotels. And he has been essentially evicted from all of them.
And I have been told personally by his guardian that when they try to place him --
MR. GOTTSTEIN: Objection, hearsay.
THE COURT: I'll allow that, as an expert can testify as to hearsay. So I will allow that.
Go ahead.
THE WITNESS: That they -- as soon as --
THE COURT: Although let me clarify. He is a treating physician, and it's a hybrid expert. I do want to be clear on that, Mr. Gottstein.
But I do allow the hearsay would be

admissible in this circumstance. So go ahead.
THE WITNESS: His guardian has said that he can't place him anywhere because they know Mr. Bigley, and they know, you know, the difficulties they are going to encounter.
MR. TWOMEY: All right. Thank you, Doctor, I have no further questions for you.
THE COURT: Go ahead, please, Mr. Gottstein. Recross? Is that where we're at here?
MR. GOTTSTEIN: I think it's redirect technically.
THE COURT: Redirect. Thank you, Madame Clerk.
MR. GOTTSTEIN: If I may, I think you have a set of these new --
THE COURT: I do.
MR. GOTTSTEIN: -- exhibits.
THE COURT: And Mr. Twomey does I assume as well?
MR. GOTTSTEIN: If I may approach the witness.
THE COURT: Go ahead.
MR. GOTTSTEIN: I'm going to give him the whole set for efficiency purposes.
And I asked Mr. Twomey if we could stipulate

to admitting them, and I don't know if he's -- we didn't have a chance to talk about it. But --
THE COURT: I wonder if Mr. Twomey's had the chance to read through all of these articles.
MR. TWOMEY: Well, I have not, Your Honor. I was just handed this stack of articles this morning when I arrived here at court. And I would question the relevance of this material at this point.
THE COURT: Mr. Gottstein, what is the use that you seek to make of the material?
MR. GOTTSTEIN: They are rebuttal to his testimony yesterday regarding the Hogarty and Ulrich study. Doctor --
MR. TWOMEY: I don't recall that testimony, Your Honor.
MR. GOTTSTEIN: It was a study he also mentioned this morning about --
THE COURT: The algorithms?
MR. GOTTSTEIN: No, no. About the placebo response rate and the response rate of psychotherapy. He explicitly mentioned -- I asked him what study. He said it was 1998 Hogarty and Hobart (as spoken), I guess in the Journal of Psychiatric Research, and that he downloaded it from my Web site.
THE COURT: Do you recall that testimony?

THE WITNESS: That the -- yes, ma'am. The individuals Hogarty and Ulrich are mentioned on your Web site.
And I believe we found this article by them cross referenced to other articles that they had published. So these are both researchers that I think you had mentioned on your Web site.
DR. RAYMOND HOPSON,
testified as follows on:
REDIRECT EXAMINATION
BY MR. GOTTSTEIN
Q So then you misspoke yesterday when you said you downloaded it from my Web site -- from Psych Rights Web site?
A I don't recall saying that I downloaded them, but that we had found these individuals listed on your Web site.
Q Okay. And had you read that -- do you have that study with you? May I see it?
THE COURT: So yes, you have a study with you?
THE WITNESS: Yes.
THE COURT: All right.
THE WITNESS: This is the -- I'm sure it's not the entire. It's the abstract possibly.

MR. GOTTSTEIN: And can we mark this as an exhibit?
THE COURT: That's fine. Have you gotten a copy of that study that your witness has?
MR. TWOMEY: No, Your Honor. I'd like to take a look.
THE COURT: Well, I guess it's not your witness technically. But we can go ahead and get a copy of that. That's fine.
Let me just say -- let me back up here, in an interest of trying to focus things here.
Dr. Hopson, have you relied on that study in coming up with the treatment plan and prognosis, diagnosis for Mr. Bigley?
THE WITNESS: No.
THE COURT: All right. So would one approach here be to strike that testimony and move forward?
MR. TWOMEY: That's acceptable to API, Your Honor.
THE COURT: And then -- I mean, if -- if Dr. Hopson hasn't even looked at other articles, I don't see how those would be admissible through him.
And if we don't have the study that he indicates he hasn't relied on, then which -- then that might allow us to move forward on Mr. Bigley's

condition and not studies that may or may not have real convenience to his particular situation. Would that be acceptable?

MR. GOTTSTEIN: If Your Honor will strike that, yes.

THE COURT: All right. So we'll strike all of the testimony from yesterday, or basically. It'll be part of the record for review, but it would not be considered by this court in rendering any decision on the medication petition.

So it remains part of the record, simply for appellate review, but would not be a basis -- the testimony would not be considered.

MR. GOTTSTEIN: Well, then it seems like, Your Honor, that I should go through this process if just his -- you know, if his part of it's going to be in the record. I guess it can't come out of the record.

But let -- maybe I'll move back to that and see.

THE COURT: Okay. Go back to that and see where we are.

MR. GOTTSTEIN: Let's go back.

THE COURT: But Mr. Twomey is agreeable to simply striking that?

MR. TWOMEY: Yes, Your Honor.

THE COURT: So let's hear where we are on that.

BY MR. GOTTSTEIN

Q So you mentioned the TMAP, and that that was widely accepted; is that correct?

A Yes.

Q And then yesterday, you said that you were not aware of the whistle blower report about the corruption involved in adopting that; is that correct?

A That's correct.

Q And --

THE COURT: And now I'm getting confused, Mr. Gottstein. And I'm sorry to interrupt here.

But as I understood it, you objected to having this witness testify outside of the issues associated directly with Mr. Bigley's care. Now I hear you asking him questions that are unrelated to that particular topic.

And you are seeking to have expert testimony from him; am I correct?

MR. GOTTSTEIN: No, Your Honor. I am conducting redirect with regard to testimony he made yesterday, and in fact this morning, about TMAP being accepted.

THE COURT: Right. And I am indicating that the state is willing to have all of that stricken from the record.

And if you seek to have him come in as -- provide expert testimony on this and open the door, it would seem that would be contrary to the position that you are seeking not to have him testify as an expert.

So the remedy with regard to your prior objections would be to strike anything that this witness has testified to with regard to these various articles, have his testimony stand which relates solely to Mr. Bigley's treatment and diagnosis.

So I guess you can't have it both ways.

MR. GOTTSTEIN: Yeah. And I didn't -- I didn't think I was trying to do that. And I am trying to understand, because I don't think I am. And there may be I think a misunderstanding on my part, or your part frankly --

THE COURT: That's fine.

MR. GOTTSTEIN: -- as to what was stricken. So I understood before that it was the testimony related to the Hogarty and Ulrich study.

THE COURT: Right.

MR. GOTTSTEIN: And this is about his testimony about TMAP and being the standard of care

and adopted by 50 states.

THE COURT: So you're agreeable to simply having the Hogarty placebo testimony stricken, and now we are at a different type of study. Maybe I am confused that we are on a different study.

MR. GOTTSTEIN: Yeah, different topic.

THE COURT: All right. This goes to Mr. Bigley directly?

MR. GOTTSTEIN: Well, it goes to Dr. Hopson's testimony about TMAP being the accepted standard of care, which he -- he said in half the states, and you inquired about that.

THE COURT: All right. So why don't we focus on that, and then --

MR. GOTTSTEIN: That's --

THE COURT: All right.

MR. GOTTSTEIN: That's where I'm at.

THE COURT: My confusion has been clarified, Mr. Gottstein, go ahead, please.

MR. GOTTSTEIN: Okay. So --

THE COURT: Realizing that you all know far more about mental health issues than I do. Let's put it that way. Go ahead, Mr. Gottstein.

MR. GOTTSTEIN: Well, hopefully some of that is being remedied here.

BY MR. GOTTSTEIN
Q I -- could you look at exhibit -- well, first, before you do that, the -- one of the fundamental premises of TMAP, or the conclusions or the algorithm as you will, is that the newer drugs such as Risperdal are superior to the older generation of drugs, such as Haldol -- how do you say it? Haloperidol?
A Haloperidol.
Q Haloperidol, which is Haldol, correct? And that it's -- that it's more effective and less harmful; is that right?
A The focus of TMAP is to allow a physician to have a systematic approach to illness. And the TMAP does include the first generation antipsychotics, as well.
So it doesn't really say one is better than the other. It's just a systematic approach, a logical approach to treatment.
Q And isn't it true that in that -- and the algorithm is kind of a hierarchy decision tree, correct?
A Of sorts. It's a -- step-wise.
Q Okay. And that you don't go to the first generations, for example, until you have used, say,

Risperdal; isn't that correct?
A Right. You start with the second generation.
Q Okay. And Haldol, I can say that better than -- I can't even say it now after you helped me.
And so what TMAP says is that Haldol should be used -- I mean, Risperdal should be used before Haldol, correct?
A Or one of the other second generations would be step one, yes.
Q Okay. So drawing your attention to Exhibit M, this is -- can I just say? I mean, this is the approval -- does this look like the approval letter for Risperdal? The date is hard to read, but December 29th, and then 1993?
A I haven't ever seen this before, so I'd have to look at it.
Q And in fact, you -- one has to make a Freedom of Information Act request to actually get this, so --
A That's what it looks like.
MR. GOTTSTEIN: Okay. I move to admit.
THE COURT: Any objection to M?
MR. TWOMEY: Well, objection on relevance, Your Honor. I'm at a loss to understand how this document relates to Mr. Bigley's care or the issues presented by this petition we are addressing here

today.
THE COURT: The objection is relevance. It relates to the medication that is being proposed, so I will overrule that.
And I will admit M. Go ahead.
(Exhibit M admitted.)
BY MR. GOTTSTEIN
Q Could you turn to the last page, Dr. Hopson, and read the highlighted portion.
A It says: At the present time we would -- you want me to read it out loud?
Q Please.
A At the present time, we would consider any advertisement or promotional labeling of Risperdal false, misleading, or lacking fair balance under Section 502(a) and 502(n) of the Act if there is presentation of data that confers the impression that Risperidone is superior to haloperidol or any other marketed antipsychotic drug product with regard to safety or effectiveness.
Q And that's exactly what the TMAP does, right?
A I don't think TMAP is trying to advertise that it is superior. They are providing an approach to treatment. I don't think they're saying -- they're not advertising that, or promotionally labeling it as

such.
Q But at least TMAP's conclusion is contrary to what this letter says, correct?
A I don't think they're saying the same thing.
Q And then I -- you're not aware, are you, of the various state lawsuits against -- is it Johnson & Johnson, the manufacturer of Risperdal?
A No.
Q Ortho -- is it Janssen?
A Risperdal is Janssen.
Q And Janssen is a subsidiary of Johnson & Johnson, isn't it?
A I don't know that.
Q Okay. But you are unaware of the various state attorney generals that have sued Janssen over their false, misleading practices over the promotion of --
A I am unaware of that.
Q Okay. Thank you. Now, you testified that there's not a higher probability of recovery with -- let me see exactly what you said, if you can figure out. Maybe you can, you know, restate it to me.
But I think you said something like that you don't think that him -- that Mr. Bigley being allowed some time off the drugs will improve his chances of

recovery?
A This morning, you are talking about the testimony?
Q Yeah.
A I said that I don't think he will recover as spontaneously without medication, in that regard, something to that inference.
Q Yeah.
A Yeah. That's based on our observation of him, repeated hospitalizations, and also seeing how he has responded in the past to medication favorably.
Q But it's -- isn't it true that the hospital's official position is that he's not ever going to recover under your treatment either, the hospital's treatment?
A I think that's -- that's not necessarily a fair statement. I think the hospital's statement would be that if treated appropriately and given the ability to live in stable housing, Mr. Bigley could achieve maximum recovery that's possible for him.
Q And that means, in the words of Dr. Worrell in his testimony, that he would be delusional, paranoid, lacking insight?
A I don't know what Dr. Worrell's testimony is.
Q But you wouldn't disagree with that, would

you? I mean, the testimony has been -- hasn't the testimony really been consistent that the drugs don't really eliminate what you, you know, call delusions, paranoia, and lack of insight? Isn't that correct?
A I think the medications do help to a degree. I mean, I have seen patients get better. And I think -- I have seen Mr. Bigley on medication, and he is able to carry on a much more appropriate conversation and is much calmer and affable.
And I think that would enable him to function at a higher level in the community.
Q Well, I -- I understand you believe he could function at a higher level in the community, and that Mr. Bigley doesn't want to do what you want to do. And I think we could agree on that, right?
But what I'm asking about is recovery. And so the hospital's plan is -- I think it's fair to say assumes that he will always be psychotic, he will always be delusional, he will always be paranoid, he will always lack insight, but that the medications really will make it so that essentially he doesn't get in -- get in as much trouble, I would say?
A I don't think that's the hospital's stand at all. You know, I think that we would hope that with appropriate treatment, that Mr. Bigley will continue

to improve.
I don't think he's had the opportunity to do that. Because he's not been on medication for a long enough period of time consistently to remain in housing long enough to really begin to make some of the gains that we would hope an individual would make in their recovery.
Q Wasn't he voluntarily taking Risperdal Consta for almost two years at one point?
A No. It didn't last that long unfortunately.
Q How long did it last?
A Oh, I would -- I don't have that paperwork with me today. But I know for about six months he came, or his case manager brought him. It may have been longer than that. I don't really know how long.
But that was the period of time I know he was in some stable housing and was doing well. I think it's the whole picture for him.
Q Right. And he was voluntarily taking it, correct?
A Yes.
Q And then when -- then the hospital decided that he needed additional medications, isn't that correct, Depakote and Seroquel?
A I don't recall that. I'd have to look at the

record.
Q But you don't -- can you --
A I know that he was on Depakote and Seroquel at one point. But I don't know that those were prescribed, you know, at that point in time when he was in the outpatient setting.
I think it's also important to note that, you know, immediately before that period of time, when he was in the little outpatient program and coming in every two weeks, he had been in the hospital for a while and had been given medication in the hospital, and had gotten to the point where he was then accepting of it.
And that frequently happens with patients. You know, they are ill. You get them on medication, and then they begin -- their insight improves, their willingness to cooperate in their treatment, and then they could voluntarily agree to a structured outpatient program. But they are just not willing to until they get to that point in their treatment.
Q And he was at one point with the Risperdal, correct?
A Yes.
Q And then you have no reason to doubt it was when the hospital insisted on adding Depakote and

Seroquel that that fell apart, that he then started refusing?
A I don't know that that's necessarily the time. You know, I think it's worthwhile because of his history -- and I did discuss this with Dr. Khari, that I think because his of unwillingness to be on medication, that we should go with just a single agent, and we shouldn't consider other medications. We should make it as simple as possible, where he could accept, you know, the regimen more easily hopefully.
Q Now, API doesn't normally provide -- you said it was an acute care facility, correct?
A Yes.
Q So it doesn't normally provide outpatient --
A That's correct.
Q And so Mr. Bigley was granted an exception for that, wasn't he?
A Under that instance for medication, yes. And that was also part of the plan to transition him then into an outpatient provider in the community.
There again, you have to present -- we present patients all the time for acceptance into an outpatient program. And if they are, you know, well

known, they will frequently say to us, we are not going to accept them. They have the ability to do that.
And so we were hoping that if we could show and demonstrate to them some longitudinal stability, that then they would accept him into their outpatient program.
Q All right. I am going to move on to another area. I think that that's really been pretty well covered.
You mentioned yesterday that what you're doing is the standard of care; is that correct?
A In regards to Medicaid?
Q Yeah. Your proposed --
A Yes.
Q Yes. Okay. Now, wasn't thalidomide prescribed -- wasn't prescribing thalidomide for morning sickness a standard of care in, say, Britain for a period of time?
A I couldn't speak to that as a standard of care. I am not an obstetrician.
Q But you would agree that it was widely prescribed for morning sickness, wouldn't you?
A I have read that, yes.
Q Yeah. And then found out that it was

creating massive amounts of birth defects and was discontinued?
A That's my understanding.
Q Yes. And then isn't it true that in this country, x-rays to diagnose pregnancy was a standard of care, wasn't it?
A I don't know that.
Q So then you don't know that that was discontinued when that was found to cause birth defects and cancer?
A I don't know that. I was not trained as a radiologist.
Q So are you -- you are aware that now recently, hormone replacement therapy was the standard of care with respect to I think -- wasn't it menopause?
A It's my understanding it still is used for that.
Q Well, hasn't there been a huge controversy over that?
A It's probably controversial, but I believe it's still used for that. Again, I am not a gynecologist, but --
Q So then you are unaware that that caused increased breast cancer, endometrial cancer, and

dementia?
A I have heard those sorts of reports. I haven't read that or dealt directly with those patients.
Q So -- but you are aware that DES -- what does that stand -- diethyl -- DES we prescribed for -- to prevent miscarriages and nausea and pregnancy?
MR. TWOMEY: Objection, Your Honor, relevance.
THE COURT: I think we're going far afield. I understand your point, Mr. Gottstein.
MR. GOTTSTEIN: Okay. That the standard of care in the past has often been --
THE COURT: Correct.
MR. GOTTSTEIN: -- found to be harmful?
BY MR. GOTTSTEIN
Q Can I -- I would like to ask one about psychiatric standard of care, if I may, which is that frontal lobotomies were the standard of care for certain conditions, what, about 50 years ago, or for quite some time?
A Probably before 50 years ago. It was a pretty early-on procedure that was performed, a rather radical procedure, yes.
Q And in fact, the person who invented it got

the Nobel Prize, didn't he?
A I am not sure of that.
Q And then that procedure was just stopped, wasn't it?
A It is no longer carried out; that's correct.
MR. GOTTSTEIN: Okay. Thank you.
THE COURT: Any other questions, Mr. Gottstein?
MR. GOTTSTEIN: I don't think so. Thank you, Your Honor.
THE COURT: Thank you.
Recross?
MR. TWOMEY: Nothing further, Your Honor.
THE COURT: Thank you, Doctor. You can be excused at this time.
(Witness excused.)
THE COURT: That brings us to Camry Altaffer; is that correct?
MR. GOTTSTEIN: Yes, Your Honor. But I think that I shall not call her.
THE COURT: All right. And then Paul Cornils. Do you seek to have -- you had questions for him, correct, Mr. Twomey? He's standing in the back. He's anxious.
MR. TWOMEY: All right. I'll be brief, Your

Honor.
THE COURT: Sir, if you would come forward, please. You have been very patient. I appreciate that. All the way around the back, if you would, please. Remain standing, if you would.
(Oath administered.)
THE CLERK: Thank you. You may be seated.
Sir, for the record, could you please state and spell your first and last name.
THE WITNESS: Paul Cornils. P-A-U-L, Cornils is C-O-R-N-I-L-S.
THE COURT: Thank you, Mr. Cornils.
Go ahead, please, Mr. Twomey.

PAUL CORNILS

called as a witness on behalf of the state, testified as follows on:

DIRECT EXAMINATION

BY MR. TWOMEY
Q First of all, I have to ask you, what did you do to your hand?
A I -- yeah.
THE COURT: Well, there is certain similarities there.
A Yeah. I was trying to fix a dryer, severed a tendon in my ring finger and my middle finger.

BY MR. TWOMEY
Q I'm sorry.
A What did you do to yours?
Q I broke my hand in a karate tournament.
A Oh, man. I feel kind of --
THE COURT: All right. Now that we've gotten that on the record, we can continue.
BY MR. TWOMEY
Q All right. Mr. Cornils, do you have any medical training?
A I do not.
Q Are you offering any opinions in this case with regard to the appropriateness of medication for Mr. Bigley's condition?
A It would depend on what you ask me. I do not have any medical training. I have opinions about medication and specific instances.
I have taken medication. The medication that is being considered today, I have taken it. I took it for a long time.
But that's not what I do. What I do is provide case management and rehab services in the community for people experiencing issues like Mr. Bigley's experiencing.
So my opinion about the course of treatment

being proposed I don't know is relevant unless you can --
Q Okay. I just want to make sure that you are not offering an opinion on that subject?
A I am not, no.
Q Okay. Is your -- are your services intended to replace treatment by medicine in Mr. Bigley's case?
A I think that the treatment -- the service that we provide can be provided whether or not Mr. Bigley takes medication.
Q What's the current status of your relationship with Mr. Bigley?
A We have none. Our organization has none at this point. We discontinued our relationship in October of last year due to the lack of resources that were required to provide adequate service to Mr. Bigley.
Q What resources were lacking at that time that caused you to discontinue your relationship with Mr. Bigley?
A Basic needs, housing. Housing is very difficult to acquire for Mr. Bigley. We were successful quite a few times over the course of our time with him, but he -- he's very challenging to his housing providers, and is frequently asked to leave,

or finds housing unsatisfactory and decides to not continue in the placement on his own.

Also his behavior is, quote, often seen in the community as -- it's disturbing to individuals, which necessitates the need for frequent intervention on our part. And quite often when he is not doing well, that can be a 24-hour-a-day thing.

Q So what was the time period that you were involved? Was it a ten-month period of time?

A Off and on from January through October, yes.

THE COURT: Of '07?

THE WITNESS: Of '07.

BY MR. TWOMEY

Q Was Mr. Bigley receiving medication during any of that period of time?

A He would receive medication when he was hospitalized and immediately discontinue it as soon as he was released. He does not like the medication.

Q Did you observe any differences in Mr. Bigley's behavior?

A Beyond the sedative effects, no. His -- his delusions are as strong. His anger and aggression is still present, he just does not express them as strongly.

He is less disturbing most of the time. I don't know if that makes sense to you or not. But if you spend a lot of time with him, like I have, he -- I have not noticed much difference except to say that his behavior is more socially acceptable when he's on medication.

Is that what you're asking?

Q Yes. Thank you.

At the present time, what do you believe is required in order to support Mr. Bigley in the community without medication?

A With or without medication?

Q Without.

A Without? Without medication, I believe Mr. Bigley would benefit from 24-hour-a-day PCA type services, services that are available for folks currently under our Medicaid system who experience developmental disabilities or medical issues. They are not currently available to folks who exclusively have mental health diagnoses.

He needs 24-hour-a-day support. Mr. Bigley, a lot of his behavior in my opinion is driven by fear and anxiety. He does not like being alone.

When he is alone, his behaviors increase. His negative and socially unacceptable behaviors

increase.

Q Are the services you provide intended to cure Mr. Bigley's condition?

A Cure, maybe not. Assist him in his recovery, yes.

Q Do you have any basis to disagree with the approach being suggested by the hospital that Mr. Bigley be given Risperdal Consta?

A My personal opinion or that of my organization? My personal --

Q In this case, do you have an opinion on that?

A In this case? I absolutely understand both sides of the argument. But I think without -- I think without an ongoing plan -- Mr. Bigley, one, very clearly does not want to take the medication. And in my experience with Mr. Bigley, just my experience with Mr. Bigley, as soon as he is released from the hospital, he will discontinue taking that medication.

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

Q Is there anything preventing your organization from assisting Mr. Bigley should the hospital be granted permission to administer Risperdal?

A We lack the financial resources to provide the service -- the support that Mr. Bigley needs at this point. These issues have been addressed over the last -- since my involvement over the last ten months by many individuals who have access to -- greater access to resources than I have. And they've -- we have not reached a solution.

Housing is the -- besides the 24-hour support, the housing is the biggest issue. What Dr. Hopson testified to, the difficulty in acquiring housing for Mr. Bigley, is very real.

I cannot think of an assisted-living home that would accept him. I have contacted most of the assisted living homes in our area, lots of programs outside of our area, just as Dr. Hopson testified, hotels, other housing situations. He has a reputation, and that reputation precedes him.

MR. TWOMEY: I have nothing further, Your Honor.

THE COURT: Go ahead, please, Mr. Gottstein. Any questions?

PAUL CORNILS
testified as follows on:
CROSS EXAMINATION
BY MR. GOTTSTEIN
Q Now, you testified here this morning that you believe he needs 24-hour PCA. That stands for personal care attendant; is that correct?
A Yes, sir.
Q Now, in your written testimony, you say that you think there is a reasonable chance that if that was provided now, that over time, that could be reduced; is that correct?
A Yes. And I think we demonstrated that early on with Mr. Bigley. His behaviors did diminish and his need for assistance did diminish, but it was very slow. And I was providing all that care, and it is emotionally exhausting and very expensive.
But with the proper -- the appropriate resources, I do believe that he could improve and maintain in the community. And I don't -- I don't think that medication necessarily has to be a part of that plan. I don't know that it doesn't, but I don't think that -- I think his -- maybe I'm going beyond what I should answer.
But I think that Mr. Bigley's desire to not

have medication would not impede his ability to function in the community given the appropriate support to be maintained outside the hospital.
THE COURT: I'm not sure I understand that. His desire not to have medication would not impede his ability to function outside the --
THE WITNESS: Right. Given the appropriate support, Your Honor.
And I believe with my experience with Mr. Bigley, quite frequently, the issues that I would intercede on or be asked to provide support were Mr. Bigley having conflicts with his public guardian or other individuals who he perceived as wanting him to take those medications and limit his rights.
It makes him quite angry. And you can see when he gets agitated just here in the courtroom how he expresses that anger. It's disturbing to the public in general, which -- very understandably so.
Which then generally, law enforcement is called, he is ex parted or he is escorted and readmitted to the hospital.
I think that if you at least gave him the ability to choose, you would mitigate that. And that, in my experience with him, was a big factor in the behaviors that I saw.

THE COURT: Okay. Thank you.
Go ahead, please.
BY MR. GOTTSTEIN
Q So just to be clear, to eliminate the double negative, is it your testimony that you feel that he could be successful in the community with the support without the medication?
A Given the appropriate support, yes.
MR. GOTTSTEIN: Okay. I have no further questions.
THE COURT: Any follow-up, Mr. Twomey? Go ahead.
MR. TWOMEY: Yes, Your Honor.
PAUL CORNILS
testified as follows on:
REDIRECT EXAMINATION
BY MR. TWOMEY
Q Mr. Cornils, you indicated that you believe that Mr. Bigley should be given the opportunity or ability to choose his course of treatment?
A Yes.
Q Do you think he has the capacity to make such a decision?
A Yes.
Q And why do you have that opinion?

A I think that given that Mr. Bigley has taken that medication or medications for 25 years or so, he very clearly -- I've seen him on the medication and off the medication. He very clearly expresses: I do not want to take this medication.
And the hospital's assertion is that when he's on the medication, he is competent, that he does not present a danger to himself or the community, and he is released, and he is able to join our community. That implies a level of competence.
And when he is at that place, he still asserts that: I do not want to take this medication. I don't know if that makes sense to you, but whether or not he's competent, the fact remains, Mr. Twomey, he is going to stop taking that medication once he's released from the hospital, and this cycle is going to continue.
So I do not believe that it is in anybody's best interests to continue to do this.
Q What is your relapse plan for Mr. Bigley?
A With Mr. Bigley, you really need to -- what do you consider to be a relapse?
Q Well, your affidavit indicates -- one of your tenets of the Choices approach is what is known as a relapse plan. I am asking in this --

A Right. So in Mr. Bigley's case, it's kind of been ongoing -- let's see how I would describe it. A relapse plan is generally in place for individuals who experience intermittent crisis. Mr. Bigley's case, his behavior is almost on a daily basis described by somebody he comes into contact with as a crisis.

What we do in that case is I or one of my colleagues go to wherever Mr. Bigley is and intervene, which generally involved negotiation and discussion. And it works. So we discuss with him how to better approach his particular issue that they -- without being aggressive and angry, which is quite -- most often, 90 percent of the time, the behavior that's getting him in trouble is his anger and his aggression are disturbing to the community.

Q Does Choices work with clients who are on medication?

A Yes. Choices, with or without medication. If the individual chooses not to take medication, and that is something they have worked out with their medical provider and they have a plan to manage their issues without medication, that's something that we support. And we assist them in developing plans to manage their behavior without medication.

But medication or not does not preclude

somebody from service.

Q Does Choices work with any clients who are refusing to take medication against their physician's recommendations?

A No. And our medical director at this time would not support that.

Q Am I correct in understanding that your medical director would not support Choices working with a patient or a client --

A Who is --

Q -- who was refusing to take medication against physician's recommendations?

A Against their -- yes, sir, that's correct.

Q And it's your understanding in this case that Mr. Bigley's treating psychiatrists are recommending that he take medication, correct?

A It is.

MR. TWOMEY: No further questions, Your Honor.

THE COURT: So would you be available to provide services to Mr. Bigley if he chose not to take medication at this time?

THE WITNESS: That is kind of a -- maybe. I would have to have a discussion with our medical director, and we would have to identify the

appropriate resources.

I would not be willing to begin to provide services to Mr. Bigley at this time without the appropriate financial resources, so that --

THE COURT: Well, setting aside the finances, I am trying to follow up on Mr. Twomey's questions, which was --

THE WITNESS: Which is I currently do not believe our medical director would agree.

THE COURT: To provide services without medication?

THE WITNESS: Yes, ma'am.

THE COURT: Follow-up on that question, Mr. Twomey?

MR. TWOMEY: No, Your Honor.

THE COURT: Mr. Gottstein?

PAUL CORNILS

testified as follows on:

RECROSS EXAMINATION

BY MR. GOTTSTEIN

Q I guess I want to -- would like to start with the last one. But if -- if Mr. Bigley had a psychiatrist who was willing to work with him without medications, then Choices would?

A Yes, sir.

Q That's correct. Okay. And in fact, when he -- when he's discharged from API, then he really doesn't have a treating physician; is that correct?

A That's correct.

Q Okay. Now, Mr. Twomey asked you about the -- I think the WRAC plan, the Wellness Recovery Action Plan, and I think --

A I don't recall.

Q -- or relapse plan, correct?

A Yeah. A relapse plan, right.

Q And you said that that wasn't really appropriate for --

A Well, I'm not saying it's -- it's -- it is appropriate.

But how relapse is generally viewed from a case management standpoint is that you have an individual who has, quote, stable behavior who reaches a point where his -- his or her behavior is no longer stable in his approaching crisis. At that time, a relapse plan is implemented.

In Mr. Bigley's case, his behavior is viewed by the community as almost constantly being in crisis. So our plan is to -- and my personal approach with Mr. Bigley was to intervene at the earliest possible point that a crisis was identified, and we'd negotiate

and discuss and find a different way to approach whatever issue he was trying to handle.
Q So is it fair to say that when you were with him, you could avoid those problems?
A Yes, sir.
Q Okay. And you -- and it's your testimony that if people were with him, you know, through -- you are saying 24 hours, but throughout the day, that that would probably avoid crises?
A Yes.
Q Okay. And in your written testimony, getting more directly to that, Mr. Twomey's question, I think you testified that you used other specific approaches that you've been trained in; is that correct?
A I do. I have kind of an eclectic approach. But I have been trained in Moral Reconation Therapy, anger management, PEER support, a lot of different psychosocial approaches. I have been doing this for ten years, and quite successfully.
Q So in terms of anger management, could you tell the court, you know, what sorts of things that you would be doing, and then how you feel it might play out with Mr. Bigley?
A Well, in -- with Mr. Bigley, relationship is key. So he has to feel that you're trustworthy,

that -- you have to earn his trust before he'll actually negotiate and respond to anything you have to say, with anything other than derision.
But my approach is negotiation and discussion. You can actually engage Mr. Bigley in discussion and --
Q May I interrupt you for a second? And that includes when he's not taking his medication?
A Yes, sir. My experience with him -- my personal experience with him is that he never took medication or he was in the process of discontinuing medication. So I have never worked with him while he was consistently taking medication.
Q I'm sorry for interrupting. But please continue.
A If you treat Mr. Bigley with respect and recognize that most of his behavior it driven by fear and anxiety, you can negotiate with him fairly easily.
Q So when you talk about negotiation, are you -- does that mean not coercing him?
A Yes.
Q And so do you think that the coercion is currently in the system is -- it would be a big factor in the problems that he -- the behavior that he exhibits?

A I -- I really can't speak to the system. But I can speak to my personal relationship with Mr. Bigley. He recognizes coercion and he resents it, and you pay for it.
He gets -- he gets angry and agitated and you pay for it. So I can't speak to any other situation. But to my relationship with him, yes, coercion does not work.
Q Could you explain Moral Reconation Therapy a little bit?
A Moral Reconation Therapy, I use parts of it with Mr. Bigley. It is an approach used primarily with antisocial personalities. It is very popular in corrections settings.
It stresses personal responsibility, and owning one's behavior, taking responsibility for one's behavior regardless of circumstances or perception.
Q And do you think that Mr. -- is it your opinion that Mr. Bigley would benefit from that?
A He has. I -- he has benefited from the approach. He has never -- I haven't worked with him long enough to -- to have -- to do anything specific with him.
My experience with Mr. Bigley has -- you know, besides my relationship, I did enjoy my time

with him, even though it was draining -- is generally helping him meet his basic needs, and in building trust that way, housing, food, those types of things.
And you know, I regret that we weren't able to provide that to the level that I think was necessary a lot of times.
Q Did you have trouble getting -- you know, did you have trouble with Mr. Bigley eating when you were working with him?
A Yes.
Q Yes?
A Yes.
Q And then how did you deal with that?
A I would take him and we'd go eat, or I would --
Q So if you went to -- say to lunch with him, he would have lunch with you, no problem?
A Nine out of ten times. Sometimes he would believe that the food was improperly handled or he would express that maybe it was poisoned or -- but quite frequently, I would eat -- I would eat off of his plate, and he would see that I was okay, and he would eat.
Given his own devices, though, he does not choose a healthy diet. He would live off of Coke and

Ding Dongs.
Q Do you think that if Choices had resources and opportunity, including housing and time to spend with him, that Mr. Bigley would have a reasonable prospect of being able to handle his nutritional needs better on himself -- by himself?
A I would think there is a reasonable chance. I believe his quality of life, regardless, would improve.
Q Right. And that, just to be clear, is without medications, correct?
A Correct. I think with or without.
Q With or without?
A Right.
Q Okay. Now, could you describe -- you said the elements of peer support. What do you mean by that?
A Peer support, one of the reasons that I have been able to connect with -- I was able to connect with Bill early on was that even though I don't have the depth of his experience, I do have personal experience with the mental health system.
I have been hospitalized. I have taken many of the same medications that he's taken. I have experienced the feeling of helplessness and a lack of

control you feel when you are in a situation. And I am able to empathize, and he recognizes that.
Q And is that a well-recognized phenomenon within the mental health field?
A Oh, it is. We are just gaining a foothold here. But across the country, states like Georgia, Tennessee, Connecticut, New Hampshire, they have -- their state departments of behavioral health or health and human services primarily take a peer-support approach. And they encourage -- they encourage choice, and consumer-directed services, which are services provided to mental health consumers by other mental health consumers. And very much like Choices.
Q And is it fair to say that it's really this peer-support method that has proven to be most successful in helping people recover?
A Yes.
MR. GOTTSTEIN: I have no further questions.
THE COURT: Have you -- last year, did you make any efforts at all to find a healthcare -- mental healthcare provider for Mr. Bigley outside of API?
THE WITNESS: There are none in our community that I am aware of that are willing to take the risk.
THE COURT: And why is that?
THE WITNESS: They see -- there is a legal

medical risk that I'm just beginning to understand. But I am not -- I am not a physician, and I am not a psychiatrist.
THE COURT: I understand. It's from that perspective.
THE WITNESS: So there -- there is a risk to -- before a psychiatrist or doctor -- my understanding, to providing -- to be providing treatment to an individual that is not compliant with the treatment.
So I assume, at least with our medical director, his concern is that an individual that we are serving go out and, God forbid, do something harmful in the community, that the psychiatrist would ultimately be held responsible for the behavior because he is ultimately overseeing the treatment, or she.
THE COURT: So based on the time you spent with Mr. Bigley, there is no medical care provider here in Anchorage currently available to him?
THE WITNESS: None that I am aware of, no. I haven't addressed that since October, but --
THE COURT: Right.
Follow-up on that topic, Mr. Twomey?
MR. TWOMEY: No thank you, Your Honor.

THE COURT: Mr. Gottstein, follow-up on that topic? That one topic. Let's not stray. But go ahead.
MR. GOTTSTEIN: Well, he testified about -- yes, I think this is within that.

PAUL CORNILS

testified as follows on:

RECROSS EXAMINATION

BY MR. GOTTSTEIN

Q Now, is it your understanding that in spite of all the things that happened -- has happened, you know, and been done to Mr. Bigley over the years, that he's never harmed anybody?
A Is my understanding. My opinion is that he's -- his personal well-being when he's in the community is my concern.
I believe that he is in danger, just as Dr. Hopson testified, of being assaulted, injured. I witness those types of incidents. I have intervened in those types of incidents on Mr. Bigley's behalf.
But I have never seen him assault anybody. I have never even seen an indication that he would.
Q And actually this surprises me, because I have heard -- I mean, you know, I kind of know of situations where people have gotten mad at him. But I

have never heard anybody else ever testify that he's actually been assaulted by anybody.
A No, he has never been assaulted. I have intervened -- the incidents -- there is an incident that stands out in my mind.
I want to say it was August of this past year, we were in Carrs, in a Carrs grocery store purchasing Mr. Bigley's groceries. And he didn't like the way a gentleman in the bread aisle was staring at him, and he let him know.
And the gentleman took exception with that. And had I not intervened, I believe Mr. Bigley would have been -- he would have been assaulted.
Q But it -- to your knowledge, it's never happened?
A It's never happened, and he's never reported that it has.
Q And so is it your experience that he -- he is actually pretty good at disengaging, you know, before that happens?
A Yes, most of the time he is. And I think he is very good at selecting his targets.
Q And so you know, it could very well be that he would have disengaged sufficiently not to have been assaulted in Carrs?

MR. TWOMEY: Objection, Your Honor. Lack of foundation. Calls for speculation.
THE COURT: That's sustained. My topic was --
MR. GOTTSTEIN: The doctor.
THE COURT: -- the effects as to mental healthcare outside of API.
BY MR. GOTTSTEIN
Q Okay. And so whether or not he has a doctor that's willing to work with him without medications, he -- once he's out in the community, he won't be on medications; is that correct?
A That's my understanding.
MR. TWOMEY: And, Your Honor, calls for speculation.
THE COURT: Well, I think the witness has testified his opinion on that already, so --
MR. GOTTSTEIN: Okay. Thank you, Your Honor.
THE COURT: All right. Follow-up at all?
MR. TWOMEY: No, Your Honor. Thank you.
THE COURT: Thank you, sir. I hope your hand gets better.
(Witness excused.)
THE COURT: I hope yours does, too, Mr. Twomey.

MR. TWOMEY: Thank you.
THE COURT: All right. Why don't we take a short break here, and then I will hear each side on some closing argument on these issues, unless I am overlooking any other witnesses.
Mr. Twomey, anybody else on behalf of the State?
MR. TWOMEY: No, Your Honor.
THE COURT: Mr. Gottstein?
MR. GOTTSTEIN: No, Your Honor.
THE COURT: All right. And how long would you -- would you request to have -- for closing, Mr. Gottstein?
MR. GOTTSTEIN: Twenty minutes.
THE COURT: All right. Mr. Twomey?
MR. TWOMEY: Five minutes, Your Honor.
THE COURT: All right. Why don't we take about five to ten minutes, and then I'll hear from both sides. We will go off record.
11:30:23
(Off record.)
11:44:45
THE COURT: All right. We are back on record here.
Mr. Twomey, are you ready to proceed?

MR. TWOMEY: Yes, Your Honor.
THE COURT: All right. Go right ahead, please.
MR. TWOMEY: Thank you. Your Honor, API is here asking the court to do what is right for Mr. Bigley. I think that there is a number of people in this courtroom who want to see Mr. Bigley's condition improved.
However, there is disagreement as to the most appropriate method for achieving success in Mr. Bigley's case.
What we have is a chronically ill mental patient who has experienced a history of admissions to API, cycled in and out of the system, and at this point, we have got -- the only medical care providers willing to treat him are those doctors at API who are now working with Mr. Bigley and who are asking this court for permission to administer medication that they believe will be beneficial for his condition.
There has been testimony presented by the doctors at API that administration of Risperidone Consta for Mr. Bigley's condition at this point in time is within the standard of care, not only in this community, but would also fall within the standard of care in 26 other states, that follow the Texas

Medication Algorithm Protocol.

There has been no testimony from any witness to indicate that what API is proposing is not within the standard of care currently here in Alaska, or elsewhere in the United States.

The testimony presented on behalf of Mr. Bigley from the doctor back east and by way of various journal articles and publications is that there may be a change in the standard of care at some point in the future, that there may be some undisclosed risks to these medicines that the doctors have not been fully informed about.

But we are not here in this proceeding today to debate the appropriateness of these medicines, their approval or the approval process through the FDA or the disclosure of information to physicians. We are here to address Mr. Bigley's condition.

And we have heard testimony from Dr. Khari, Dr. Hopson indicating that they believe that Mr. Bigley should receive Risperidone. They believe that based upon their medical training, their experience with not only Mr. Bigley, but with other patients, and significantly with Mr. Bigley, the experience has been that when he is on medication, he does much better. When he is off his medication is

when he has difficulty in the community.

We've heard testimony this morning from Mr. Cornils at Choices indicating that even Choices is not a viable option to deal with Mr. Bigley's condition in the absence of him taking medication. The medical director of Choices would not accept Mr. Bigley as a client knowing that Mr. Bigley would refuse medication against physician's orders.

So we really need to get Mr. Bigley stabilized and to a point where he is willing to accept treatment outside of the acute care facility, which is API.

Now, API is an acute care hospital. It is the only mental psychiatric hospital in the state. We have a very important role to fulfill. Dr. Hopson has explained that there is a waiting list to be admitted to API. Very important that we treat patients effectively, efficiently, and move them out of the system.

We do not want to see Mr. Bigley as a long-term resident of API. And we can't change the mission of API from an acute care facility to a residential housing option for Mr. Bigley so that he can come and go as he chooses in order to facilitate his functioning in society.

What we need is medical care for Mr. Bigley. And there is a process set forth in our statute that allows API to seek permission to administer this medication over the objection of Mr. Bigley when the court finds that Mr. Bigley is not competent to consent to the administer -- administration of the medication.

I think that API has established that Mr. Bigley is not, in fact, competent. We have heard from the visitor, who has indicated that over her years of experience in interviewing and working with Mr. Bigley, she has observed a decline in his capacity.

The most recent attempt by the visitor to interview Mr. Bigley was unsuccessful. He wasn't even able to speak with her and complete her assessment of his capacity. She believes he is not capable of giving informed consent.

He doesn't appreciate and understand his condition. Although he has made statements in the past that he does not want to take drugs, I think that's clear that he has made those statements.

However, the fact remains that he has taken the drugs in the past, and when on the drugs, he functions at a much higher level in society. He stays

out of trouble, does not present a danger to others or to himself.

And we really need to stop the cycle of in and out, and we need to do what's right for Mr. Bigley. The physicians taking care of him are urging this court to do what's right and to grant permission so that they can give him the treatment that they believe is within the standard of care and that they believe will assist him in achieving a higher level of function in our society.

This proceeding here is not about the appropriateness of our statutory scheme for granting permission. It seems to me that some of the arguments that we have heard, some of the testimony that's been offered goes to the issue of whether or not there should be a procedure for coercion in terms of administration of medicine. And that's not what this case is about.

This case is about compliance by API with the statutory requirements, not a debate over whether that statute should exist in the first place.

The court has heard testimony about the specific medicine that we were requesting permission to administer here, Risperidone Consta. The testimony is that that medicine may carry some side effects.

And there has been testimony from the physicians as to how they will monitor for those side effects.

In fact, some of the side effects that are of concern in Mr. Bigley's case are not at this point in time a significant concern. He does not have diabetes. He is being monitored, his blood glucose levels. Weight gain is not a concern for Mr. Bigley. In fact, he could use a little additional weight.

THE COURT: Mr. Twomey, do you have a position as to whether an order that was restricted to one type of medication is appropriate or consistent with the statute?

MR. TWOMEY: I'm not sure I understand.

THE COURT: So that rather than an order being entered that simply authorized the involuntary administration of medication, the court order would indicate that API was authorized to administer Risperidone Consta? Do you understand my question?

MR. TWOMEY: As opposed to a more general order?

THE COURT: Correct, correct. Whether that's appropriate or statutorily consistent with -- or consistent with the statute or warranted.

MR. TWOMEY: I think that the statute contemplates psychotropic medication. Risperdal

Consta would be such a medicine. Medicines that are not psychotropic, I think, would fall outside of the scope of the statute.

THE COURT: So to specify -- I guess my question is to specify the type of medication based on the evidence, is that appropriate or outside the -- the statutory scheme?

MR. TWOMEY: Well, I believe it would be appropriate to specify, Your Honor. I believe a statute addresses psychotropic medicines or medications.

So for instance, if Mr. Bigley's physicians felt that it was in Mr. Bigley's best interests to receive a psychotropic medication in addition to some other medication, they would make that recommendation.

If Mr. Bigley refused to take the other non-psychotropic medication, then they could seek approval from Mr. Bigley's guardian to administer that medicine for Mr. Bigley.

But I believe that the statute addresses only the psychotropic medicine.

THE COURT: And to specify a specific psychotropic medicine based on the evidence presented is within your reading of the statutory scheme?

MR. TWOMEY: It is, Your Honor.

THE COURT: Thank you, Mr. Twomey. Go ahead, please.

MR. TWOMEY: And we have heard testimony, Your Honor, as to what the doctors wish to prescribe.

THE COURT: Correct, correct.

MR. TWOMEY: The dosages and method of administration, and so forth.

THE COURT: Right.

MR. TWOMEY: I think it's important for the court to hear that and to consider that evidence --

THE COURT: All right. Thank you.

MR. TWOMEY: -- as part of the court substituting its judgment here in terms of consenting to the medication, on behalf of Mr. Bigley, due to the fact that Mr. Bigley lacks the capacity for making that decision on his own.

API wishes to make clear that we don't come to court with every patient or every schizophrenic patient that we provide treatment to.

Mr. Bigley is, however, a chronic patient. His history is such that the only viable treatment available for him at this point in time is the receipt of medication.

Keeping him at API without treating him does no good for Mr. Bigley's condition. So we really have

our hands tied if the court refuses to grant permission to treat Mr. Bigley by medication. The evidence is that the psychosocial support will not be successful without medication.

It's like going to the doctor with chest pain and before having the personnel at the emergency room hook up the EKG to see what's going on with your heart, to have a social worker come in and talk about your diet and social factors that may affect your heart health.

So we really need to treat Mr. Bigley appropriately. And that treatment is medicine in this case. Despite the fact that there may be some debate in the medical profession over the effectiveness of these current medications, there is no viable alternative.

Non-treatment is not going to be appropriate for Mr. Bigley. What we have seen is a decline in Mr. Bigley's functioning. In the past, Mr. Bigley has been able to provide for his basic needs. That ability to function in society has declined to the point where he is no longer able to provide for his basic needs.

There's been testimony, both here in this proceeding and in the commitment proceeding, that

those basic needs are not able to be met at this point in time, even with the extraordinary efforts of people like Mr. Cornils and the guardian who is assigned to Mr. Bigley's case.

There is no place for Mr. Bigley to live. He is unable to maintain for his own safety. He is threatening other people in the community. They feel threatened.

In fact, Mr. Gottstein has called the police to have Mr. Bigley removed from his office on multiple occasions. There have been incidents at First National Bank where they have now hired a security guard in response to Mr. Bigley and his behavior.

So it's time that something be done to stop this cycle and the decline that we are observing with Mr. Bigley's condition. And we are really urging this court to grant the permission to treat him and to treat him appropriately within the standard of care, with the hopes that he can improve his level of functioning, and with appropriate supports, regain some level of functioning in society that is acceptable and that will keep him from cycling in and out of the jail system and API.

Because we don't want to see Mr. Bigley come to any harm. We want to do what's best for him and

care for him. And that's what we're asking the court to do.

THE COURT: Thank you, Mr. Twomey.

MR. TWOMEY: Thank you, Your Honor.

THE COURT: Mr. Gottstein, go ahead, please.

MR. GOTTSTEIN: Thank you, Your Honor. As a preliminary matter, I think I've already done it, but I want -- in the submission -- or the limited entry of appearance in the documents is that -- and I think that the state is a long way from even proving its case by a preponderance of the evidence, let alone clear and convincing, as it needs to do.

But while normally there is a delay in time for the effectiveness of an order, I feel like I have -- and I have prophylactically moved for a stay pending -- you know, to allow time to appeal if the decision were to go against Mr. Bigley.

And so I just want to -- if it's not clear that that motion has been made, I am making it now. Irreparable harm is, as based on the testimony presented here, and that's Dr. Moser's testimony, Dr. Jackson's testimony, Mr. Whitaker's testimony.

I'd also note that the Alaska Supreme Court in both Myers and Wetherhorn acknowledged that what the hospital -- what the state is proposing here has

been equated with the intrusiveness of lobotomy and electroshock. And so we're talking about very severe irreparable harm. And Dr. Jackson, you know, talked quite a bit about the brain damage caused by these drugs.

So -- and I would also note that there was a stay pending appeal during the pendency of the Myers appeal while she was there. So anyway, just to be clear on that, because -- okay.

With respect to the competency, I think we went over that quite a bit on Monday, the arguments and stuff. God, my language. Stuff. On that.

But I want to emphasize that there are instruments that have been validated for the assessment of competency, in addition to -- you know, in addition to the Meyer arguments that they are really inconsistent -- logically inconsistent to say that he is competent to accept the medication. As soon as he decides not to, then he is incompetent -- are inherently an admission that he is competent, in that the most it proves is that the treatment has turned him incompetent.

But in addition to that argument is that there are these capacity instrument -- assessment instruments that have been subjected to critical

review as to their validity, strength, and weaknesses. And I'd refer the court to Grisso, G-R-I-S-S-O, et al., evaluating competencies, forensic assessments and instruments, pages 404 and 50, second edition, 2003.

THE COURT: Well, given what's in the record here, what evidence would you point to with respect to demonstrating Mr. Bigley's competency?

MR. GOTTSTEIN: I think that it's basically been admitted that he was competent to accept the medication, and that that logically requires that he's competent to decline it. And that's admitted, and by the state.

And I think it's also been admitted that no valid competency assessment has been conducted.

THE COURT: So you are -- let me make sure I understand your argument. With respect to his current competency, I understand your position that there has been no formal competency assessment. Is there other evidence that you would point to with regard to Mr. Bigley's current competence?

MR. GOTTSTEIN: Yes, Your Honor. And Mr. Cornils this morning testified he thought he was competent.

And I think that -- and he was, I think, very astute in the way he went about it, which is that for

28 years, Mr. Bigley has experienced this. And he knows how it feels and all that. And it's just, I think, a glib response to say that he's incompetent over all that time, and with all that experience that he has with it, so I thank Mr. Cornils, and all that.

The state has focused on the statutory issue of competency. But really, Myers, you know, essentially declared that unconstitutional. And I would point that the court is required to find, in addition to by clear and convincing evidence that he has never been competent and is incompetent now, that it's in his best interests, and there is no less-intrusive alternative.

And Mr. Twomey just totally ignored that in his -- in his argument. So -- and I would draw the court's attention to footnote 25 of Myers, where the court says that at a minimum, I believe it says, that the information set forth in AS 47.38.37(d)(2)(d) should be looked at. And the ones that I really want to -- do you want to --

THE COURT: Go ahead. I know I had Myers here earlier this week, and I am looking for my copy. But that's fine. I know where to find it.

MR. GOTTSTEIN: I can get you a copy if you like.

THE COURT: Go ahead, Mr. Gottstein. That's fine.

MR. GOTTSTEIN: But --

THE COURT: Oh, I found it. Go ahead, please.

MR. GOTTSTEIN: Okay. So look at -- I think I want to highlight a couple of them or a few of them, is the prognosis or the predominant symptoms with and without the medication.

THE COURT: So are you referring to footnote 25 now?

MR. GOTTSTEIN: Yes.

THE COURT: All right. I see it right here.

MR. GOTTSTEIN: Okay. And so what -- what we really have heard from the hospital is we are just going to have this continued psychosis, continued revolving door. They are going to continue to, you know, pump him full of drugs, literally pump him full of drugs while he's there, and then he'll go out and quit, and that he won't -- he won't recover. And that is his prognosis.

Whereas we have got a lot of testimony in the record here by Mr. Cornils, also by Mr. Whitaker, and Dr. Jackson, and Lawrence Moser, and Sarah Porter about -- including very chronic patients have a

reasonable prospect of recovering if they're given a chance to get off these drugs.

And Dr. Jackson really explained how these drugs are causing this chronicity and causing this decline -- that causes declines in people, and that's entirely consistent with what -- with what the hospital has testified to.

THE COURT: So what alternative would you propose for Mr. Bigley?

MR. GOTTSTEIN: Well, I've got -- you know, I have proposed it. And --

THE COURT: That he can come and go from API, basically?

MR. GOTTSTEIN: Well, it's kind of housing of last -- I mean, I really would think that as I repeatedly said, you know, that the -- you know, we should try and get together and work this out.

And the hospital has been very clear, just will refuse to consider anything that doesn't require medication. And that's very clear in the testimony.

And Dr. Hopson, you know, stated his reasons for it. And the only problem with that is it's unconstitutional. And so there is a less -- motion for less-intrusive alternative that was, you know, filed in the previous case. But it's basically the

same thing.

But the API thing -- or the API is really housing of last resort. Because what we heard consistently from people, and especially from Mr. Cornils, who no doubt has had more time with Mr. Bigley than any other person that testified, that this housing is critical. And when he loses it, that's when things deteriorate.

So I don't think anybody expects that Mr. Bigley really at this point would even voluntarily go to API. But I think it should be an option for him. I think it's constitutionally really required.

THE COURT: So how would he receive mental health treatment under your proposal?

MR. GOTTSTEIN: Well, I -- you know, Dr. Hopson has equated treatment with drugging. And so then you know, Mr. Cornils and these other people, Dr. Moser, Sarah Porter, (indiscernible), Mr. Whitaker, and Dr. Bassman explained that there are other approaches that work.

THE COURT: And I haven't heard with regard to Mr. Bigley in Anchorage, Alaska who would provide him care, or who's willing to.

MR. GOTTSTEIN: Well, I mean, I think that the hospital is required to provide a constitutional

level of care. And that's what Wyatt versus Stickney out of Alabama in the federal court, under the federal constitution requires that.

And then in Alaska, there's -- it's a little different place on my outline here. In the Molly Hooch case, 536 Pacific Second 793, 809, indicated that the court won't hesitate to intervene if a violation of the constitutional rights to equal treatment under either the Alaska or United States constitution is established.

In that case, it was a question of whether or not the court was going to mandate that -- the state --

THE COURT: I am very familiar with the Molly Hooch case.

MR. GOTTSTEIN: Okay.

THE COURT: So you can move on.

MR. GOTTSTEIN: So -- well --

THE COURT: I understand. It is an education clause case.

MR. GOTTSTEIN: But there is an analogy here. There is no due process.

THE COURT: Go right ahead.

MR. GOTTSTEIN: But the point is that the state may not provide -- provide social services in an

unconstitutional manner.

And it's required to provide the service if it's available -- if reasonably available. And they could make it available. They can't just decide not to make it available. API could provide that treatment, and I think the court should order it.

THE COURT: Well, I guess what you are seeking to have is an order that API provide mental health treatment that does not include drugs?

MR. GOTTSTEIN: Excuse me, I'm getting excited here.

THE COURT: That's all right, Mr. Gottstein.

MR. GOTTSTEIN: It's really very carefully laid out. And a lot of thought has gone into it, which is basically that he -- that there be someone with him. And API can provide that. They can pay someone to be with him. And if funds are found another way to do that, then that would be fine, too.

And in fact, in the January placement, what was called, at country club, the state went and got a special source of funds to provide extra money for an assisted-living facility that required him to take the drugs. And of course, that didn't work out. And they should be required to do that and provide services in a constitutional manner.

So we've had testimony -- in fact, Dr. Hopson testified that this intensive case management would work for Mr. Bigley. And I think the hospital should be required.

And the other thing is this housing is -- everybody should work together to get housing that will work for him. And that also requires the ability to have someone kind of help him keep it.

And the other part of it is right now, he is getting $10 a day to -- you know, to live on with food and everything. And that's unreasonable. And the rest of his money is being budgeted for housing. And it's just unreasonable.

And so I think the state is required to do that. And there are various programs that can provide subsidized housing. And I think that those can be looked at. And in the absence of that, that the hospital should provide that. And it's acknowledged that Mr. Bigley is a unique case.

And again, I think having invoked its awesome power to come to this court and try and get this court to forcibly drug him, that these rights to a less-intrusive alternative spring into action.

Now, I think it's ambiguous what available means in Myers. Does it mean that the state can just

choose not to provide it? And I think that's kind of the -- the -- that's the attitude that the state is taking.

But that's -- I don't believe -- that is not constitutional. This service could be -- the services that Mr. Cornils described can be provided and the court should order it.

Okay. So there's -- I think the first thing after the limited entry of appearance is the motion for less-intrusive alternative.

THE COURT: I don't think one was filed in this particular case.

MR. GOTTSTEIN: Well, maybe --

THE COURT: I have copies of your pleadings in other cases.

MR. GOTTSTEIN: Right. And so I am making the same motion now. And I think really under Myers I don't really have to make the motion, because the court has to find that there is no less intrusive alternative. But I am making that motion.

THE COURT: But you're seeking to create an order that would create a less restrictive alternative, as opposed to a demonstration by the state that there is no other option available, as I understand it.

MR. GOTTSTEIN: It's clearly available. All they have to do is pay for it. I mean, API can do it.

Okay. I am a little bit off track here. But I think this was good, because I think this is one of the core issues in the case.

And in footnote 25(c), a review of the patient's history, including medication history and previous side effects from medication. And it is very clear that for 28 years, the hospital's approach hasn't worked. You know, end of story.

Mr. Cornils described it as futile. You know, that is very clear. Okay. And information and alternative treatments, their risks, side effects, benefits, including the risks of non-treatment.

And I think there is a tremendous amount of testimony about that, same people, in terms of alternatives, Sarah Porter, which I really -- I assume Your Honor will read it. It's very informative about how you work with people to, you know, move to the place -- really what the hospital is saying, where they become -- so it becomes a cooperative effort.

And as Mr. Cornils says, that can include medication or not. And this isn't about medication or not medication. It's about the state's right to force, and there are very strict limitations on that

as opposed to a cooperative approach.

And when you -- when you read Ms. Porter's testimony, you will see that it really confirms what Mr. Cornils was saying about how when you get into this coercion situation, that, you know, then you are in a fight. And that's very counter therapeutic.

And Dr. Moser, who the Alaska Supreme Court acknowledged in Myers was -- had especially impressive credentials. His testimony goes directly to this issue of how counter therapeutic coercion is. And one of the interesting things is that he said that he had been with more unmedicated people who were with psychosis than anybody alive today he thought.

And he has passed away now, may he rest in peace. A beautiful man.

And he had never had -- he had never had to file a commitment on anybody because he spent the time and effort to work with someone. And that's with everyone.

The other thing I thought was very interesting, and he said, and I find them among my most interesting customers, and that's, I think, really an important point.

And then number -- where is it. Oh, the court also referred to -- cited with approval, the

supreme court of Minnesota. And the one I want to really focus on is No. 5, the extent of intrusion into the patient's body and the pain connected with the treatment.

And Dr. Hopson testified that if you refuse it, that he will be physically restrained and injected, and that -- and that's I think something to be considered. He said usually people submit, you know, but also that, you know, they don't, as well.

And I'd also point out with respect to this that these -- the forced medication is experienced as torture. And I'll cite to Tina Minklewitz (phonetic), the United Nations convention on the rights of persons with disabilities and the right to be free from non-consensual psychiatric interventions, 34 Syracuse Journal of International Law and Commerce 405, where -- where, four, psychiatric drugging is classified as torture. And that's really what people experience it as.

That's why Mr. Bigley has resisted it for 28 years, is it is -- is that. And in fact, you know, we know that someone who was tortured for 28 years, you know, was likely to exhibit psychiatric symptoms.

Most -- I mean, on this best interest thing, I think most importantly is this issue that the state

has really focused on the standard of care. And that is clearly not the issue here. The standard of care is a liability issue of the physicians who practice defensive medicine, and as Mr. Cornils says, think they need to drug someone in order to avoid liability.

And there is a couple of things to be said about that, is that the standard of care does not allow -- that is not a license to force people. That is a different standard.

And a quote -- Myers, quoting the Minnesota supreme court, that when medical judgments collide with a patient's fundamental rights, it is the courts, not the doctors, who possess the necessary expertise. The final decision to accept or reject a proposed medical procedure and its attendant risk is ultimately not a medical decision, but a personal choice.

And the court says, we agree with these decisions, and joined them in concluding that the right to refuse psychotropic medication is a fundamental right, though not an absolute one, that the ultimate responsibility for providing adequate protection of that right rests with the courts, and that the -- and that adequate protection of that right can only be insured by an independent judicial determination of the patient's best interests

considered in light of -- in light of any available less-intrusive treatments.

And so that inherently rejects -- and really explicitly rejects the standard of care argument. And when Mr. Twomey says that because the standard of -- it doesn't matter if these -- what they are proposing is harmful. Because that's the standard of care, we get to harm him. That's what he's arguing. And that is not the case law, and that is not what Myers said.

Okay. So I get excited about that. Because that is something that I find that psychiatrists really have a difficult time with is not understanding that even though they may recommend the medication as a standard of care, that's the standard of care, the recommendation. It's not an entitlement to force.

Okay. Now, moving to some of the -- the testimony, there is unrebutted scientific evidence regarding the harm and lack of efficacy of Risperdal.

And, Your Honor, you, I think, expressed some concern about Dr. Jackson's testimony not pertaining to Risperdal. But if you carefully review it, she was very clear that her testimony applied to Risperdal.

And as an aside, I think you'll recall that I really protested the petition as being inadequate because the petition -- you know, as I said, I think

requires the state to say what they're going to -- what they are trying to get the court to approve. Because otherwise, how -- you know, how is the respondent able to rebut and respond to what you came -- you know, about Risperdal without knowing when the petition was filed what it is that they are proposing.

And then also all of the other factors. But we're past that. But I just kind of wanted to emphasize that -- that we -- I got thrown off here. And I was really in a -- going here.

Anyway, I think there is unrebutted testimony regarding the harm and lack of efficacy of Risperdal. There is -- well, I have down here unrebutted testimony that best outcome is by far a non-coercive, non-drug one.

And I think that's -- that's really right in terms of the science. Because that's where we were getting into, excuse me, you know, what Dr. Hopson was testifying.

But in terms of the science, it's very clear. There is unrebutted testimony that the best outcome by far is non-coercive, non-drug use.

And I'll point out that Mr. Twomey referred to evidence that was stricken when he talked about

evidence of psychosocial support not working. That was exactly what was stricken. And I had all kinds of exhibits that rebutted that. And that was stricken, so there is unrebutted testimony on that.

So kind of -- well, I already said that. Okay. Okay. I'm here. My outline of a less-intrusive alternative, and we've already talked about it some, so I'll try not to repeat.

THE COURT: Okay.

MR. GOTTSTEIN: But one thing, you know, in terms of having someone with Mr. Bigley. I think the court has observed even while this proceeding that on Monday when Mr. Bigley was here with me, he was talking to me and it was kind of difficult.

And then the last two days, my assistant, Ms. Smith back there. And he's been able to talk to her. He's been -- you know, all that. And it's really gone much better.

And even when he didn't have that, you certainly didn't see the type of behavior described, you know, that was so disturbing in the community. And he's been off medication now for quite some time.

And so I think just by his demeanor in the courtroom, that you can see that if he's got people around him and has those supports, that things can go

okay.

Okay. So in support of less-intrusive alternatives, there is Mr. Cornils' testimony, Ms. Porter's testimony, Dr. Bassman's testimony, Dr. Jackson's testimony, Dr. Moser's testimony, Mr. Whitaker's testimony, and in fact Dr. Hopson's testimony. He -- he has -- he testified that, yeah, if he had -- if Mr. Bigley had intensive case management, that would work okay, and just that the hospital is unwilling to do it. And -- but it certainly can, and the court should order it.

He also admitted that -- that being locked up makes Mr. Bigley angry. And they're not letting him out on passes, which really helps a lot.

And I would request an order right today that Mr. Bigley be allowed out on passes for four hours a day, with or without escort as the hospital might determine.

And in the -- I don't know if it was the most recent commitment case or the one before it, there was testimony that the doctor was convinced by staff that he could be let out, and he kind of -- he was skeptical, but he was let out without an escort, and he came back. And I think the court should order that.

And one of the things that's happened here is this Taku -- placement in Taku, I mean, just kind of that's the rule, no passes. But there -- as Dr. Hopson testified to, and was implicit in Mr. Cornils's testimony, is this locking him up and not letting him out really gets him upset and angry and exacerbates his symptoms. And this court can ameliorate that immediately by ordering four-hour passes.

Okay.

THE COURT: So I think you've been about half an hour. So we need you to finish up, Mr. Gottstein. Go ahead.

MR. GOTTSTEIN: Well, his ten minutes was about 20 -- or five minutes was 20. But anyway, I am just going to go through what Mr. Twomey said.

Mr. Twomey said what -- they are here to do what is right for Mr. Bigley, but there are disagreements about that obviously.

But really, that is not the legal standard. The legal standard is do they have -- have they made the case to force him to take drugs against his will, and they haven't.

He said that, you know, the testimony was that on meds, he does better. You have direct

contradictory testimony from Mr. Cornils about that.

You know, he said that the hospital needs to get Mr. Bigley to accept the drugs. You know, give me a break. It's been 28 years. I actually think it's 80 admissions, not 75. But 28 years and 75 or 80 admissions. They've not gotten him to do that except for that one period of time. And there is no reason to expect that they should again unless they adopt this cooperative method.

Mr. Twomey mentioned the decline in capacity, and I think that's completely consistent with Dr. Jackson's dramatic testimony yesterday about CBI, chemical brain injury, that that's the most likely thing that's really happened is that the damage to his brain by these drugs is causing this cognitive decline. And that at this point, it's very dangerous to continue to do it.

There was a lot of talk about what the statute requires. And he said -- Mr. Twomey says it's not about appropriateness. It's about the statutory scheme for granting permission. Well, I beg to differ. He has essentially ignored Myers.

Okay. We talked about that.

He said that the basic needs not able to be met without extraordinary efforts. I think that's not

true. Mr. Cornils testified that they could be met if the resources were there, and Dr. Hopson testified to that.

There's -- this is a little bit difficult. Mr. Twomey mentioned my calling the police, and I -- there was --

THE COURT: It's not in the record, so --

MR. GOTTSTEIN: Okay. So I think that's pretty inappropriate. Okay.

That's what I have.

THE COURT: Thank you. Did you want to respond at all, Mr. Twomey?

MR. TWOMEY: Well, Your Honor, I was here Monday, I was here yesterday, and I was here today. And I guess I didn't hear Dr. Hopson testify that treatment in the absence of medication would be beneficial for Mr. Bigley, that it would provide any sort of therapeutic effect or that it was in fact an alternative appropriate for Mr. Bigley's condition.

What I heard in the way of testimony was that the administration of the antipsychotic medicine was the treatment that was being recommended and is the only available alternative.

I also sat here and heard Mr. Cornils testify to -- I understood his testimony to be different from

that described by Mr. Gottstein.

My understanding of his testimony is that Choices is not a viable alternative today for Mr. Bigley's condition. Choices in fact would not accept him as a client knowing that he would refuse medicine against physician's orders.

And I want to make clear that the state or API is not arguing that the court need not consider the constitutional requirements set forth in the Myers case.

In fact, that's what we've been talking about with our witnesses the last couple of days, what is in the best interest of Mr. Bigley? Is it in his best interest to receive these medicines?

And we have unrebutted testimony from the only people willing to care for Mr. Bigley that it is in his best interests and it is appropriate. It's within the standard of care in the medical community to treat Mr. Bigley with these medicines. We have no one willing to step forward and accept Mr. Bigley as a patient.

The doctor from South Carolina is not willing to take him as a patient. She is a researcher. She is a critic of the medical profession.

We have got journalists writing articles

about the dangers of these drugs, but they are not willing to step forward and accept Mr. Bigley and provide him with treatment.

The only medical care providers available in this community are indicating that they are recommending and they believe it's in the best interests of Mr. Bigley to receive the medicines.

And I think the court has heard both sides of the debate, in terms of the dangers of these medicines, acknowledgment that there may be some side effects. We've heard testimony as to how those side effects are monitored.

And despite the fears about these medicines, they are still being used. They are prevalent in this country.

And despite Mr. Gottstein's goal of advancing his objectives through Mr. Bigley in this case, of changing the way mental healthcare is delivered in this country, the fact is we have to deal with Mr. Bigley today in this courtroom now, and make an assessment today of his capacity, not what may have happened to him over the course of 28 years.

We need to decide now whether he has the capacity to consent to the administration of this regimen of treatment or not. And if he does not have

that capacity, whether it's in his best interests to receive this medicine.

And clearly, the only testimony from anyone capable of providing that treatment to him is that it is in his best interests. So we urge the court to grant permission, allow us to treat Mr. Bigley, and to do what's right in this case.

The alternative really is to leave things as they are. And what we're seeing is a decline in Mr. Bigley's functioning.

Testimony from Mr. Cornils is that he is no longer able to work with Mr. Bigley due to the decline in his function. So there is no currently available alternative to address the situation.

Mr. Gottstein would suggest that the court can create an alternative out of thin air, and to convert the mission of API from an acute care mental health hospital to some sort of residential facility, so that Mr. Bigley can come and go as he pleases, that he be allowed on passes.

And there is no testimony that that will in fact improve his mental condition or address the underlying problem, which is his psychosis. And that's what we need to address.

So we are, again, requesting permission from

this court pursuant to the statutory requirements and pursuant to the additional Myers constitutional requirement that there be a finding that it's in his best interest and that there's no less restrictive alternative available. I believe we have shown that by clear and convincing evidence, and we ask for it to grant the petition for administration of medicine.

THE COURT: All right. Thank you, Mr. Twomey.

What I'm going to do is the following. I am not going to issue any orders today. I am going to take the matter under advisement. My hope is to issue a decision tomorrow on the issue.

I am cognizant of the request for a stay in the event that I were to grant the state's petition, and I will address that, as well.

But my hope is tomorrow. And if not tomorrow, then certainly no later than Monday, I will issue a decision. At this point, I am not certain whether it will be in writing or I'll call counsel and tell you when I'll put it on record. But it will be one or the other.

Anything further today, Mr. Twomey, on behalf of the State?

MR. TWOMEY: No, Your Honor. Other than to

just note for the court that we are scheduled to have hearings at API tomorrow afternoon.

THE COURT: All right. I'll tell you my schedule. I have a trial 8:30 to 1:30. And if they resolved, that is when I plan to address this case. If not, then it is Monday. So that is my timeframe.

But thank you for that reminder, Mr. Twomey.

Anything further, Mr. Gottstein?

MR. GOTTSTEIN: No, Your Honor.

THE COURT: All right. Well, I will certainly give this careful attention, further thought, and I will give you a decision in the near term.

We will go off record.

MR. TWOMEY: Thank you, Your Honor.

(Off record.)

12:39:39

TRANSCRIBER'S CERTIFICATE

I, Jeanette Blalock, hereby certify that the foregoing pages numbered 196 through 300 are a true, accurate, and complete transcript of proceedings in Case No. 3AN-08-00493 PR, In the Matter of WB: William Bigley, Motion Hearing held May 15, 2008, transcribed by me from a copy of the electronic sound recording, to the best of my knowledge and ability.

_____ _____

Date Jeanette Blalock, Transcriber

EMERGENCY

Law Project for Psychiatric Rights
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Attorney for Appellant

IN THE SUPREME COURT FOR THE STATE OF ALASKA

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

(EMERGENCY) MOTION FOR STAY PENDING APPEAL
(Updated)

Pursuant to Appellate Rules 504 and 205, Appellant hereby moves on an emergency basis for a stay of the Superior Court's Order Concerning Court-Ordered Administration of Medication (Forced Drugging Order)[1] pending appeal. In Part I, Appellant addresses the Emergency Motion provisions of Appellate Rule 504 and in Part II the Motion for Stay under Appellate Rule 205.

[1] A copy of the Forced Drugging Petition is attached hereto as Exhibit A and a copy of the Forced Drugging Order is attached hereto as Exhibit B. Attached hereto as Exhibit C is a copy of the Limited Entry of Appearance filed below in this case by the Law Project for Psychiatric Rights and a portion of the exhibits thereto, which provides background and context regarding Appellant and the proceedings.

I. Appellate Rule 504 Emergency Motion Application

A. Telephone Numbers and Addresses of Counsel.

Counsel for Appellant's telephone number is 274-7686 and his office address is 406 G Street, Suite 206, Anchorage, Alaska 99501. Timothy Twomey, counsel for Appellee Alaska Psychiatric Institute (API)'s phone number is 269-5168 and his office is 1031 West 4th Avenue, Suite 200, Anchorage, Alaska 99501.

B. Nature of Emergency and the Date and Hour Before Which a Decision is Needed.

At the hearing in this matter there was unrebutted scientific testimony from Dr. Grace E. Jackson, who was qualified as an expert in psychiatry and psychopharmacology,[2] that the medication the Superior Court has ordered to be administered to Appellant against his will reduces people's prospects for recovery, causes a great deal of physical harm, including brain damage and dementia, and leads to early death. In addition, the unrebutted written testimony to the same effect by Loren R. Mosher, MD and Robert Whitaker was submitted.[3] During oral argument, counsel for Appellant prophylactically moved for a stay pending appeal, citing this testimony for the irreparable harm that will be inflicted on Appellant.[4] The Forced Drugging Order did not grant the motion for stay pending appeal, but did grant a 48 hour stay from 12:30 p.m., May 19, 2008, so as to permit Appellant to seek a stay from this Court.[5] Therefore, a decision on

[2] Exhibit D is a copy of Dr. Jackson's Curriculum Vitae.
[3] Exhibits F & G respectively.
[4] This motion has been updated from the version filed May 20, 2008, to include transcript references and add the penultimate paragraph.
[5] Exhibit B, p. 5.

the stay must be made and communicated to the Alaska Psychiatric Institute by 12:30 pm, Wednesday, May 21, 2008, in order for this Court to be able to afford effective relief.

C. Grounds Submitted to Superior Court

All of the grounds for the motion were submitted to the Superior Court with the exception of the affidavit of Grace E. Jackson, MD (Dr. Jackson Affidavit) prepared after the Forced Drugging Order, which sets forth additional detail regarding the irreparable harm to be suffered by Appellant should the stay be denied, which is attached hereto as Exhibit H. Unless this Court grants interim relief, a remand to the Superior Court for reconsideration will, as a practical matter, eliminate the possibility of relief from irreparable harm identified herein.

D. Notification of Opposing Counsel

Mr. Twomey, API's counsel, was notified of this motion by hand delivery, e-mail and phone. Moreover, at the hearing of May 15, 2008, at which Mr. Twomey was present, counsel for Appellant prophylactically moved for a stay pending appeal in the event a forced drugging order was issued against Appellant, so he essentially had notice at that time that such a motion would be forthcoming, if the Forced Drugging Petition was granted.

II. Appellate Rule 205 Motion for Stay Pending Appeal

At the beginning of oral argument on API's forced drugging petition after the close of evidence, counsel for Appellant prophylactically moved for a stay pending appeal

should the forced drugging petition be granted.[6] This was done because the normal ten day stay provided in Civil Rule 62 is ignored in these cases and without a specific order granting a stay, API will immediately inject Appellant with medication this Court has equated with the intrusiveness of Electroshock and Lobotomy, the harm of which has been confirmed by Dr. Jackson.[7]

Attached hereto as Exhibit B is the Curriculuum Vitae of Dr. Jackson, which was admitted into evidence in the forced drugging hearing below. Dr. Jackson was qualified in this case as an expert in psychiatry and psychopharmacology.[8] API's witnesses were disallowed from testifying as to any scientific opinions regarding the proposed treatment, their testimony being limited to their experience and the standard of care.[9] In fact, API withdrew the testimony of Dr. Hopson, API's Medical Director, when faced with cross examination over a citation he provided and his testimony thereon was stricken.[10]

Dr. Jackson also testified in the *Myers* case in which Loren Mosher, the former Chief for the Center for Studies of Schizophrenia at the National Institute of Mental Health,[11] testified about Dr. Jackson's knowledge about psychiatric drugs as follows:

Q Dr you know Dr. Grace Jackson?

A I do.

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[6] Tr. 274.
[7] *Myers v. Alaska Psychiatric Institute* 138 P3d 238, 242 (Alaska 2006); *Wetherhorn v. Alaska Psychiatric Institute*, 156 P.3d 371, 382 (Alaska 2007).
[8] Tr. 111.
[9] Tr. 26, 48-9 (but, *see* 50), 54-5, 189, 204, 211, 218-21.
[10] Tr. 218.
[11] Exhibit F, page (page 171 of transcript, lines 14-16).

Q Do you have an opinion on her knowledge of psychopharmacology?

A I think she knows more about the mechanisms of actions of the various psychotropic agents than anyone who is a clinician, that I'm aware of. Now, there may be, you know, basic psychopharmacologists, you know, who do lab work who know more, but as far as a clinician, a practitioner, I don't know anyone who is better-versed in the mechanisms, the actions, the effects and the adverse effects of the various psychotropic drugs.[12]

In Dr. Jackson's Report, she summarizes the brain damage caused by the drug authorized to be forcibly injected in Appellant here[13] as follows:

> Evidence from neuroimaging studies reveals that ***old and new*** neuroleptics contribute to the progressive shrinkage and/or loss of brain tissue. Atrophy is especially prominent in the frontal lobes which control decision making, intention, and judgment. These changes are consistent with *cortical* dementia, such as Niemann-Pick's or Alzheimer's disease.
>
> Evidence from postmortem analyses in lab animals reveals that ***old and new*** neuroleptics induce a significant reduction in total brain weight and volume, with prominent changes in the frontal and parietal lobes.
>
> Evidence from biological measurements suggests that ***old and new*** neuroleptics increase the concentrations of tTG (a marker of programmed cell death) in the central nervous system of living humans.
>
> Evidence from *in vitro* studies reveals that haloperidol reduces the viability of
>
> hippocampal neurons when cells are exposed to clinically relevant concentrations. (Other experiments have documented similar findings with the second-generation antipsychotics.)

[12] Exhibit F, page 7 (page 179 of transcript, lines 1-12).

[13] Risperdal, also known as risperidone, is one of the "new neuroleptics" and Dr. Jackson specifically testified at the hearing that her testimony pertaining to this class of drugs applied to Risperdal. Tr. 137, 138, 139, 140. There was also a tremendous amount of specific testimony regarding Risperdal throughout Dr. Jackson's testimony. Tr. 107-165.

> Shortly after their introduction, neuroleptic drugs were identified as chemical lobotomizers. Although this terminology was originally metaphorical, subsequent technologies have demonstrated the scientific reality behind this designation.
>
> Neuroleptics are associated with the destruction of brain tissue in humans, in animals, and in tissue cultures. Not surprisingly, this damage has been found to contribute to the induction or worsening of psychiatric symptoms, and to the acceleration of cognitive and neurobehavioral decline.

(boldfacing in original, underlining added)

Dr. Jackson amplified on this in her live testimony, making it clear that Risperdal, as with all the drugs in this class, causes dementia, and other serious health problems, and the types of worsening behavioral symptoms described of Appellant.[14] Dr. Jackson also testified that very few clinicians are aware of the lack of effectiveness and extreme harm caused by the drugs, including Risperdal, because of the ability of the pharmaceutical industry to control what clinicians are exposed to.[15] Dr. Jackson further testified that the "improvement" described by clinicians are the lobotomizing effects of the drug, making it impossible for the troublesome patient to be so troubling.[16] Dr. Jackson also testified that the analysis of the research presented in the Affidavit of Robert Whitaker[17] was accurate.[18]

Finally, in support of this motion, a further affidavit of Dr. Jackson is presented regarding the irreparable harm to Appellant should API be allowed to drug him against

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[14] Tr. 107-65.
[15] Tr. 115-133..
[16]Tr. 141.
[17] The Affidavit of Robert Whitaker is attached hereto as Exhibit G.
[18] Tr. 111-12.

his will pending this appeal as authorized by the Superior Court.[19] This expert scientific testimony includes the following from Dr. Jackson's Affidavit, attached hereto as Exhibit H:

> Mr. Bigley's initial dose of Haldol guaranteed the induction of Parkinsonian symptoms by day #3 of treatment (4/17/80). Furthermore, the continued administration of Haldol -- a chemical which replicates the mitochondrial effects of rat poison and insecticide -- guaranteed the rapid deterioration of his condition. (p.5) . . .
>
> [T]he materials which I have reviewed (see Section III, #3 above) demonstrate a persistent and continuing failure of API clinicians to consider the most likely diagnosis in the case at hand. In all probability, Mr. Bigley now suffers from a chemical brain injury (CBI). This development should preclude the attachment of any and all psychiatric labels at this time. It should also trigger the legal and medical systems to prioritize the delivery of interventions which promote neuro-rehabilitation, rather than neurodegeneration. (p.5) . . .
>
> 4) risperidone (Consta or oral forms) will potentially kill Mr. Bigley while offering no significant prospect of improvement, and zero probability of recovery . . .
>
> [Risperidone] possesses some features which make it particularly undesirable, even among drug enthusiasts.
>
> First, risperidone is unique among the newer "antipsychotic" drugs in terms of its potential to elevate prolactin. In some studies, hyperprolactinemia has occurred in as many as 90% of the risperidone patients. This is more than a trifling occurrence, due to the fact that hyperprolactinemia has been repeatedly linked to cardiac disease (e.g., via platelet aggregation, cardiomegaly, and heart failure).
>
> Second, even at typical or "ordinary" doses (D2 blockade of 60-80%), risperidone induces Parkinsonian side effects at a rate which equals

[19] Exhibit H, the original of which shall be filed upon its receipt. In this testimony Dr. Jackson discusses the failure of API to conduct needed tests, including for diabetes and other metabolic problems. While Dr. Hopson testified that tests for diabetes and other blood sugar problems were done, based on the records provided by API, this appears to be untrue.

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

Dr. Jackson's testimony makes clear that allowing API to restart the psychiatric drugging of Appellant with Risperdal will result in irreparable harm.

It is apparent from the Forced Drugging Order and even more apparent from the testimony of Dr. Hopson that the justification for inflicting this continued brain and physical damage on Appellant is because it is "the standard of care" and because it makes Appellant easier to deal with, or even pleasant. However, as this Court said in *Myers*:

> Many cases describe the unavoidable tensions between institutional pressures and individual best interests that can arise in this setting: "The doctors who are attempting to treat as well as to maintain order in the hospital have interests in conflict with those of their patients who may wish to avoid medication.... Economic considerations may also create conflicts [.]"[20]

Dr. Hopson's testimony illustrates this perfectly in that API refuses to provide a less intrusive alternative for institutional considerations (e.g., not the hospital's mission) and economic considerations.[21]

Ultimately, with respect to the motion to stay pending appeal and irreparable harm, this Court provided very cogent guidance in *Wetherhorn*, as follows:

> 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.[22]

This holding applies with equal force to the current motion for stay. Appellant can not be undrugged after being administered the very long-acting Risperdal with the irreparable harm identified by Dr. Jackson.

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[20] 138 P.3d at 250.
[21] Tr. 180-183.
[22] 156 P.3d at 381.

For the foregoing reasons, Appellant implores the Court to grant his motion for stay pending appeal.

Dated this 20th day of May, 2008, at Anchorage, Alaska as updated May 21, 2008.

LAW PROJECT FOR PSYCHIATRIC RIGHTS

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

Exhibits

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

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

C. Limited Entry of Appearance with selected attachments thereto.

D. Grace E. Jackson Curriculum Vitae.

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

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

G. Affidavit of Robert Whitaker (Whitaker Affidavit).

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

IN THE SUPREME COURT FOR THE STATE OF ALASKA

W.S.B., Appellant, v. ALASKA PSYCHIATRIC INSTITUTE, Appellee.	Supreme Court No. S-13116 Trial Court Case No. 3AN-08-493 PR

OPPOSITION TO UPDATED EMERGENCY MOTION FOR STAY PENDING APPEAL

The State of Alaska, Department of Health and Social Services, Division of Behavioral Health, Alaska Psychiatric Institute (API), by and through the Office of the Attorney General, opposes the Appellant's Updated Emergency Motion for Stay Pending Appeal.[1] Whether to grant a stay is committed to this Court's sound discretion.[2] In *Powell*, the Court suggested that the criteria for a stay should be much the same as for determining whether to grant a preliminary injunction.[3]

In *State, Division of Elections v. Metcalfe*, the Court set forth the test for a preliminary injunction:

> The showing required to obtain a preliminary injunction depends on the nature of the threatened

[1] API has agreed to delay administration of medication to the Appellant until after 12:00 noon on Friday, May 23, 2008, so that this opposition could be prepared with consideration of the Appellant amended motion, served on May 21, 2008. API also objects and moves to strike the new affidavit of Grace E. Jackson, M.D. prepared after the trial court has considered this matter and which purports to encapsulate "testimony." The trial court heard and considered the testimony of Grace E. Jackson, M.D. during the hearing and there is no basis for offering this late-created "evidence" of what transpired at the hearing to bolster the instant request for emergency relief.

[2] *Powell v. City of Anchorage*, 536 P.2d 1228 (Alaska 1975).

[3] *Id.*

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> injury. If the plaintiff faces the danger of "irreparable harm" and if the opposing party is adequately protected, then we apply a "balance of hardships" approach in which the plaintiff "must raise 'serious' and substantial questions going to the merits of the case; that is, the issues raised cannot be 'frivolous or obviously without merit.'" If, however, the plaintiff's threatened harm is less than irreparable or if the opposing party cannot be adequately protected, then we demand of the plaintiff the heightened standard of a "clear showing of probable success on the merits."[4]

In this case the Appellant overstates his case for irreparable harm and fails to address the fact that API's significant interests, including its interest in the Appellant's well being and proper treatment, would not be adequately protected should a stay be granted. He also fails to make a clear showing of probable success on appeal. Instead, a stay in this matter would deprive the Appellant of treatment for his mental illness without any real showing that the superior court's conclusion was wrong, only that it is different from the position that the Appellant's experts support. Because the Appellant does not meet the standard to justify a stay, his motion should be denied.

I. The Appellant Does Not Establish The Necessity For Emergency Action Based On Irreparable Harm

Because some individuals perceive that the risks associated with psychotropic medication outweigh its benefits, the Appellant contends that irreparable harm will result should he receive such treatment at API. However, the Appellant fails to address the fact that the superior court rejected these same arguments that psychotropic medications "do more harm than good" after considering *all* of the evidence, not just that presented by the experts advocating the Appellant position. Here, the trial court carefully considered both sides of the issue and the Appellant simply does not accept the result[5].

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[4] 110 P.3d 976, 978 -979 (Alaska 2005) (footnotes and citations omitted).

[5] The 30-day commitment proceeding pursuant to AS 47.30.735 was conducted on April 30, 2008 and involved five witnesses presenting live testimony. The subsequent hearing on API's petition for court-ordered administration of medication pursuant to AS

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The superior court determined that clear and convincing evidence was presented that treatment with medication is in the Appellant's best interest notwithstanding its recognition that the Appellant presented evidence of the potential side effects or perceived dangers of medication.[6] The superior court recognized that no evidence was presented by the Appellant of a viable alternative to medication,[7] discussed evidence pertaining to the Appellant specific prior experience with medication,[8] and narrowly tailored its order, specifying the medicine to be administered as well as permitted dosage.[9]

The Appellant suggests that testimony was "unrebutted" that the drug prescribed will harm him. That contention misstates the evidence and presents a distorted view of the superior court's decision. The superior court did not ignore the Appellant's evidence, but simply was not convinced that the Appellant's position should prevail after hearing all of the evidence. Significantly, the Appellant fails to explain how the administration of psychotropic medicine can remain within the standard of care in the medical community for treatment of the Appellant's mental illness if the drugs are going to "kill" the Appellant and not provide any benefit.[10] the Appellant fails to address the fact that he has not experienced many of the possible side effects when he has previously

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47.30.839 was conducted on May 12, 14 and 15, 2008 and involved testimony from 7 live witnesses as well as written testimony offered on behalf of Mr. Bigley's position.

6 Even Mr. Bigley's experts acknowledged that their views on the "dangers" of medication are not commonly accepted in the medical or psychiatric community and that the administration of psychotropic medicine is accepted practice and prevalent in this country. Transcript at pages 152-153 Furter, Mr. Bigley's own expert admitted that she has continued patients on Risperidone and that she could not really quantify the likelihood of side effects in Mr. Bigley's case. See Transcript at pages 155-160.

7 Findings and Order Concerning Court-Ordered Administration of Medication dated May 19, 2008 ("Order"), at page 4.

8 Order at pages 3-4.

9 Order at page 5.

10 Appellant's brief at page 7.

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received medication.[11] The Appellant cannot meet his burden of showing irreparable harm merely by contending that the trial court should have agreed only with his experts' view, without showing error or presenting the other side of the equation.

The superior court has determined, consistent with the evidence, that the administration of medication to the Appellant is within the standard of care for psychiatry, is appropriate for the Appellant and further, that no less restrictive alternative treatment is available. The court recognized the high risk to the Appellant associated with the "no treatment" alternative and supported the authorization of medication, in part upon evidence of the Appellant's own successful history while on medication[12]. The court weighed the evidence and found the administration of medication not an agent of harm, but in the Appellant's best interest.

II. There is No Clear Showing of Probable Success On the Merits

Even if the Appellant could establish irreparable harm would ensue from the administration of medication, API's interests must still be considered before any stay is entered. the Appellant does not give fair consideration to API's interests and instead demeans them as no more than a desire for a more compliant patient[13]. As discussed below, API's interests are far more compelling than the Appellant allows and cannot be protected if a stay is entered.

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[11] Order at pages 3-4. Transcript at pages 49-52.

[12] Order at pages 4-5.

[13] Appellant's brief at page 8.

API has the mission of providing acute care to the mentally ill[14]. A stay pending appeal in the context of court-ordered administration of medication has the practical effect of preventing API from administering treatment and fulfilling its mission. Indeed, permitting a stay here denies the Appellant any treatment, contrary to the superior court's finding that the no-treatment alternative was not viable or in the Appellant's best interest.

As the superior court explained, the administration of medication will permit the Appellant to function in the community.[15] The goal of the medication is not to make API's life easier by making the Appellant a more compliant and pleasant patient. The court's clear aim in finding medication to be in the Appellant's best interest was that it would permit him to function outside API, and get housing and necessary services, a capacity that un-medicated, the Appellant lacked.[16]

A stay would result in the untenable position of API having committed the Appellant but being left without the ability to carry out its mission of providing acute care to the mentally ill. API is an acute-care psychiatric hospital. It is not a home for the mentally ill. One of the purposes of civil commitment is that the commitment has, "a reasonable expectation of improving [the patient's] mental condition."[17] API practices an evidence-based medical approach to treating psychiatric illness. Housing someone at API is not treatment. The stay requested by the Appellant forces API into the untenable position of potentially housing him during commitment, without providing necessary treatment. The trial court recognized that such an outcome would be inconsistent with

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[14] Transcript at pages 213-214.

[15] Order at 3, 4.

[16] *See,* Order at 3; Transcript at pages 230-232.

[17] AS 47.30.655(6).

API's mission as an acute care facility for individuals throughout the state that are in need of acute mental health care.[18] API has an interest in improving the Appellant's condition by providing psychiatric treatment for his mental illness. That interest cannot be protected unless proper treatment can be provided in a timely manner.

Further, if the Appellant obtains a stay pending appeal based on no more than the perceived harm resulting from the medication itself, the statutory scheme for administration of psychotropic medication, AS 47.30.839 could be "undone" by any litigant unhappy with the outcome in their case. It is likely that the period of commitment under AS 47.30,735 et seq. would expire before the appeal was resolved and any medication could be administered. In the event the person was still committed, and the order was upheld, API would not be able to implement it because any new medication order would probably need to be based on the current situation. That would require a new hearing. The findings from any new hearing could be appealed again, and new stay sought, starting the cycle again.

More than a merely non-frivolous argument against the order should be required to deprive the Appellant of treatment both his doctors and the court finds to be in his best interest. A stay in this setting should be reserved for those exceptional cases where there is a clear showing of probable success on the merits.[19] If the Court were to merely assume that API is protected and that the Appellant will suffer irreparable harm if he received the approved treatment (based on general effects of psychotropic drugs), the Appellant could indefinitely postpone the implementation of a medication order because the order would, as noted above, always become moot.

As discussed more fully below, this is not a case where a stay should be entered as the Appellant makes no clear showing of probable success. Instead

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[18] Order at page 3.

[19] *Powell v. Anchorage*, 536 P.2d 1228 (Alaska 1975) at 1272 (quoting *A.J. Indus., Inc. v. Alaska Pub. Serv. Comm'n*, 470 P.2d 537, 540 (Alaska 1970), *modified in other respects*, 483 P.2d 198 (Alaska 1971)). See also *State, Division of Elections v. Metcalfe*, 110 P.3d 976, 978 -979 (Alaska 2005).

the Appellant simply argues that the trial court was wrong because it did not accept the Appellant position that drugs do more harm than good. the Appellant's position was considered but API presented evidence that the proposed medication was not going to "kill" the Appellant, but was the appropriate course of treatment[20].

III. Mr. Bigley Fails to Make A Clear Showing of Probable Success On the Merits.

Because API's interests cannot adequately be protected if a stay is entered, the Appellant needs to make a clear showing of probable success on the merits.[21] the Appellant has failed to meet that burden. He has not established that the superior court was wrong in its assessment of the Appellant's best interest, only that the court's conclusion differs from that of his experts. That should not be sufficient to deprive the Appellant of the treatment deemed in his best interest or to deprive API of its ability to provide medical care to the mentally ill.

The superior court fully explained why treatment with the proposed medication was in the Appellant's best interest. The treatment authorized is within the standard of care and without treatment, the Appellant cannot function[22]. The court supported the use of the medication so that the Appellant may regain his ability to function outside of an institutional setting, not for the purpose of making the Appellant a more compliant or less disruptive patient while at API. Indeed, the trial court fully explained the risks of no treatment as being very high and concluded that the Appellant will continue to be unable to function in the community without the only treatment available, the administration of medication, medication that the Appellant has received in the past and which, according to evidence presented by API made his condition better, not worse as

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[20] Transcript at pages 205-206; 208-209; 231-232

[21] *See, State, Division of Elections v. Metcalfe*, 110 P.3d at 978 -979; *Powell v. Anchorage*, 536 P.2d at 1272 (quoting *A.J. Indus., Inc. v. Alaska Pub. Serv. Comm'n*, 470 P.2d 537, 540 (Alaska 1970).

[22] Transcript at pages 53-57; 230-234.

the Appellant would suggest[23]. API requests that the Appellant's Emergency Motion for Stay be denied so that necessary mental health treatment may be provided to the Appellant without further delay.

DATED: 5/22/08

TALIS J. COLBERG
ATTORNEY GENERAL

By: Timothy M. Twomey
Assistant Attorney General
Alaska Bar No. 050503

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[23] Transcript at pages 55-57; 230-232.

IN THE SUPREME COURT FOR THE STATE OF ALASKA

W.S.B, Appellant, v. ALASKA PSYCHIATRIC INSTITUTE, Appellee.	Supreme Court No. S-13116 Trial Court Case No. 3AN-08 493 PR

ORDER

The appellant's Opposition To Updated Emergency Motion For Stay Pending Appeal is DENIED/GRANTED.

DATED: _____

_____
SUPREME COURT JUSTICE

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IN THE SUPREME COURT FOR THE STATE OF ALASKA

W.S.B, Appellant, v. ALASKA PSYCHIATRIC INSTITUTE, Appellee.	Supreme Court No. S-13116 Trial Court Case No. 3AN-08 493 PR

CERTIFICATE OF SERVICE

I hereby certify that on this day, correct copies of the **OPPOSITION TO UPDATED EMERGENCY MOTION FOR STAY PENDING APPEAL** and **ORDER** in this proceeding were hand delivered to:

Liz Brennan, PDA

Beth Russo, OPA

and mailed to:

James B. Gottstein, Esq.

406 G Street, Suite 206
Anchorage, AK 99501

Signature 5/22/08 Date

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In the Supreme Court of the State of Alaska

William S. Bigley,	)	
	)	Supreme Court No. **S-13116**
Appellant,	)	
v.	)	**Order**
	)	
Alaska Psychiatric Institute,	)	
	)	
Appellee.	)	Date of Order: **5/23/08**
	)	

RECEIVED
MAY 27 2008

Trial Court Case # **3AN-08-00493PR**

By motion of 5/20/08 (updated 5/21/08), appellant has moved on an emergency basis for a stay of the superior court's findings and order of 5/19/08 granting API's petition to administer psychotropic medication during appellant's period of commitment. The order limits the medication to Risperadone in an amount not to exceed fifty milligrams per two weeks. On 5/19/08 12:30 p.m. the superior court also entered a forty-eight hour stay to allow appellant to seek a stay in this court. API has opposed appellant's stay motion. API has also moved to strike an affidavit executed 5/20/08 by Grace E. Jackson, MD and submitted with appellant's 5/20 stay motion. Appellant has responded, at the court's request, to the motion to strike, and has requested alternative stay relief. Upon consideration of the stay motion and opposition, and the motion to strike and the response to that motion,

IT IS ORDERED:

1. It is first necessary to identify the standard for deciding whether a stay is appropriate. The standard depends on the nature of the threatened injury and the adequacy of protection for the opposing party. Thus, if the movant faces a danger of

irreparable harm and the opposing party is adequately protected, the "balance of hardships" approach applies. Under that approach, the movant "must raise 'serious' and substantial questions going to the merits of the case; that is, the issues raised cannot be 'frivolous or obviously without merit.' " *State, Div. of Elections v. Metcalfe*, 110 P.3d 976, 978 (Alaska 2005). On the other hand, if the movant's threatened harm is less than irreparable or if the opposing party cannot be adequately protected, the movant must demonstrate a "clear showing of probable success on the merits." *Id.* The latter standard is proposed here by API. Appellant has not clearly identified the standard he thinks controls. He does, however, assert that he will suffer irreparable harm if he must undergo involuntary medication.

There is at least implicit disagreement in this case about whether administration of psychotropic medication causes medical health problems that are potentially grave or whether it may even contribute to mental illness. At least by implication, the involuntary administration of medication against appellant's fervent wishes may cause psychic harm. Whether long-term administration of such medication causes irreparable harm is an issue that implicates the merits of this appeal. The evidence appellant produced at the mid-May hearing permits a conclusion long-term medication will cause him irreparable harm. It also appears to imply that even the administration of a single dose, or an additional dose, intravenously may contribute to irreparable harm. The 5/20 affidavit of Dr. Jackson does not seem to expressly address the harm that might result from a single fifty-milligram intravenous injection of Risperadone. But it also appears that the likelihood the medication will end with the proposed injection authorized 5/19/08 by the superior court is small. Appellant has been admitted seventy-five times to API. It is

likely that if he is released with or without medication (his thirty-day commitment order was entered 5/5/08), he will be readmitted to API in the future and that API staff will again seek a medication order. Thus, if the medication is administered as presently authorized, it seems likely that he will sooner or later following return to the community decline to voluntarily accept medication and that API will seek permission to administer additional doses. In other words, whether irreparable harm will result from the medication authorized by the 5/19 order necessarily raises longer-term questions.

API asserts that its interests cannot be adequately protected. It certainly has an important interest in fulfilling its duty to patients and in satisfying its charter obligations to the public. But the evidence to date does not establish that medication is necessary to protect appellant from self-inflicted harm or from retaliatory harm in response to his behavior, threatening as it may seem to others. Nor has API identified any need to protect others from him, including API staff during his commitment or the public upon his release. This is not to minimize API's interest both in doing what it believes best for appellant and in carrying out its responsibilities. But it does not appear that API cannot adequately protect those interests. API's interest in protecting appellant does not dramatically outweigh his desire to make treatment decisions for himself. It therefore appears that the appropriate standard for a stay pending appeal is whether appellant has raised serious and substantial questions going to the merits of the case. He does not have to demonstrate a clear showing of probable success on the merits.

2. Applying that standard, the court concludes that a stay of the 5/19 order is appropriate. The evidence presented at the mid-May hearing supports appellant's contentions, but does not necessarily foreclose API's contentions. Because the findings

of fact of the superior court are reviewed under a clearly erroneous standard, and because necessary conclusions of law are considered de novo, this court cannot now conclude on the basis of the evidence review conducted in context of the stay motion that appellant's appellate issues are all frivolous or obviously without merit. The court cannot say that appellant has clearly demonstrated probable success on the merits. But he is not required to do so in this case to obtain a stay. His motion for stay is therefore **GRANTED**.

3. API's motion to strike the 5/20 affidavit of Dr. Jackson is **DENIED**. The affidavit appears to largely summarize other evidence offered at the May hearing. But the only alternative to striking or accepting the affidavit would be remand to the superior court for reconsideration of appellant's stay motion. The superior court, as a fact-finding court, is in a superior position to weigh Dr. Jackson's most recent statements and determine whether appellant has demonstrated irreparable harm. But doing so will simply delay the ultimate resolution of the medication issue. Unless a stay were granted in the superior court, it is probable appellant would renew his stay motion in this court, and then, if that motion were denied, seek full-court reconsideration. In the meantime, the thirty-day commitment period is running. In any event, the 5/20/08 affidavit is not the evidentiary basis for this stay order.

4. This appeal was filed 5/20/08, and the appellant characterized it as a Rule 204 appeal in his notice of appeal and docketing statement. Even if appellate briefing is expedited, it is highly likely the present commitment order will have expired before briefing is complete, and therefore before this court can rule on the merits. The possibility of technical mootness is substantial. The parties should anticipate this issue

in their briefing and discuss whether the court should nonetheless reach the merits of the 5/19/08 order permitting administration of Risperadone.

Entered at the direction of an individual justice.

Clerk of the Appellate Courts

Lori A. Wade, Chief Deputy Clerk

cc: Supreme Court Justices
Judge Gleason by fax
Trial Court Clerk by fax

Distribution by fax, phone and mail:

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IN THE SUPREME COURT FOR THE STATE OF ALASKA

W.S.B., Appellant, vs. ALASKA PSYCHIATRIC INSTITUTE, Appellee.	)	Supreme Court Case No. S-13116
	)	Trial Court Case No. 3AN-08-493 PR

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

Pursuant to Appellate Rule 503(h), the State of Alaska, Department of Health and Social Services, Division of Behavioral Health, Alaska Psychiatric Institute , through the Office of the Attorney General, makes the following motion for reconsideration of the single justice order dated May 23, 2008, granting Mr. Bigley's Updated Emergency Motion for Stay Pending Appeal, which stayed the superior court's grant of a medication petition pending a decision by this Court on Mr. Bigley's appeal. API contends that reconsideration is warranted because the Court overlooked, misapplied, or failed to consider a principle directly controlling, a material fact, and/or a proposition of law.

A. Probable Success on the Merits Should be the Required Showing, Given API's Interests Concerning Mr. Bigley and Other Individuals

While the Court's May 23, 2008, order recognized that API has an important interest in fulfilling its duty to patients and satisfying its charter obligations to the public, the Court gave minimal analysis to how those interests are protected when a stay is granted pending appeal. Instead, the Court concluded that API's interest in protecting Mr. Bigley did not dramatically outweigh Mr. Bigley's desire to make treatment decisions for himself. This not only overlooked the superior court's conclusion that Mr. Bigley was not competent to make informed decisions concerning the administration

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of psychotropic medication and lacked the "capacity to participate in treatment decisions by means of a rational thought process"—conclusions supported by substantial evidence, as set forth in the superior court's order—it effectively precludes API from administering medication for Mr. Bigley during this, or any future, commitment periods. [Superior Court Order, p. 1-2]

Significantly, the Court recognized that this matter presented a substantial possibility of technical mootness, as the underlying thirty-day commitment order will expire well before a decision is issued in this appeal. Despite recognizing the mootness issue, the Court declined to require a showing of probable success on the merits before granting the motion to stay. Without such a showing, Mr. Bigley's strategy of seeking an emergency stay places API in the position of being unable to provide treatment to him while an (involuntary) patient at API, despite the fact that the superior court concluded that the proposed course of treatment, which included the administration of antipsychotic medication, was in Mr. Bigley's best interests based on his mental condition, even when taking into account the potential risk of side effects and the intrusion into Mr. Bigley's constitutional right to individual choice in his mental health treatment. [Superior Court Order, p. 3-5]

If API cannot provide treatment to committed patients because they will strategically seek a "stay" of a medication order, and such stays could be granted on a lesser showing of a non-frivolous argument on appeal, the entire statutory scheme for court-approval of psychotropic medication will be substantially undetermined. Anytime a committed patient is not satisfied with trial court's approval of psychotropic medication, the patient could effectively prevent API from administering the medication and avoid treatment simply by seeking a stay with this Court and making a *de minimus* showing that he or she possesses some sort of colorable argument on appeal. If reconsideration of the May 23 order setting a new, lower standard for granting stay is not permitted, patients could escape jurisdiction of the statutory approval scheme simply by contending that their interest in avoiding treatment or medication is significant without requiring them to demonstrate a likelihood of success on the merits.

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Here, the trial court properly weighed Mr. Bigley's claimed interest in not receiving medication against the "need" for treatment, finding that the proposed treatment was in Mr. Bigley's best interest. [Superior Court Order, p. 3-5] Given the likelihood that patients seeking to avoid the administration of medication will simply seek a stay pending appeal of the court-approval process by a "balance of the hardships" showing, API urges reconsideration and adoption of the "probable success on the merits" standard.

Under the evidence presented, Mr. Bigley would be unable to demonstrate probable success on his appeal and a stay order should not be granted when doing so would undermine the court-approval process and the constitutional inquiries required in connection with that process. Here, the superior court determined, consistent with substantial evidence, that the administration of medication to Mr. Bigley is within the standard of care for psychiatry in Alaska, is appropriate for Mr. Bigley, and no less restrictive alternative treatment is available. [Superior Court Order, p. 1-5] The superior court recognized the high risk to Mr. Bigley associated with the "no treatment" alternative and supported the authorization of medication, in part upon evidence of Mr. Bigley's own history while on medication. [Superior Court Order, p. 3-5]

If a stay is available to an involuntarily-committed mental health patient who does not want to take medication without a showing of probable success on the merits, the result will be that API is required to maintain committed patients, including Mr. Bigley, in its facility without providing the care that their mental-health care providers deem is not only appropriate and beneficial to the patients' mental condition, but that meets the relevant standard of care in Alaska. Further, the statutory scheme for court-approval of medication when the patient lacks capacity to provide informed consent would be rendered meaningless if such a "back-door" is opened to avoid treatment.

The trial court fully explained why treatment with the proposed medication was in Mr. Bigley's best interest. The treatment authorized is within the standard of care and, without treatment, Mr. Bigley cannot function in society, in part, because he is now unable to obtain shelter or necessary mental health services outside of

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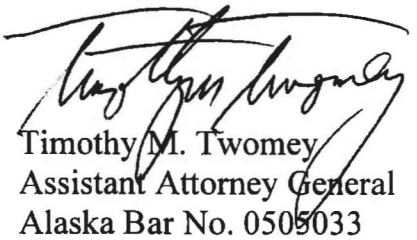
API as a result of his aggressive and angry behavior. [Superior Court Order, p. 3] The superior court supported the use of the medication so that Mr. Bigley may regain his ability to function outside of an institutional setting, not for the purpose of making Mr. Bigley a more compliant or less disruptive patient while at API. Indeed, it fully explained that the risks of no treatment were very high and concluded that Mr. Bigley will continue to be unable to function in the community without the only treatment available, the administration of medication. Under the circumstances, API requests that the Court reconsider the May 23, 2008, order and deny Mr. Bigley's Emergency Motion for Stay so that necessary and appropriate mental health treatment may be provided to Mr. Bigley without further delay.

DATED: 5/28/08

TALIS J. COLBERG
ATTORNEY GENERAL

By: 
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IN THE SUPREME COURT FOR THE STATE OF ALASKA

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

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

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

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

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

I. Appellant's Discharge and Mootness

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

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

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

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

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

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

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

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

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

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

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

II. The Balance of Hardships Standard Applies

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

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

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

A. The Evidence of Irreparable Harm Is Compelling and Unrebutted

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

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[12] Pages 1-2.

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

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

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

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

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

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

> Evidence from neuroimaging studies reveals that ***old and new*** neuroleptics contribute to the progressive shrinkage and/or loss of brain tissue. Atrophy is especially prominent in the frontal lobes which control decision making,

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

> intention, and judgment. These changes are consistent with *cortical* dementia, such as Niemann-Pick's or Alzheimer's disease.
>
> Evidence from postmortem analyses in lab animals reveals that ***old and new*** neuroleptics induce a significant reduction in total brain weight and volume, with prominent changes in the frontal and parietal lobes.
>
> Evidence from biological measurements suggests that ***old and new*** neuroleptics increase the concentrations of tTG (a marker of programmed cell death) in the central nervous system of living humans.
>
> Evidence from *in vitro* studies reveals that haloperidol reduces the viability of hippocampal neurons when cells are exposed to clinically relevant concentrations. (Other experiments have documented similar findings with the second-generation antipsychotics.)
>
> Shortly after their introduction, neuroleptic drugs were identified as chemical lobotomizers. Although this terminology was originally metaphorical, subsequent technologies have demonstrated the scientific reality behind this designation.
>
> Neuroleptics are associated with the destruction of brain tissue in humans, in animals, and in tissue cultures. Not surprisingly, <u>this damage has been found to contribute to the induction or worsening of psychiatric symptoms, and to the acceleration of cognitive and neurobehavioral decline</u>.

(boldfacing in original, underlining added)

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

[24] Tr. 107-65.

the drugs.[26]

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

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

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

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

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

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

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

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

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

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

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

> [I]n future non-emergency cases a court may not permit a treatment facility to administer psychotropic drugs unless the court makes findings that comply with all applicable statutory requirements and, in addition, expressly finds by clear and convincing evidence that the proposed treatment is in the patient's best interests and that no less intrusive alternative is available.[31]

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

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

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

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

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

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

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

> (A) an explanation of the patient's diagnosis and prognosis, or their predominant symptoms, with and without the medication;
>
> (B) information about the proposed medication, its purpose, the method of its administration, the recommended ranges of dosages, possible side effects and benefits, ways to treat side effects, and risks of other conditions, such as tardive dyskinesia;
>
> (C) a review of the patient's history, including medication history and previous side effects from medication;
>
> (D) an explanation of interactions with other drugs, including over-the-counter drugs, street drugs, and alcohol; and
>
> (E) information about alternative treatments and their risks, side effects, and benefits, including the risks of nontreatment[.][38]

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

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

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

(3) the experimental nature of the treatment;

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

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

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

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

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

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[40] *Id.*

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

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

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

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

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

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

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

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

(2) Information About The Proposed Medication, Its Purpose, The Method Of Its Administration, The Recommended Ranges Of Dosages, Possible Side Effects And Benefits, Ways To Treat Side Effects, And Risks Of Other Conditions, Such As Tardive Dyskinesia;

(a) Possible Side Effects

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

(b) Possible Benefits

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) The Risks Of Adverse Side Effects;

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

(8) The Experimental Nature Of The Treatment.

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

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

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

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

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

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

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

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

B. There Is A Less Intrusive Alternative Available

One of the core holdings of *Myers* is the State may not forcibly drug someone with psychotropic medication(s) against his wishes unless "no less intrusive alternative treatment is available."[75] API may not avoid its obligation to provide a less intrusive alternative by choosing to not provide funds. *Wyatt v. Stickney*, 344 F.Supp. 387, 392 (M.D.Ala.1972) ("no default can be justified by a want of operating funds."), affirmed, *Wyatt v. Anderholt*, 503 F.2d 1305, 1315 (5th Cir. 1974)(state legislature is not free to

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

provide social service in a way that denies constitutional right). In *Wyatt* the federal courts required the State of Alabama to spend funds in specific ways to provide constitutionally adequate services.

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

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

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

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

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

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

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

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

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

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

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

there is now growing recognition that medication is not a satisfactory answer for a significant proportion of the people who experience mental distress, and that for some people...it creates more problems than solutions. . . .

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

A I do.

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

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

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

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

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

A . . . [C]oercion, itself, creates trauma and further distress for the person, and that that, in itself, actually undermines the benefits of the treatment that is being provided in a forced context. And so our aiming and teaching is to be able to support the person to resolve the issues without actually having to trample . . . on the person's autonomy, or hound them physically or emotionally in doing so. . . . .

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

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

[84] Exhibit F, pp 12-19.

Dr. Mosher's testimony included the following:

> Q . . . Now, in your opinion, is medication the only viable treatment for schizophrenia paranoid type?
>
> A Well, no, it's not the only viable treatment. It is one that will reduce the so-called positive symptoms, the symptoms that are expressed outwardly for those kinds of folks. And that way they may seem better, but in the long run, the drugs have so many problems, that in my view, if you have to use them, you should use them in as small a dose for as short a period of time as possible. And if you can supply some other form of social environmental treatment -- family therapy, psychotherapy, and a bunch of other things, then you can probably get along without using them at all, or, if at all, for a very brief period of time. But you have to be able to provide the other things. You know, it's like, if you don't have the other things, then your hand is forced.[85]

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

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

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

community without psychiatric medication.[88]

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

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

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

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

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

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

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

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

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

IV. CONCLUSION

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

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

LAW PROJECT FOR PSYCHIATRIC RIGHTS

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

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

Exhibits

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

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

C. Limited Entry of Appearance with selected attachments thereto.

D. Grace E. Jackson Curriculum Vitae.

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

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

G. Affidavit of Robert Whitaker (Whitaker Affidavit).

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

I. Affidavit of Ronald Bassman, PhD.

J. Affidavit of Paul Cornils.

K. Notice Re: Discharge

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

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

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

REASONS FOR & CONDITION ON ADMISSION: As recorded on the Admission Psychiatric Evaluation for 04/25/2008:

IDENTIFYING DATA: "This is the 75th API admission for this 55-year-old, Alaska Native male who is divorced. He is currently unemployed, a nonveteran, admitted on a POA. The patient reports his religious preference as Nazarene.

PRESENTING PROBLEM/CHIEF COMPLAINT: "I don't belong here."

HISTORY OF PRESENT ILLNESS: The patient was recently evicted from his hotel room in which he was staying. He arrived at API on a POA with APD escort after being served with trespassing, both at the bank and OPA. It is reported that the patient spit on the OPA staff. The patient was verbally abusive upon arrival to API and was escorted directly to the unit.

MENTAL STATUS EXAMINATION: The patient met with writer in treatment team room. He was agitated, disheveled in appearance. His hair was in disarray. He was dressed in hospital scrubs. The patient's cognitive skills were difficult to assess due to his inability to participate in the assessment. The patient's speech is pressured and rambling and difficult to understand throughout the interview. His affect is labile. His mood is agitated. At one point, the patient began yelling at writer, throwing papers around the room resulting in escorting him from the interview. The patient discusses 9/11 and incidences of bombs going off and very delusional in content. He denies any harm to himself or others. The patient's judgment is very impaired and his insight is poor. Leona Gillespie, ANP

ADMITTING DIAGNOSIS:

Axis I: Schizophrenia, Paranoid Type, Chronic.

Axis II: Deferred.

Axis III: History of gastroesophageal reflux disease.

Nicotine dependence.

Axis IV: Stressors: Problems with primary support group. Problems related to the social environment. Housing problems.

Axis V: GAF: 26."

COURSE IN HOSPITAL: Mr. Bigley was admitted on a POA status, which appears related to his grave disability. He was admitted with a petition for commitment granted, but petition for involuntary medications was stayed by the Supreme Court. The patient remains very psychiatrically ill, with prominent delusions. Over the course of this admission, his threats towards staff and dangerousness have decreased, particularly over the last ten days. Housing is to be arranged for the patient and he does have funds available. He is not considered gravely disabled at the present time, and a petition for his continued commitment to API is not possible. He denies thoughts of suicide or desire to harm others, and his report is believed. He denies auditory or visual hallucinations. He refuses antipsychotic medication or follow-up treatment. Requests for case management will be made, but there are no options currently available for him. He has a history of gastroesophageal reflux disease, anorexia, and nicotine dependence. He had a negative PPD on 09/27/2006. He has been screened for tuberculosis as recently as 04/26/2008. He refused an admission History and Physical.

CONDITION ON DISCHARGE: The patient's psychiatric condition was improved somewhat from his admission, as noted by a decrease in his dangerousness, as well as his acceptance of food and fluids. He has a severe psychiatric disability, but is not considered gravely disabled at discharge. He denies suicidal or homicidal ideation, and his report is believed. He has funds for housing, though has a history of homelessness.

FINAL DIAGNOSIS:

Axis I: Schizophrenia, Paranoid Type, Chronic.

Axis II: Deferred.

Axis III: Gastroesophageal reflux disease, by history.

Nicotine dependence.

Axis IV: Stressors: Housing problems; Other psychosocial and environmental problems.

Axis V: GAF: 29.

Normally rights not facilitated by attorney (PD)

PROGNOSIS: The patient's prognosis is poor. The patient refuses psychiatric treatment and this refusal is facilitated by his attorney.

POST HOSPITAL PLAN, MEDICATIONS, & RECOMMENDATIONS: The patient is discharged without medication as he refuses these. It is recommended that he follow-up with antipsychotic medication, case management, and stable housing.

There are no restrictions on diet or activity.

Lois I. Michaud, Ph.D.
Licensed Psychologist (#451)
Staff Psychologist
Forensic Evaluation Unit
Alaska Psychiatric Institute

Kahnaz Khari, M.D.
Staff Psychiatrist

LIM/KK/sc/DISCH/31887F/APE/31281F
d. 06/11/08
t. 06/12/08 (draft)
dr/ft. 06/23/08

ALASKA PSYCHIATRIC INSTITUTE
LEGAL STATUS RECORD

DO NOT WRITE ON THIS SHEET
THIS STATUS RECORD IS MAINTAINED AND UPDATED BY HEALTH INFORMATION MANAGEMENT SERVICES
COMMUNICATE INFORMATION REGARDING STATUS TO LEGAL TECHNICIAN

DATE	STATUS	TYPE OF DOCUMENT / STIPULATIONS	ORDER EXP
05/19/2008	T-47	rec'd Order for Meds dated 5-19-08 signed by Sup. Ct. Judge Gleason, Anchorage	
06/04/2008	NONE	DISCHARGED Notice of Release sent to Anchorage Court	

What about Stay?

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
AT Anchorage

In the Matter of the Necessity for the Hospitalization of:
William Digley,
Respondent.

Case No. 3AN 08 493 PR

NOTICE OF RELEASE

To: Superior Court at Anchorage, Alaska.

☐ **Release After Evaluation**. Respondent was admitted to _____ for evaluation on _____, 20____ and was discharged from the facility on _____, 20____, at _____ ___.m. because the evaluation personnel did not find that respondent met the standards for commitment specified in AS 47.30.700,

☒ **Release After Commitment Period**. Respondent was committed for treatment on 5/5, 20 08, for 30 days. Respondent was released on 6/4, 20 08.

☐ **Certificate of Early Discharge**. Respondent was committed for treatment on _____, 20____, for _____ days. I certify that on _____, 20____, respondent was discharged early because:

☐ respondent is no longer gravely disabled or likely to cause serious harm as a result of mental illness.

☐ _____

_____

I request the court to enter an order officially terminating the involuntary commitment.

6/5/08
Date

Signature

Print Name and Title

MC-410 (3/01)(st.2)
NOTICE OF RELEASE

AS 47.30.720
AS 47.30.725(b)
AS 47.30.780

IN THE DISTRICT COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

STATE OF ALASKA,

Plaintiff,

vs.

WILLIAM S BIGLEY,
DOB: 1/15/1953
APSIN ID: 0593929
DMV NO. 0593929 AK
ATN: 110-832-678

Defendant.

FILED IN OPEN COUR
6.23.08

No. 3AN-08-6820 CR

INFORMATION

I certify this document and its attachments do not contain the (1) name of a victim of a sexual offense listed in AS 12.61.140 or (2) residence or business address or telephone number of a victim of or witness to any offense unless it is an address identifying the place of a crime or an address or telephone number in a transcript of a court proceeding and disclosure of the information was ordered by the court.

The following counts charge a crime involving DOMESTIC VIOLENCE as defined in AS 18.66.990:NONE

Count I - AS 11.61.110(a)(2)
Disorderly Conduct
William S Bigley - 001

Count II - AS 11.46.484(a)
Criminal Mischief In The Fourth Degree
William S Bigley - 002

THE DISTRICT ATTORNEY CHARGES:

Count I

That on or about June 22, 2008, at or near Anchorage in the Third Judicial District, State of Alaska, WILLIAM S BIGLEY in a public place or in a private place of another without consent, and with intent to disturb the peace and privacy of another or

DISTRICT ATTORNEY, STATE OF ALASKA
310 K STREET, SUITE 520
ANCHORAGE, ALASKA 99501
(907) 269-6300

with reckless disregard that the conduct was having that effect after being informed that the conduct was having that effect, made unreasonably loud noise.

All of which is a class B misdemeanor offense being contrary to and in violation of AS 11.61.110(a)(2) and against the peace and dignity of the State of Alaska.

Count II

That on or about the 22nd day of June, 2008, at or near Anchorage in the Third Judicial District, State of Alaska, WILLIAM S BIGLEY having no right to do so or any reasonable ground to believe the defendant had such a right (1) with intent to damage property of another, the defendant damaged property of another in an amount of $50 or more but less than $500; (2) the defendant tampered with a fire protection device in a building that is a public place; (3) the defendant knowingly accessed a computer, computer system, computer program, computer network, or part of a computer system or network; (4) the defendant used a device to descramble an electronic signal that had been scrambled to prevent unauthorized receipt or viewing of the signal; (5) the defendant knowingly removed, relocated, defaced, altered, obscured, shot at, destroyed, or otherwise tampered with an official traffic control device or damaged the work upon a highway under construction.

All of which is a class A misdemeanor offense being contrary to and in violation of AS 11.46.484(a) and against the peace and dignity of the State of Alaska.

Dated at Anchorage, Alaska, this ____ day of June, 2008.

TALIS J. COLBERG
ATTORNEY GENERAL

By: _____
Emma Haddix
Assistant District Attorney
Alaska Bar No. 0805019

DISTRICT ATTORNEY, STATE OF ALASKA
310 K STREET, SUITE 520
ANCHORAGE, ALASKA 99501
(907) 269-6300

005665

IN THE DISTRICT/SUPERIOR COURT FOR THE STATE OF ALASKA
AT Anchorage

☒ STATE OF ALASKA
☐

Plaintiff,

vs.

William S. Bigley

Defendant.

DOB: 1-15-1953

RECEIVED
JUN 24 2008
Alaska Psychiatric Institute
LEGAL OFFICE

CASE NO. 3AN-08-6820 CR

ORDER FOR PSYCHIATRIC EXAMINATION

I. APPOINTMENT OF PSYCHIATRIST

☒ The Director/CEO of the Alaska Psychiatric Institute (API) is appointed to name a qualified psychiatrist who shall examine the defendant for the purposes described in Section II below and report findings to the court. If the examination is to determine mental culpability, two qualified psychiatrists or two forensic psychologists certified by the American Board of Forensic Psychology must be named.

☒ This matter is set for further hearing as follows:

DATE: 7-1-08 TIME: 2:30 pm
COURT LOCATION: Anchorage, Nesbett COURTROOM: 204

The report is due to the court prior to the above date and time. If the report is completed prior to the date above and if, in the medical judgment of the evaluator, the defendant is considered to be mentally competent for criminal proceedings prior to the above hearing date, the undersigned judge's chambers shall be promptly notified so that an expedited hearing pursuant to AS 12.47.100 can be scheduled.

II. PURPOSE OF EXAMINATION

☒ **A. Examination for Competency to Proceed (AS 12.47.100)**

The purpose of the examination is to determine if the defendant, by reason of mental disease or defect, is incompetent for criminal proceedings. The report of the examination of the defendant shall contain the following:

1. a description of the nature of the examination;
2. a diagnosis of the mental condition of the defendant; and
3. an opinion as to whether the defendant suffers from a mental disease or defect and, as a result of the mental disease or defect, lacks the capacity to understand the proceedings against defendant or properly assist in defendant's own defense.
4. If the examination cannot be conducted because of the defendant's unwillingness to participate, the report shall so state and shall include, if

possible, an opinion as to whether the unwillingness of the defendant is the result of mental disease or defect.

☐ 5. (if box checked) An opinion as to whether the defendant is mentally capable of conducting defendant's defense without qualified counsel or whether, due to mental incompetence, defendant is not capable of doing so.

☐ **B. Examination for Mental Culpability (AS 12.47.070)**

The purpose of the examination is to make a determination and report the following:

1. a description of the nature of the examination;
2. a diagnosis of the mental condition of the defendant;
3. an opinion as to whether the defendant suffers from a mental disease or defect, and an opinion as to defendant's capacity to understand the proceedings against defendant and assist in defendant's own defense.

☐ 4. the defendant has filed notice of a defense under:

☐ AS 12.47.010(b). Therefore, the report must include an opinion as to the extent, if any, to which the capacity of the defendant to appreciate the nature and quality of defendant's conduct was impaired at the time of the crime charged;

☐ AS 12.47.020(a). Therefore, the report must include an opinion as to the capacity of the defendant to have a culpable mental state which is an element of the crime charged; namely the culpable mental state of _____

☐ 5. Defendant has filed a notice under AS 12.47.090(a). Therefore, the report must consider whether the defendant is presently suffering from any mental illness that causes the defendant to be dangerous to the public.

III. GENERAL PROVISIONS

IT IS FURTHER ORDERED:

A. The examination was requested by the
☐ District Attorney ☐ Defendant ☒ Court

B. The prosecuting attorney shall within 2 days (5 days if not otherwise noted) send a copy of the charging document, police report(s) and the defendant's criminal history directly to API in a large envelope with the words "Confidential - Court Ordered Examination" written on the bottom of the envelope.

C. The defense attorney shall within 2 days (5 days if not otherwise noted) send to API in the manner described in paragraph B above a copy of all reports required to be disclosed to the prosecution under Criminal Rule 16(c)(4).

D. The defense or prosecuting attorney may provide any other relevant information for consideration during the psychiatric examination by delivering it to API in the manner described in paragraph B above within the required timeframe.

E. The clerk of court shall immediately send to API a copy of: this order, the temporary order, the charging document in this case, any presentence report filed in this case and any psychiatric report filed in this case if the report was prepared by a psychiatrist other than one designated in this order. The clerk shall place copies of any confidential reports in a separate sealed envelope labeled "Confidential - Court Ordered Examination."

F. The examining psychiatrists or psychologists may use any medically acceptable source of information available.

G. If the defendant is in custody, the Department of Corrections shall make available to API all current medical records concerning the defendant.

H. The report ordered herein shall be filed with the clerk of the court at Anchorage, Alaska who shall deliver copies of the report to the prosecuting attorney and to the defendant's attorney.

☐ **IV. COMMITMENT AND TRANSPORTATION (In-Custody Examination Only)**

☐ Commitment. Defendant is ordered committed to a secure facility to be designated by the Department of Corrections (DOC) for a period of commitment not to exceed 60 days. Upon completion of the examination, defendant may be released on bail as previously set.

☑ Transportation. The examination will be conducted at API or at the correctional facility in Anchorage where defendant is held as agreed to by DOC and API. If necessary, the Alaska State Troopers (AST) are ordered to arrange for transportation of defendant to API, and upon completion of the examination, return the defendant to Corrections. Transportation to and from API from outside Anchorage will occur as soon as practicable.

If the defendant is in either DOC or API custody by the authority of a court order, AST shall arrange for the transportation of defendant to court for the hearing listed in Section I above.

☐ AST shall arrange for transportation of defendant to Anchorage for examination. Transportation to and from API from outside Anchorage will occur as soon as practicable. Prior to transportation, AST will coordinate the transportation with DOC and API. DOC shall notify API when defendant arrives in Anchorage if the defendant is committed by the court to DOC. AST will notify API when the defendant arrives in Anchorage if the defendant is committed by the court to API.

V. OUTPATIENT EXAMINATION (Only For Defendants Who Are Not In Custody)

☐ Defendant's counsel ☐ Defendant is ordered to contact the Alaska Psychiatric Institute within the next _____ days to schedule an examination.

6-24-08
Date

Judge

Type or Print Judge's Name

I certify that on 6-24-08 a copy of this order was sent to:
☑ AST (2 copies of order & T.O.) ☐ API
☐ Prosecuting Attorney ☑ Defense Attorney
Clerk: VS

Screen for VRA

IN THE DISTRICT/SUPERIOR COURT FOR THE STATE OF ALASKA
AT ANCHORAGE

(x) STATE OF ALASKA
( ) MUNICIPALITY OF ANCHORAGE

Plaintiff,

vs.

WILLIAM S. BIGLEY

Defendant.

DOB: 1/15/53

Amended

TEMPORARY ORDER

CASE NO. 3AN- 08-06820 CR

TIME: 3:00

Original Charge: I. DISORDERLY CONDUCT II. CRIM MISCHIEF 4th

Current Charge:

☐ Defendant is not in custody on this charge.

INSTRUCTIONS TO JAIL

☑ **Commitment.** It is ordered that the above-named defendant be held in custody:

☑ pending action by this court or until bail is posted in the amount of 250 9C + TPC

☐ pending receipt of formal judgment. Defendant was sentenced as follows:

☐ **Release.** This is your authority to release the defendant

☑ **Transportation.** TO API for Compent. eval. ~~KS~~ To DOC to coordinate with API for comp eval

☐ **Other Instructions.**

NEXT COURT APPEARANCE

DATE: 7-1-08 TIME: 230 PLACE: Anch

___Arraignment ___Sentencing ___Pre-Indictment Hearing
___Omnibus Hearing ___Bail Hearing ✓Representation Hearing
___Trial ___Trial Call ✓Other: CRP

Defendant ✓ is ___is not represented by counsel: ✓Public Defender Agency
Other:

Defendant ___has ___has not had a bail review.

6/24/08
Date

District/Superior Court Judge

(SEAL)

Type/Print Name: R. Postma

CR-200 ANCH (5/95)(st.3)
TEMPORARY ORDER

Crim. R. 4(e) and 5(a)(2)

In the Supreme Court of the State of Alaska

William S. Bigley, Appellant, v. **Alaska Psychiatric Institute,** Appellee.	Supreme Court No. **S-13116**
	Order
	Date of Order: **6/25/08**

Trial Court Case # **3AN-08-00493PR**

Before: Fabe, Chief Justice, and Matthews, Eastaugh, Carpeneti, and Winfree, Justices.

On consideration of appellee's 5/28/08 motion to reconsider the 5/23/08 individual justice order granting appellant's emergency motion to stay the 5/19/08 superior court order granting API's petition to administer psychotropic medication during appellant's period of commitment, and the 6/9/08 opposition,

IT IS ORDERED: the motion is **DENIED**.

Entered by direction of the court.

Clerk of the Appellate Courts

Lori A. Wade, Chief Deputy Clerk

cc: Supreme Court Justices

In the Supreme Court of the State of Alaska

William S. Bigley,	)	
	)	Supreme Court No. **S-13116**
Appellant,	)	
v.	)	**Order**
	)	
Alaska Psychiatric Institute,	)	
	)	
Appellee.	)	Date of Order: **6/25/08**
	)	

Trial Court Case # **3AN-08-00493PR**

IT IS ORDERED, SUA SPONTE:

On or before **7/7/08**, the parties are to briefly (memos not to exceed 3 pages) address whether the appeal should be expedited.

Entered by direction of an individual justice.

Clerk of the Appellate Courts

Lori A. Wade, Chief Deputy Clerk

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ALASKA PSYCHIATRIC INSTITUTE
LEGAL STATUS RECORD

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COMMUNICATE INFORMATION REGARDING STATUS TO LEGAL TECHNICIAN

DATE	STATUS	TYPE OF DOCUMENT / STIPULATIONS	ORDER EXP
06/26/2008	E&O	Adm via Order for Psychiatric Examination d/6-24-08, sgd by Dist. Ct. Judge Postma, Anchorage #3AN 08 6820 CR ".. Examination for Compentency to Proceed..." This matter is set for further hearing 7-1-08 @1430	
06/30/2008	NONE	DISCHARGED	
07/01/2008	NONE	Report by Dr. Michaud dated 6-27-08 faxed and sent by courier to Dist. Ct. Judge Postma, Anchorage	

REASONS FOR & CONDITION ON ADMISSION: As recorded on the Admission Psychiatric Evaluation for 06/26/2008:

IDENTIFYING DATA: "This is the 76th API admission for this 55-year-old, divorced, Alaska Native male. He is unemployed and receives Social Security Disability benefits based upon his psychiatric status. He is a military nonveteran. His records indicate a religious preference of Nazarene. He is admitted on a T12 Order for Evaluation for Competency to Continue Legal Proceedings.

PRESENTING PROBLEM/CHIEF COMPLAINT: The patient was admitted on a T12 Order for an Evaluation for Competency to Continue Legal Proceedings. He is charged with two misdemeanors, disorderly conduct and criminal mischief in the fourth degree. He exhibits no insight into the reason for his admission nor into his legal status. He presents as psychotic and delusional.

HISTORY OF PRESENT ILLNESS: This is the patient's 76th inpatient admission to API. He carries a diagnosis of Schizophrenia, Paranoid Type. His last discharge from API was April 25, 2008. Inaccurate

MENTAL STATUS EXAMINATION: Upon admission, the patient presented as agitated and hostile. He was observed to be yelling profanities at the staff and refused to allow anyone to interview or touch him. He quieted down over the course of the day, though continued to mumble and express anger and threaten aggression. His speech content is delusional, claiming to be the president and wishing to travel to Cuba. His speech volume rises when engaged in conversation. His mood remains agitated and irritable, and affect is congruent. He is able to make eye contact. It was not possible to assess him for orientation. It was not possible to test intellectual functioning. It was not possible to test memory. However, he is able to recognize staff from prior visits, indicating intact long-term memory. His judgment and insight are poor. It was not possible to assess him for suicidal or homicidal ideation. Lois I. Michaud, Ph.D. and Kahnaz Khari, M.D.

ADMITTING DIAGNOSIS:

Axis I: Schizophrenia, Paranoid Type, chronic.

Axis II: Deferred.

Axis III: Gastroesophageal reflux disease, by history.

Nicotine dependence.

Axis IV: Stressors: Problems related to interaction with the legal system/crime; Problems with primary support group; Problems related to the social environment; Other psychosocial and environmental problems; Housing problems.

Axis V: GAF: 30."

COURSE IN HOSPITAL: The patient was admitted on a T12 Order for an evaluation for Competency to Continue Legal Proceedings. He was agitated and hostile upon admission, yelling profanities at staff, expressing delusional beliefs. He continued to refuse psychotropic medication and remained psychotic throughout his stay on the Taku Unit. He was more subdued during the course of this stay than in the past, though continued to talk to himself, made unwelcome comments to staff, evidenced agitation, and voiced persecutory and grandiose beliefs. He was unable to demonstrate any understanding of his legal status or ability to engage in his own defense.

The patient had refused a history and physical as well as admitting labs. He has no known surgical history. He has a history of gastroesophageal reflux disease. He has a history of nicotine dependence. There are no lab findings to report.

CONDITION ON DISCHARGE: The patient remains psychotic and delusional. His mood continues to be agitated and irritable. His insight and judgement remain poor. His assets include financial support through Social Security Disability and his relatively intact physical health. It was not possible to assess him for suicidal or homicidal ideation at the time of discharge due to his psychotic state, though he did not voice any ideation, plan, or intent.

FINAL DIAGNOSIS:

Axis I: Schizophrenia, Paranoid Type, Chronic.

Axis II: Deferred.

Axis III: Gastroesophageal reflux disease, by history.

Nicotine dependence.

Axis IV: Stressors: Problems related to interaction with the legal system/crime; Other psychosocial and environmental problems; Housing problems.

Axis V: GAF: 30.

PROGNOSIS: The patient's prognosis is poor. The patient is noncompliant with psychotropic medications with his attorney's encouragement. He is delusional, hostile, with poor insight and judgment.

POST HOSPITAL PLAN, MEDICATIONS, & RECOMMENDATIONS: The patient is discharged without medications, as he consistently refused psychotropic medications due to lack of insight into his mental health symptoms. The patient is encouraged to follow-up with psychiatric treatment, though is unlikely to do so.

There are no restrictions on diet or activities post discharge.

Lois I. Michaud, Ph.D.
Licensed Psychologist (#451)
Staff Psychologist
Forensic Evaluation Unit
Alaska Psychiatric Institute

Kahnaz Khari, M.D.
Staff Psychiatrist

LIM/KK/tc/DISCH/32195F/APE/32146F
d. 06/30/08
t. 06/30/08 (draft)
dr/ft.07/02/08

Law Project for Psychiatric Rights
James B. Gottstein, Esq.
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(907) 274-7686

Attorney for Appellant

IN THE SUPREME COURT FOR THE STATE OF ALASKA

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

RESPONSE Re: EXPEDITED APPEAL

In response to this Court's June 25, 2008, Order, Appellant believes this appeal should be expedited. Appellant believes the appeal should be expedited not because of the stay, however, but because this Court should order he be provided as soon as possible with the less intrusive alternative to which he believes he is entitled under *Myers v. Alaska Psychiatric Institute*, 138 P.3d 238, 239, 248, 252, 254 (Alaska 2006).

In *Myers*, this Court held the state may not administer psychiatric drugs against a person's will under AS 47.30.839 if there is a less intrusive alternative available. *Id.* Appellant believes API may not avoid its obligation to provide such a less intrusive alternative merely by choosing that it shall not be provided. *Wyatt v. Stickney*, 344 F.Supp. 387, 392 (M.D.Ala.1972) ("no default can be justified by a want of operating

funds"), affirmed, *Wyatt v. Anderholt*, 503 F.2d 1305, 1315 (5th Cir. 1974)(state legislature is not free to provide social service in a way that denies constitutional right).

The *Wyatt* case was decided under the U. S. Constitution, and Appellant believes this Court should hold the same under the Alaska Constitution. In *Hootch v. Alaska State-Operated School System*, 536 P.2d 793, 808-09 (Alaska 1975), while this Court held that resolution of the complex problems pertaining to the location and quality of secondary education are best determined by the legislative process, it stated: "We shall not, however, hesitate to intervene if a violation . . . under either the Alaska or [United States] Constitutions is established." *Hootch* was an equal protection case, while here due process is involved, which does not involve such deference to the legislature.

Appellant has been locked up in the Alaska Psychiatric Institute (API) 75 times.[1] In addition, mostly as a result of expressing his extreme anger at the way he has been treated, he has been arrested multiple times for minor offenses not involving violence, including since his discharge from his most recent commitment.[2] The unanimous testimony in this case is that if Appellant were to have someone with him in the community and provided dependable housing, he could probably avoid being readmitted to API or landing back in jail.[3] Unfortunately, API refuses to provide such a less

---

[1] Stay Order, p.2.

[2] *State v. Bigley*, 3AN 08-06820CR, dismissed after finding Appellant incompetent to stand trial.

[3] Affidavits and oral testimony of Paul Cornils and Grace Jackson, MD, and the oral testimony of Dr. Hopson, the medical director of API. *See*, also, affidavits of Ronald Bassman, PhD, and Robert Whitaker, as well as the live testimony of Sarah Porter from the September 5, 2007, hearing in 3AN 07-1064, which was submitted under Evidence Rule 804(b)(1).

intrusive alternative. Instead, when it has been prevented from drugging Appellant against his will, including in this case, it has discharged him even though it has just come into court and obtained involuntary commitment orders upon the sworn testimony of its employees that he is gravely disabled and/or a danger to himself.[4]

Appellant believes he is entitled to the less intrusive alternative requested from the Superior Court.[5] Unless API is ordered by this Court to provide a less intrusive alternative during the pendency of this appeal, Appellant will be without the constitutionally required less intrusive alternative to which he is entitled during the time it takes to decide this appeal. This will cause Appellant unnecessary, and inherently irremediable suffering.

For these reasons, Appellant believes this appeal should be expedited or this Court should order API to provide the requested less intrusive alternative during the pendency of this appeal.[6]

Dated this 7th day of July, 2008, at Anchorage, Alaska.

LAW PROJECT FOR PSYCHIATRIC RIGHTS

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

---

[4] *See, e.g.*, September 18, 2007, Notice to the Court in 3AN 08-1064 PR, which appears at Exc. 27 in Appeal No. S-13015 before this Court.

[5] *See*, Motion for Less Intrusive Alternative attached to Limited Entry of Appearance and Tr. 281-285 (May 15, 2008).

[6] If this appeal is not expedited, it is anticipated Appellant will file a motion for such interim relief.

IN THE SUPREME COURT OF THE STATE OF ALASKA

William S. Bigley,

Appellant,

v.

Alaska Psychiatric Insitute,

Appellee.

Supreme Court No. S-13116

RECEIVED
JUL 0 8 2008

Trial Court Case No. 3AN-08-00493 PR

MEMO RE: EXPEDITED APPEAL

The Public Guardian, by and through undersigned counsel, does not believe the appeal in the above-captioned matter needs to be expedited. Mr. Bigley has been released from Alaska Psychiatric Institute and is no longer hospitalized.

DATED July 07, 2008 at Anchorage, Alaska.

OFFICE OF PUBLIC ADVOCACY

Phillip (Jay) McCarthy Jr.
Assistant Public Advocate
Bar No. 8206046

for Elizabeth Russo
Assistant Public Advocate
Bar No. 0311064

CERTIFICATE OF SERVICE
The undersigned hereby certifies that a copy of the foregoing was delivered to: Twomey, AGO; Brennan, PDA; Marieann Vassar, CV and mailed to AAG Stacie Kraly; James B. Gottstein Esq.;

7/7/08
Signature Date

ANCHORAGE CIVIL SECTION
OFFICE OF PUBLIC ADVOCACY
900 West 5th Avenue, Suite 525
Anchorage, Alaska 99501
Phone (907) 269-3500 • Fax (907) 269-3535

In the Supreme Court of the State of Alaska

William S. Bigley,

Appellant,

v.

Alaska Psychiatric Institute,

Appellee.

Trial Court Case # **3AN-08-00493PR**

Supreme Court No. **S-13116**

Order

Date of Order: **7/14/08**

Having considered the responses of appellant and the Public Guardian to this courts 6/25/08 order, this appeal is ordered **EXPEDITED**.

Appellant's request for alternative relief is therefore **DENIED** without prejudice. Briefing will proceed as set forth in Appellate Rule 218. No routine extensions of time will be granted.

Entered at the direction of an individual justice.

Clerk of the Appellate Courts

Shannon M. Brown, Deputy Clerk

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Marieann Vassar
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Anchorage AK 99517

IN THE DISTRICT/~~SUPERIOR~~ COURT FOR THE STATE OF ALASKA
AT Anchorage

file

☐ STATE OF ALASKA
☒ MOA
Plaintiff,

vs.

William Bigley
Defendant.

CASE NO. 08-9290 CR

DOB: 1-15-53

ORDER OF COMMITMENT AND TRANSPORT ORDER

Based on a finding of mental incompetence, the proceedings in this matter are STAYED.

1. COMMITMENT

Defendant is ordered committed to the custody of the Commissioner of Health and Human Services' authorized representative, Alaska Psychiatric Institute (API), for further evaluation and treatment* until:

the defendant is rendered mentally competent to stand trial; or
the pending charges in this matter are disposed of according to law; or
the expiration of this order.

During the period of commitment, the Commissioner of Health and Social Services, or the Commissioner's appropriate medical representatives, will administer treatment* as necessary to render the defendant competent to stand trial, will evaluate the defendant's competence, and will submit a report of competency to the court prior to the hearing date below.

The undersigned judge's chambers must be promptly notified so that an expedited hearing pursuant to AS 12.47.100 can be scheduled if, prior to the hearing scheduled below, the defendant's custodian considers the defendant to be mentally competent to stand trial or to be enabled by treatment to understand the proceedings and to properly assist in his or her own defense.

* Defendant may not be involuntarily medicated pursuant to this order. *See Sell v. United States*, 539 U.S. 166 (2003).

2. TRANSPORTATION

The Alaska State Troopers must transport the defendant to API for commitment as soon as practicable.

3. HEARING ON COMPETENCE is set for:

Date: 8/5/08 Time: 2:00 ☐ am ☒ pm
Location: Nesbett

This order expires 90 days from the date of this order unless renewed at the hearing (set in #3 above) or at another hearing.

7/31/08
Date

Rhoades
Judge

I certify that on 7-31-08 a copy of this order was sent to: ☒ AST ☐ API ☒ Prosecuting Attorney ☐ Defense Attorney Clerk: CR

Rhoades
Type or Print Name

CR-265 (6/07)(st.4)
ORDER OF COMMITMENT AND TRANSPORT ORDER

AS 12.47.100, .120

ALASKA PSYCHIATRIC INSTITUTE
LEGAL STATUS RECORD

DO NOT WRITE ON THIS SHEET
THIS STATUS RECORD IS MAINTAINED AND UPDATED BY HEALTH INFORMATION MANAGEMENT SERVICES
COMMUNICATE INFORMATION REGARDING STATUS TO LEGAL TECHNICIAN

DATE	STATUS	TYPE OF DOCUMENT / STIPULATIONS	ORDER EXP
08/01/2008	T12	ADM via ORDER OF COMMITMENT dated 7-31-08 signed by Dist. Ct. Judge Rhoades, Anchorage #08 8290 CR The proceedings in this matter are STAYED Def. is ordered committed to API for further evaluation and treatment until: ...the def. is rendered mentally competent to stand trial; or ...the pending charges in this matter are disposed of according to law; or ...the expiration of this order This order expires 90 days from the date unless renewed at the hearing HEARING ON COMPETENCE is set for: 8-5-08 @1400 in Anchorage The judge's chambers must be promptly notified so that an expedited hearing can be scheduled if, prior to the hearing, API considers the def. to be mentally competent to stand trial or to be enabled by treatment to understand the proceedings and to properly assist in his own defense.	
08/05/2008	NONE	DISCHARGED	

IN THE DISTRICT/~~SUPERIOR~~ COURT FOR THE STATE OF ALASKA AT ANCHORAGE

☐ STATE ☒ MUNICIPALITY OF ANCHORAGE CASE NO. 3AN- M 08. 8290 CR

DEFENDANT William Bigley DOB: 1.15.57

ORIGINAL CHARGES: 1. trespass II. disorderly conduct

AMENDED CHARGES:

COURT ORDERS:

TAPE # 2408. 137 2 LOG # 21155 21 DATE 8.5.08 TIME 200 AM/PM	Competency Type of Hearing Rhoades Judge/~~Magistrate~~ S. Bagely ☐ Clerk	Hammond PRESENT FOR STATE/MOA PRESENT FOR DEFENDANT	DEFENDANT: ☒ Present ☐ Not Present ☒ In-Custody ☐ Not In Custody 1000.-
Case initially assigned to Judge Peremptory Challenge Filed By ☐ State/MOA ☐ Defendant Case Reassigned to Judge	RIGHTS BY: ☐ Video ☐ Court	CRIMINAL RULE 39: ☐ $200 ☐ $250 ☐ Other	FINGERPRINTS: ☐ Taken ☐ Ordered

PLEA:
☐ Not Guilty Cts ☐ Guilty Cts ☐ No Contest Cts
☒ Dismissal Per Rule 43a Cts I-II
PETITION TO REVOKE PROBATION: ☐ Admit ☐ Deny
CRIMINAL RULES 5 & 45: ☐ Runs ☐ Tolled ☐ Rule 45 Expires
From to

Dr. Michaud: A not taking meds

MA: dismisses case

BAIL: ☐ EXON ☐ FORFEIT ☐ REINSTATE
BAIL SET/CONTINUED:
☐ OWN RECOGNIZANCE
☐ CASH APPEAR / CASH PERF. $
☐ CASH/CORPORATE $
☐ UNSECURED BOND $
☐ Third-Party Custodian approved:
☐ Concurrent w/

CONDITIONS OF RELEASE:
☐ Obey all laws & commit no jailable offenses
☐ No alcohol
☐ No non-prescription drugs
☐ No possession of weapons
☐ No driving w/o valid DL and insurance
☐ No direct or indirect contact with
☐ Attend all court dates
☐ Do not return to residence
☐

INSTRUCTIONS TO DEFENDANT

Appointment of Counsel. The court has ☐ GRANTED ☐ DENIED your request to have an attorney appointed to represent you. **You must contact your attorney within 2 working days from today.** If convicted, you will be ordered to pay part of the cost of counsel under Criminal Rule 39. The attorney appointed to represent you is:

☐ Public Defender Agency	☐ Office of Public Advocacy	☐ Gorton, Logue & Graper	☐ Conflict Attorney
900 W. 5th Ave., Ste 200	900 W. 5th Ave., Ste 525	737 M Street	Address:
Phone: 334-4400	Phone: 269-3500	Phone: 276-1945	Phone:

THESE ARE YOUR NEXT COURT DATES.
You must appear at all hearings listed below unless your attorney notifies you that you do not need to be present. A warrant for your arrest will be issued if you fail to appear for any hearing.

Type of Hearing	Date & Time	Type of Hearing	Date & Time
Pre-Indictment Hearing		Adjudication/Disposition	
Bail Review/Forfeiture Hearing		Pretrial Conference	
Representation Hearing		Trial Call / Trial	
Change of Plea/Sentencing		Date to Report to Jail/Remand	
Wellness/Veteran/CRP			

CR-150 ANCH (12/06)(st.5)
CRIMINAL LOG NOTES

I certify that on this date a copy of this form was given to:
Defendant; Prosecutor; Def's Atty; Calendaring Clerk: CB

REASONS FOR & CONDITION ON ADMISSION: As recorded on the Admission Psychiatric Evaluation for 08/01/2008:

IDENTIFYING DATA: "This is the 77th API admission for this 55-year-old, divorced, Alaska Native male. He reportedly has one adult daughter. He is unemployed and receives Social Security Disability benefits due to his psychiatric illness. He is a military nonveteran. He has expressed a Nazarene religious preference. He is admitted on a T12 Order having been found Not Competent To Continue Legal Proceedings by the Court and committed to API for competency restoration. At the same time, he is admitted without an order for involuntary medications.

PRESENTING PROBLEM/CHIEF COMPLAINT: The patient is committed to API for competency restoration, having been found Not Competent to Continue Legal Proceedings by the Court. He has been charged with Trespass and Disorderly Conduct, both misdemeanor counts. He exhibits no insight into the reason for his admission nor into his legal status. He presents as delusional and psychotic, despite having begun involuntary medications while in the custody of the Department of Corrections.

HISTORY OF PRESENT ILLNESS: This is the patient's 77th inpatient admission to API. He carries a diagnosis of Schizophrenia, Paranoid Type, chronic. He has a history of noncompliance with psychotropic medications, encouraged by his attorney. His last discharge from API was 06/30/2008.

MENTAL STATUS EXAMINATION: The patient was dressed in hospital garb at the time of the intake interview. He is oriented to person and place but not to situation. He shows no insight into the purpose of his admission to API nor into his legal status. He makes good eye contact. His speech is pressured and loud at times, often illogical and incoherent. His memory was not assessed due to his noncooperation. It was not possible to assess for suicidal or homicidal ideation. He does appear to respond to internal stimuli at times. His intellect is estimated to be below average. His mood is largely agitated and irritable, though he does respond to redirection if put to him in a calm manner. His affect is congruent. Lois I. Michaud, Ph.D. and Kahnaz Khari, M.D.

ADMITTING DIAGNOSIS:

Axis I: Schizophrenia, Paranoid Type, Chronic.

Axis II: Personality Disorder Not Otherwise Specified.

Axis III: Gastroesophageal reflux disease, by history.

Nicotine dependence.

Malnutrition.

Axis IV: Stressors: Problems related to interaction with the legal system/crime. Problems related to the social environment. Housing problems.

Axis V: GAF: 30."

COURSE IN HOSPITAL: This was the 77th admission for this individual to API. He was admitted on a T12 Order on an Evaluation and Observation status. He had been found Not Competent to Continue Legal Proceedings by the Court and was committed to API for competency restoration. He was admitted without an order for involuntary medications and refused psychotropic medications during his stay at API. He remained psychotic and delusional throughout his stay. His mood was often hostile and angry, yelling at staff, occasionally threatening, and often cursing. It was not possible to complete a Mental Status Exam. It was not possible to garner a contract for safety. He was noncooperative with groups and most staff requests, though was somewhat more subdued during this admission than in the past. His legal charges were dropped by the State upon being found Not Restorable by the Court. The patient is not gravely disabled, nor does he exhibit signs of being a danger to self or others, so was not civilly committable.

The patient refused a history and physical. He is missing teeth and wears no dentures. He has a history of gastroesophageal reflux disease and has been treated with Protonix for this. He is undernourished and appears emaciated. There are no current labs to report due to his refusal. He has no known surgical history. He has no known allergies.

CONDITION ON DISCHARGE: The patient remained psychotic, but is not deemed gravely disabled or a danger to himself or others, so is not civilly committable. He has services in the community.

FINAL DIAGNOSIS:

Axis I: Schizophrenia, Paranoid Type, Chronic.

Axis II: Personality Disorder Not Otherwise Specified.

Axis III: Gastroesophageal reflux disease, by history.

Nicotine dependence.

Malnutrition.

Axis IV: Stressors: Other psychosocial and environmental problems.

Axis V: GAF: 30.

PROGNOSIS: The patient's prognosis is fair to poor. He has no insight into his mental illness and refuses psychotropic medication, with his attorney's encouragement. He has a long history of deteriorating in the community due to his failure to comply with psychiatric treatment.

POST HOSPITAL PLAN, MEDICATIONS, & RECOMMENDATIONS: The patient has services in the community and is urged to remain in housing arranged by his guardian through the Office of Public Advocacy. He is urged to comply with psychiatric treatment and to follow-up with medical care as needed.

There are no restrictions on diet or activity.

Lois I. Michaud, Ph.D.
Licensed Psychologist (#451)
Staff Psychologist
Forensic Evaluation Unit
Alaska Psychiatric Institute

Kahnaz Khari, M.D.
Staff Psychiatrist

LIM/KK/tc/DISCH/32756F/APE/32715F
d. 08/06/08
t. 08/06/08 (draft)
dr/ft. 08/08/08

Screen for VRA

IN THE DISTRICT/~~SUPERIOR~~ COURT FOR THE STATE OF ALASKA
AT ANCHORAGE

( ) STATE OF ALASKA
(X) MUNICIPALITY OF ANCHORAGE

Plaintiff,

vs.

William Bigley

Defendant.

DOB: 1-15-53

TEMPORARY ORDER

CASE NO. 3AN- M08-8290 CR

TIME: 2:00 Competency

Original Charge: 1. trespass
11. disorderly conduct

Current Charge: _____

☐ Defendant is not in custody on this charge.

INSTRUCTIONS TO JAIL

☐ **Commitment.** It is ordered that the above-named defendant be held in custody:

☐ pending action by this court or until bail is posted in the amount of _____
~~$1,000.00~~

☐ pending receipt of formal judgment. Defendant was sentenced as follows:

_____

_____

☒ **Release.** This is your authority to release the defendant _____
case dismissed 43a

☐ **Transportation.** _____

_____

☐ **Other Instructions.** _____

_____

NEXT COURT APPEARANCE

DATE: _____ TIME: _____ PLACE: Anchorage

___Arraignment ___Sentencing ___Pre-Indictment Hearing
___Omnibus Hearing ___Bail Hearing ___Representation Hearing
___Trial ___Trial Call ___Other: _____

Defendant ___is ___is not represented by counsel: ___Public Defender Agency
___Other: _____

Defendant ___has ___has not had a bail review.

5 Aug. 2008
Date

(SEAL)

_____
District/Superior Court Judge
Type/Print Name: Rhoades

CR-200 ANCH (5/95)(st.3)
TEMPORARY ORDER

Crim. R. 4(c) and 5(a)(2)

Cont Note #5695

him. Walked within an inch of writer and said, "What are you scared" when reminded about personal space. During social skills pt was flipping off staff through FDR window and smiling. Remains on 1st degree COSS.

Electronically signed by:
MDH_MONICA_D_HEITMAN, RN

5696 Admission Date:08/01/2008 Patient # 00-56-65
08/05/2008 @ 14:44:40 Patient Response -
Progress Note PSO

Testified telephonically in a hearing with Judge Rhoades regarding his restorability to competency. I offered the opinion that he is not restorable without medications and the State dropped the charges against him. Judge Rhoades ordered him to be returned to API to be discharged or civilly committed.

Electronically signed by:
LIM_LOIS_I_MICHAUD, MHC

5697 Admission Date:08/01/2008 Patient # 00-56-65
08/05/2008 @ 15:25:42 Patient Response -
Progress Note Discharge Planning SW

Pt will discharge today to a local motel in community. Pt's legal charges have been dismissed and he does not meet criteria for civil commitment. Pt denies thoughts to hurt others or himself and is functioning at baseline. SW contacted pt's OPA guardian who reported that pt can return to the Paradise Inn in Anchorage for his housing. OPA guardian, Steve Young, agreed to contact the motel to notify them of pt's return and pay for another week. SW will provide cab slip for pt to reach the Paradise Inn. Pt is not on medications, but will continue to utilize API on an outpatient basis to receive his weekly money from OPA.

Electronically signed by:
MSN_MALINDA_S_NATANEK, LCSW

imc

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

In The Matter of the Guardianship of	)	COPY Original Received Probate Division
	)	
of William (Bill) S. Bigley	)	AUG 06 2008
	)	
Respondent	)	Clerk of the Trial Courts
	)	

Case No. 3AN 04-545P/G

HEARING SUBMISSION

The Respondent, by and through undersigned counsel, hereby submits the following for the court's consideration with respect to the review proceeding for which a hearing has been set for August 7, 2008.

I. Supporting Materials

The following evidence has been filed in support of this submission:[1]

1. Hearing Submission;
2. Appendix to Hearing Submission;
3. Sworn Report of Grace E. Jackson, MD;
4. Affidavit of Grace E. Jackson, MD;
5. Affidavit of Robert Whitaker;
6. Affidavit of Ronald Bassman, PhD;
7. Affidavit of Paul A. Cornils;
8. September 5, 2007, testimony of Sarah Porter;
9. April 3, 2007, testimony of Steve Young, Ann Nelson & William Worrall, MD; and
10. May 14, 2008, testimony of Grace E. Jackson MD.

II. Background

(A) Historical Facts

Prior to 1980, Respondent was successful in the community, he had long-term employment in a good job, was married with two daughters.[2] In 1980, Respondent's wife

[1] It is also anticipated that testimony at the hearing will augment this evidence.

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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).[3] When asked at the time what the problem was Respondent said "he had just gotten divorced and consequently had a nervous breakdown."[4] He was cooperative with staff throughout that first admission.[5] 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."[6]

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.[7] 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 variety of unpleasant Extra Pyramidal Symptoms (EPS)."[8] The Discharge Summary of this admission also

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---

[2] Appendix 1-8.
[3] Appendix 1.
[4] Appendix 1.
[5] Appendix 5.
[6] Appendix 8.
[7] The sworn report and affidavits of Grace E. Jackson, MD., and affidavit of Robert Whitaker describe 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, including brain damage and early death.
[8] 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

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.[9]

Twenty-Three years and over Fifty admissions later, the Visitor's Report of May 25, 2004 in this 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." On March 23, 2007, at discharge from his 68th admission to API, Dr. Worrall, summarized his condition after having reached the maximum benefit from the drugs that Respondent was "delusional" had "no insight and poor judgment, . . . paranoid and guarded." [10]

(B) Office of Public Advocacy --

It is believed the Office of Public Advocacy ("OPA" or "Guardian") was appointed Respondent's conservator in Case No. 3AN-99-1108. On April 14, 2004, the Alaska Psychiatric Institute (API) filed a petition for temporary and permanent

---

"therapeutic dose" had been achieved when Extra Pyramidal Symptoms appeared. Dr. Jackson testified to this in the May 14, 2008, hearing.

[9] Appendix 11.

[10] Appendix 27.

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guardianship. On June 30, 2004, OPA was appointed Respondent's temporary full guardian and on December 26, 2004, permanent full guardian. After being appointed, the Guardian unilaterally, without consultation with the Respondent, decided Respondent should become Medicaid eligible even though Respondent did not want Medicaid Services.[11]

Because Respondent'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 Respondent or certainly obtaining his consent.[12] This removed a substantial percentage of Respondent's income as available for general financial support.[13] Respondent is eligible for free medical care as an Alaska Native and doesn't need Medicaid to be eligible for such services.[14]

The Guardian has filed a number of *ex parte* petitions to have the Respondent committed in order to have him forcibly drugged against his will.[15] 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, Dr. Worrall, did not believe his survival was in jeopardy.[16]

---

[11] Tr. 4/3/07:216.
[12] *Id.*
[13] *Id.*
[14] Tr. 4/3/07:208. .
[15] *See*, e.g., Tr. 4/3/07:202.
[16] Appendix 22.

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OPA has arranged for extra funding to house and provide community support in a program that required Respondent to be compliant with medication.[17]

In furtherance of the Guardian's goal that Respondent be forcibly drugged against his will, and contrary to the assertions of OPA that this was not being done and would not be done,[18] on January 11, 2007, Steve Young signed a consent to the administration of psychotropic drugs in his capacity as the Guardian.[19]

On either February 22, 2007, or March 2, 2007, in furtherance of the Guardian's goal to have Respondent forcibly drugged, Steve Young called API and said he "is hoping for an early release due to patient's proven inability to maintain his med regimen in the community w/o support services. Pt reportedly 'fired' [Anchorage Community Mental Health Services] but they have not closed the case. SW will contact."[20] This was the official API plan for Respondent.[21] When questioned under oath at the April, 2007 public jury trial about whether he had a plan with API about utilizing early releases, Steve Young, Respondent's assigned guardian, apparently perjuriously denied that he had ever had such a plan.[22] The early release plan is illegal under AS 47.30.795 because

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[17] Appendix 33.
[18] *See*, Appendix 13. Mr. Parker of OPA had also assured counsel that OPA would not be authorizing the administration of such drugs over Respondent's objections.
[19] Appendix 18.
[20] Appendix 29.
[21] Appendix 23.
[22] Tr. 224, 225, 254 (April 3, 2007).

failure to take prescribed drugs is not an allowed ground for ordering someone back to the hospital. However, this illegal plan was implemented on March 19, 2007.[23]

On December 6, 2006, represented by PsychRights, Respondent filed a petition in his 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.

(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).

However, the Guardian's treatment of Respondent has led to an irreconcilable conflict, with Respondent taking extreme measures to try to get out from underneath the Guardian's oppressive yoke. As a result, Respondent is mostly refusing to cooperate in virtually any way with the Guardian. For example, the 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. The

[23] Appendix 30-32.

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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. These actions have then been labeled as psychiatric symptoms and used by the Guardian to justify having the Respondent locked up and forcibly drugged against his will.

(C) The Drugging of Respondent Is Ineffective and Very Harmful

The testimony of Grace E. Jackson, MD, and Robert Whitaker prove that the drugging of Respondent has been very harmful to him, including probably causing dysmentia and dementia and that if it is continued he will likely die within five years.

(D) Non-Coercive, Community Supports, Including Housing Is Needed

The testimony of Grace E. Jackson, Robert Whitaker, Ronald Bassman, PhD, Sarah Porter and Paul Cornils establish the type of non-coercive community support that would be extremely helpful to Respondent.

III. Argument

The Guardian has failed to discharge its duties to the Respondent and has actively engaged in behavior that harms him.

AS 13.26.150(c) provides in pertinent part:

> (c) . . . Except as modified by order of the court, a full guardian's. . . duties include, but are not limited to, the following:
>
> > (1) the guardian . . . shall assure that the ward has a place of abode in the least restrictive setting consistent with the essential requirements for the ward's physical health and safety;
> >
> > (2) the guardian shall assure the care, comfort, and maintenance of the ward;
> >
> > (3) the guardian shall assure that the ward receives the services necessary to meet the essential requirements for the ward's physical

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health and safety and to develop or regain, to the maximum extent possible, the capacity to meet the ward's needs for physical health and safety;

(4) the guardian shall assure through the initiation of court action and other means that the ward enjoys all personal, civil, and human rights to which the ward is entitled;

The Guardian has not and has proven to be unable to fulfill its duty to assure Respondent has a place of abode in the least restrictive setting as required in AS 13.26.150(c)(1). The Guardian has not and has proven unable to assure the care, comfort, and maintenance of Respondent as required by AS 13.26.150(c)2). The Guardian has not and has proven unable to assure that Respondent receive the services necessary to meet the essential requirements for the ward's physical health and safety and to develop or regain, to the maximum extent possible, the capacity to meet the ward's needs for physical health and safety as required in AS 13.26.150(c)3). The Guardian has not only failed and proven unable to shall assure through the initiation of court action and other means that the ward enjoys all personal, civil, and human rights to which the ward is entitled as required under AS 13.26.150(c)(4), it has actively violated Respondent's rights and obtained the assistance of others to violate Respondent's rights.

IV. Conclusion

In light of this, the Guardian should be relieved of its duties and the guardianship/conservatorship terminated.[24] In the alternative, the Guardian should be

[24] In *H.C.S. v. Community Advocacy Project of Alaska*, 42 P.3d 1093, 1097-1098, 1099 (Alaska 2002), the Alaska Supreme Court held that Alaska's "removal statutes do not purport to be exhaustive or comprehensive in describing the grounds for removal or the procedure to be followed when removal is sought." The court went on to say changed

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ordered to properly discharge its duties, with monthly reports to this Court thereon. This order should include that:

1. OPA obtain housing in the community for Respondent, which will remain available to him, and that will allow Respondent a reasonable amount of discretionary income from his funds, which shall not be less than $1,000 per month.

2. OPA procure the services in the community for people to be with Respondent for extended periods of time to listen to him, assist, as necessary to meet his needs, and keep him out of trouble.

DATED this 6th day of August, 2008.

Law Project for Psychiatric Rights

By: _____
James B. Gottstein
ABA # 7811100

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circumstances was required to justify a contested change of guardian, but Respondent suggests this does not prevent this court from fashioning an appropriate remedy in circumstances, such as here, where the guardian has abjectly failed to fulfill its duties.

IN THE SUPERIOR COURT OF THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

IN THE MATTER OF:)
)
WILLIAM BIGLEY,)
)
Case No. 3AN-04-00545PR

GUARDIANSHIP HEARING
BEFORE JUDGE DUGGAN

Thursday, August 7, 2008
10:18 a.m.

APPEARANCES:

For Mr. Bigley: James B. Gottstein
406 G Street, Suite 206
Anchorage, Alaska 99501
(907) 274-7686

For the State
of Alaska: Scott Friend
Timothy Twomey
Mara Rabinowitz
1031 West 4th Avenue, Suite 200
Anchorage, Alaska 99501
(907) 269-5168

Also Present: William Bigley
Ms. Stanley, Court Visitor
Mr. Hughes, OPA

PROCEEDINGS

THE COURT: We're back on the record this morning in the matter of a guardianship proceeding concerning William Bigley, Case Number 04-545.

I apologize to the parties for starting a few minutes late. We had an adoption hearing that ran a little long this morning.

And this is -- I just note Ms. Stanley, the court visitor is present. She filed a report on July 29, 2008. Mr. Friend is here from the office of the attorney general.

Mr. Gottstein is here representing Mr. Bigley, who is present. Mr. Hughes from the office of public advocacy, who I believe is Mr. Bigley's assigned guardian from the public guardian's office at this time is present.

And Ms. Rabinowitz is here, and you're representing Mr. Hughes and the office of public advocacy today; is that correct?

MS. RABINOWITZ: That's correct, Your Honor.

THE COURT: This was a hearing that we have scheduled based on Mr. Bigley's request. He had filed a petition for review of the guardianship. It was dated August 20th of 2008, and it was filed on March 20, 2008.

Mr. Bigley indicated in his request that --

asked the court to review the guardianship, conservatorship, because, and he says, "They took my money." So that's the matter that we have scheduled then for hearing today.

And I didn't know if there is an annual report. The last annual report that we had from the public guardian was filed on January 30, 2008, and that does include an accounting concerning Mr. Bigley's funds up through that date, and it's not clear from his request what funds that he said were taken.

I'm assuming that he is talking about his guardian taking the funds since he wanted the guardianship reviewed, but Mr. Gottstein, if you could just clarify Mr. Bigley's request, if you would.

MR. GOTTSTEIN: Thank you. Your Honor, I filed a hearing submission yesterday.

THE COURT: That was filed yesterday at 11:30, and so that did get in the file and the file got to me this morning, but it's about a volume thick and has not been reviewed by the court.

MR. GOTTSTEIN: Well, I apologize for that. I intended to do it much earlier, and I had a series of intervening things, including an expedited appeal.

THE COURT: Mr. Bigley, you filed the request to review this, so we would prefer if you stuck

around.

I'll just ask Mr. Gottstein, if you want to have a moment to talk with your client to see if he wants to stay or if he wants to leave. It's at his discretion, but, again, the hearing was scheduled at his request.

Mr. Gottstein, if Mr. Bigley is going to wait outside, that's just fine. If you can clarify with him, or maybe you already know, what money he is talking about, so we can, while we have everybody here, we can account for that and be able to answer his question.

Just note for the record that Mr. Bigley has chosen to, as I understand it, to wait outside while we continue the discussion, but he would remain available out there.

Is that your understanding, Mr. Gottstein?

MR. GOTTSTEIN: Yes, Your Honor. With him, one never knows.

THE COURT: All right.

MR. GOTTSTEIN: I have spoken with Mr. Bigley and he wants the guardianship terminated. I think he is very clear about that, and he has been for many times. I think the form he filed was a little bit unclear.

And I think that -- my suggestion is maybe

that this ought to be continued because I think that the submission I made yesterday raises some important issues, and if I could just briefly summarize it.

It's basically that the current regime that has kind of been interrupted at this point of forcing Mr. Bigley to take medications he didn't want, has not been working, and he is, you know, having difficulties in the community that cause him to be arrested for very minor things and taken to API and then released and all kinds of troubles.

And what's very clear in the submission is that if he had housing that was going to remain available to him and someone that he could have that would be with him for substantial periods during the day, that he is very likely to be much more successful in the community.

And I don't think that the guardian actually disagrees with that. It's just that has had problems with -- or has -- hasn't really identified funds to do that.

In the past, I think it's very clear the guardian has really gone against Mr. Bigley's wishes in terms of the medication and has really been part and parcel of that regime which I think it's fair to characterize has been misguided.

And the materials I submitted go into that in some detail, but I think the main point is that it seems to me that the guardian should be reoriented towards honoring Mr. Bigley's desire not to take the drugs and working on ways for him to be successful in the community without the drugs.

And events have kind of, I think, just over taken us, and it seems to me that a continuance for them to kind of have a chance to deal with that and maybe have a chance for us to get together and try and work something out makes sense.

One of the pieces in the appendix is an e-mail from Ms. Russo where she indicated she had intended to move for mediation and I think events just kind of proceeded without that happening.

So that's pretty much what I have.

THE COURT: Well, the only issue that's promptly before the court at this time is Mr. Bigley's request back in March that, "They took my money," request that, "They took my money," which I assume to be that he thought that the public guardian that was assigned to his case has somehow dealt improperly with his finances and that that's what this hearing was noticed about.

There was objections to the appointment of

visitor and things. We have done a master's report about that. Judge Christen entered an order about that, so that was resolved, and the matter then came on for this hearing, and everybody is here to take up that issue and the court is allowing an hour to address Mr. Bigley's issue about his money.

This hearing submission that you filed was filed less than 24 hours before this hearing. There has been -- the court hasn't had a chance to read through that. None of the parties have had a chance to respond to that, and it doesn't sound like it has anything to do with Mr. Bigley's request for review.

So what I'll do is we have this time, we have some parties here that -- first, I'm just going to try and determine if there is an issue about money, what money he thinks was taken. And we have Mr. Hughes with his counsel to explain or respond to any questions he has about his finances. We'll see if we can answer those today.

As far as decisions about housing or other arrangements for Mr. Bigley, again, if there is an issue or request that he has and that Mr. Hughes is here represented by his attorney, and we can at least clear up what the issues are about that. And then if there is a new or different request for review, then the court

will take that up, the parties will have a chance to respond, but I'm not going to continue the hearing today on this request that was filed back in March. We're going to try and resolve that.

So before we get to these other things, is there any specific money that Mr. Bigley thinks the public guardian has handled improperly or converted or anything like that?

MR. GOTTSTEIN: Well, I wasn't served with the annual accounting, I don't think, but I think fundamentally -- I don't think I was, but --

THE COURT: It's in the court file here, so I don't know that -- that was filed with the court on January 20th. You have entered an appearance, limited entry of -- I saw your entry of appearance I think sometime after January, I thought.

MR. GOTTSTEIN: December 6, 2006.

THE COURT: It's in the file that certainly his attorney that -- let's see, January 30, 2008, it looks like when I got this annual report filed.

And I thought I saw an entry of appearance that was since the time we filed our notice of review, but I could be mistaken.

UNIDENTIFIED SPEAKER: Excuse me, Your Honor. I got a call from the front counter. Mr. Bigley

is at the front counter and will not proceed back into the lobby.

THE COURT: All right. Well, Mr. Gottstein, I'm not sure why Mr. Bigley is at the front counter, but we're going to recess for just a minute.

If you can go out there and talk to Mr. Bigley to find out -- I think what will happen at the front counter is they will escort him out of the building, so if he wants to stay for our hearing, he is going to need to leave the front counter and sit outside the courtroom.

Otherwise, he is going to get escorted out, so if you will just take a minute and go and do that, sir. We'll be off the record.

(Off record.)

(On record.)

THE COURT: We're back on the record, and Mr. Gottstein, Mr. Bigley is still out there?

MR. GOTTSTEIN: Yeah, and a couple of bailiffs are out there with him.

THE COURT: Mr. Bigley can come in. It's his hearing, but it was his preference I think to step outside. If he is here, he is welcome to come in.

If he would prefer to sit outside, he can do that, but he can't go over to the front counter. He

just needs to sit outside the courtroom or come in. Those are his choices.

Come up and have a seat by your attorney. If you need to leave again, that's okay, but you can't go up to the front counter. You can only go sit outside the court. This is your hearing, so please have a seat.

Have a seat, Bill. Mr. Gottstein, were you able to --

We're back on the record? Yeah.

Were you able to determine if there is any specific funds that Mr. Bigley had a concern about?

MR. GOTTSTEIN: Well, I think Mr. Bigley can perhaps speak to that. I think one of the problems is that he has really only been allowed, the last I heard, $10 a day, you know, in spending money.

And from his perspective, of course, all of his money has been taken away and, you know, not under his control. But I think the big problem is -- you know, that's one of the really big problems is that he has so little spending money, and that was -- you know, that was actually addressed in the settlement agreement, but hasn't really been resolved.

And I think a big piece of that is, you know, how much of his money is going to housing.

THE COURT: We have had reviews of

Mr. Bigley's case before and have talked about money in those reviews. Mr. Bigley had, first of all, concern that all of his money had been taken by the public guardian, so we talked about that before.

Also, had concerns about the allowance and what he needed to spend money on, and so we have talked about those things before too.

We have -- so just to clarify. My understanding is that Mr. Bigley's complaints about money based on his requests for review are, number one, that the public guardian has his money and he disagrees with that. And number two, that an allowance of $10 a day is insufficient, and he wants to have at least those two things addressed today.

Bill, you need to listen. You have to be quiet so we can have some people answer some questions.

MR. GOTTSTEIN: Well, Your Honor, I think --

THE COURT: What I'm offering is I can have Mr. Hughes, through his attorney, respond to the questions about where Mr. Bigley's money is generally, and specifically can address what they have done about the allowance.

You can certainly ask questions about that and request a change if there is an issue about that we can take up here.

MR. GOTTSTEIN: Well, I think, and, again, I apologize for the lateness of the submission yesterday, but I think that there are really larger issues about the administration of this guardianship, and so that is definitely a piece of it.

It is certainly a piece of what I put in the submission yesterday. So I mean, obviously, we can proceed that way, but I do think that these other issues should be addressed.

MS. RABINOWITZ: Your Honor, if I may, the public guardian objects to the hearing submission based on the lateness of the filing and potentially the relevancy of the hearing submission.

The matter, as indicated by the court, before the court is just related to money and the respondent's request for a change of guardianship based on OPA allegedly taking funds.

We're willing to speak to that and that issue only today. The hearing submission apparently goes beyond the scope.

THE COURT: Let me repeat what I understood the status to be was that everybody was on notice about Mr. Bigley's concern about money based on his short request for a hearing. A hearing was scheduled based on that, and that's what brought the parties here to talk

about.

Mr. Gottstein, on Mr. Bigley's behalf, has submitted this hearing submission yesterday. What I'm going to do is I'm going to inquire briefly through Ms. Rabinowitz about the financial arrangement for Mr. Bigley at this time so at least everybody knows what that information is.

If Mr. Bigley has other issues that he wants to request a review about, about medication arrangements through the public guardian, the housing arrangement, those sorts of things, then through Mr. Gottstein he can file a request for review on those issues and then everybody will be on notice what his request is and have a chance to review the submission and respond to that.

But all we're going to do today is try and get a little information about the finances, so if there is specific things that Mr. Bigley has objections to about that, Mr. Gottstein can let us know about that.

And I'm going to try and get some general information about the housing information and answer a couple of the questions that Mr. Gottstein has, if Mr. Hughes is able to do that today about housing arrangements and the other things Mr. Gottstein mentioned.

But I think that's the limit of what we can

do today based on notice and status, so with that, let me just ask, Mr. Hughes, the annual report was filed January 20th, I think with the court.

Do you know who got copies of that?

MR. HUGHES: Let me see if I have a -- it says on the service list. It looks like it was just served on the court.

THE COURT: Mr. Gottstein, we can make the court file available at the front counter so we can get you a copy of that annual report form, which shows finances through January 20th.

I appreciate that since you don't have a copy of it today that you can't ask specific questions about that, but as far as Mr. Bigley's --

Go ahead, Mr. Hughes.

MR. HUGHES: I was just going to add that as far as his money concerns, it hasn't changed since the settlement agreement as far as the income that was laid out in Mr. Gottstein's settlement agreement.

So the section on finances is the same as far as income, so I mean that information is known.

THE COURT: And again, I haven't reviewed the settlement agreement today, but, Mr. Gottstein, so you're aware on Mr. Bigley's behalf generally of what the arrangement is concerning his income and monthly

expenses?

MR. GOTTSTEIN: Yes, Your Honor. I mean, generally, yes.

THE COURT: I thought you said there were a couple of things in the settlement agreement that hadn't been followed through concerning financial matters.

MR. GOTTSTEIN: Well, the settlement agreement really provided that the parties were going to try and find subsidized housing as a way to give Mr. Bigley more discretionary income.

And one of the things that happened was that the guardian found some money actually to put him up in an assisted living facility in Big Lake called the Big Lake Country Club. I think maybe it actually took more of his money and then --

THE COURT: Mr. Twomey is present from the AG's office, but Mr. Bigley can't bother Mr. Twomey. Mr. Bigley needs to either pay attention to us, or if you could ask him to --

Mr. Bigley -- Mr. Bigley?

MR. BIGLEY: Do you have a problem?

THE COURT: I do. You are not allowed to bother Mr. Twomey in the back. I want you to pay attention to what we're doing because this is a hearing about you, so please don't bother Mr. Twomey in the back

of the courtroom.

We're talking about your money, so if you will listen to Mr. Gottstein --

You were saying that they found some money to put him in assisted living?

MR. GOTTSTEIN: Yeah, but the problem was that that assisted -- my understanding is that assisted living facility required him to, you know, be compliant with medications, and, you know, then that didn't work out.

And so I think that the idea is that we really need to find a good housing situation with some subsidized housing that really he won't lose, and also that will increase his discretionary income, and so that's basically the thrust of the submission yesterday.

THE COURT: Does Mr. Bigley have any specific places that he has located or that you have located on his behalf that you want the public guardian to consider as options?

MR. GOTTSTEIN: I haven't. I think he -- the last I heard he was at Paradise Inn, so I think he has been there. I don't know how sustainable that is with his budget, so I think that it's basically not sustainable, and so what we found is that --

THE COURT: Is that an apartment building or

a hotel?

MR. GOTTSTEIN: It's a motel. I think accurately characterized as a cheap motel. But even in that category, it's not something that is really sustainable long-term.

My impression is that his account kind of builds up when he is held at API and held by corrections, and that has then enabled kind of some extra funding really to be available short-term for that kind of housing, but it's not sustainable in the long run in that he has difficulties in his housing, which in my view is due to not having, you know, support to enable him to kind of basically stay out of trouble.

And so then when he loses his housing, then things really deteriorate from there. But with respect to this hearing, I think the way that it's postured at this point is the need to have some subsidized housing that will kind of remain available to him that will allow him a reasonable amount of discretionary spending money, because $10 a day I think is just really not something that anybody would be happy with.

THE COURT: Just to explore it, Mr. Hughes, Ms. Rabinowitz, may I inquire of you and your client, is there any housing alternatives that the public guardian is looking at for Mr. Bigley at this time that would be

less expensive possibly so he would have a little better allowance, do you know.

MS. RABINOWITZ: Mr. Hughes can speak to that. I know he has definitely worked on that.

MR. HUGHES: Sure. This is something we have definitely worked on. The Big Lake Country Club was one example of assisted living. It was paid for by mental health GR funds. It was a level four -- or level three, something like that.

It was a type of mental health funding paid for by the Medicaid system that apparently there is only four statewide slots. I was able to get one for Mr. Bigley. He stayed a very short time at the Big Lake Country Club, because even they were not able to deal with his behaviors, so he was basically evicted.

He was asked not to come back. He ended up in API after that. Then we have tried many different hotels and motels, even the --

MR. BIGLEY: Slums.

MR. HUGHES: Yeah. And he makes a good point. They are not the best hotels. Unfortunately, with his behavior, some of the -- well, even if he could afford some of the nicer ones, for example, Motel Six he stayed at for maybe two, three nights.

He calls the police repeatedly. His

behavior gets him kicked out.

Money, going over to money though, has been a very difficult issue with Mr. Bigley. A big concern is waste. He wastes his money. He will either give it away, he'll buy trinkets, he'll throw it away.

I have seen him tear up money. He also -- don't do it, Bill.

The current problem we're facing now is our system here at OPA uses checks, paper checks. We had done daily checks to Mr. Bigley that he would then take to FNBA and have them cashed.

The system worked for a long time until his behavior became so out of control that they have trespassed him from there. I was with him one day when he became arrested because he -- I was trying to cash the check for him and bring him the cash, but even that wasn't working.

So unfortunately, checks to vendors, he doesn't like. Checks made out to him get him arrested, and we're not able to dispense cash. So we tried debit cards. Debit cards, he lost them immediately. I had two $100 debit cards. He lost them within two days.

I gave him one one day, came back the next day, gave him the other one, and he lost it. He has this impression that he has lots of money, billions of

dollars.

And unfortunately, he thinks I'm hiding this from him, which isn't the case, as you can see by the annual report, so it's a very difficult situation we have had trying to fulfill our duties to keep him housed.

He had Rural Cap subsidized housing for a short period of time. He became evicted from that. And I'm not aware of another program in the short term that's willing to serve Mr. Bigley, or another kind of support person either through recipient support services or individual skill development, paid for by mental health Medicaid, which he qualifies for, that are willing to serve him.

Unfortunately, his behavior, he can be quite rude and service providers either don't want to put up with him or they feel that they are reimbursed at a rate that's too low that will make that work, so unfortunately, I -- the public guardian is put up against this Medicaid program that has very specific rules and it's elective for the providers.

They don't have to deal with the person if they don't want to, and we don't have a lot of different providers to work with, so --

THE COURT: Is it accurate, Mr. Hughes, it's

a $10 a day allowance? Is that what the current --

MR. HUGHES: To be truthful, it changes very rapidly because of the -- I deal with this case almost every day.

$10 a day is actually -- it's not getting that right now, because he is getting -- API was able to work with us. We send over $50 checks once a week. In the meantime, the rest of his money has been going to Paradise Inn for housing and then also for the restaurant there, they serve food.

Unfortunately, my communication with Mr. Bigley is such that I'm not able to find out if that's working very well. I get my information either through Paradise Inn or through other people that talk to him.

He didn't like me very much and is not able to be very forthcoming with information to help him, meet his needs.

THE COURT: My understanding from your response is that $10 is the amount today, but that fluctuates based on what he has after expenses and what other moneys that he might receive?

MR. HUGHES: Right. And as Mr. Gottstein said, when he is in API or in custody, because he gets SSDI, it's not cut off when he is institutionalized, so

it does build up.
I have tried saving him money by using part of his trust -- money out of his trust to purchase cigarettes, which he was coming in every day to pick up, which I don't do for anybody else, but in order to keep an eye on him and to try to engage him in conversation about where he would like to live and if he would like to engage in services or with a provider or anything like that, and unfortunately, he is now banned from the office due to his behavior, his destructive behavior in the lobby.
So the $50 a week is cash that he gets through API, and we're still trying to come up with another plan to make sure that he gets food and gets housing.
THE COURT: Thank you.
MR. HUGHES: So as long as he has money, we make an effort to make sure that he is housed. Unfortunately, he is not able to follow through with appointments to get any sort of apartment, and he is not willing to engage and to take on assisted living residence right now.
We're not in a position to force him to do anything like that, so motels seem to be the only thing that's marginally working at the present moment.

THE COURT: It sounds like a difficult predicament. Are there any positive things concerning placement or -- (indiscernible) -- or anything like that you're considering or can suggest at this time?
MR. HUGHES: I have to apologize. I have been out for the past week, so I don't know what his absolute current situation is. It does change from day-to-day.
We have started meetings with the mental health trust trying to brainstorm other ways. Those started last year, and, unfortunately, nothing -- there is no magical solution that's presented itself.
Medication, as Mr. Bigley just brought up, is a point that we disagree on. My feeling is -- well, I probably shouldn't talk about medication today, but it's a separate issue, and it's something that's not been resolved.
THE COURT: Thank you. Ms. Rabinowitz, any questions that you want to ask?
MS. RABINOWITZ: No, Your Honor. I just wanted to make sure that we indicate to the court that we're obviously aware of the report of the visitor, and we realize that she has filed that in a timely manner for the hearing today.
And we -- she has some recommendations that

we'll be responding to, especially with respect to the settlement agreement.
THE COURT: Thank you. Mr. Gottstein, did you want to ask Mr. Hughes any questions about the financial information that he has provided, or I guess the efforts that he is making on these other fronts.
MR. GOTTSTEIN: No. I think that we have a shared understanding of that pretty well. I don't know -- yeah, so just for the record, I do not think that the settlement agreement should be terminated.
I think it's set up so that at any time that he, you know, meets those criteria, then we come in and implement it, so there is no particular time limit on when that might be implemented, so I think it was worked out and so I don't think that that is really something that ought to be done.
THE COURT: Thank you.
MR. GOTTSTEIN: I can respond in writing. Maybe if they end up -- I would like the opportunity to respond to whatever OPA files on that.
THE COURT: Certainly. Mr. Friend, any questions that you have for Mr. Hughes about the current financial arrangement and housing efforts for Mr. Bigley?
MR. FRIEND: Not so much a question, so I

don't know if you're going to ask if we have --
THE COURT: I just want to find out who has questions on this. Speak briefly to Ms. Stanley and then go around and see if anybody else wants to comment about this limited scope of our hearing today.
Ms. Stanley, you have had a chance as a visitor then to review that annual report and familiarize yourself with the financial arrangements that they are making for Mr. Bigley at this time?
MS. STANLEY: Yes, Your Honor.
THE COURT: Any questions you have for Mr. Hughes about what he said?
MS. STANLEY: No. I think that his testimony targeted the problems that Mr. Bigley's circumstances change from day-to-day and it's very difficult to know where he is at and what he gets.
But his money is being spent for him and, unfortunately, Mr. Bigley has burned some bridges behind him and we don't have all of the resources that we had even three years ago to be able to help him out.
THE COURT: In your capacity as visitor, are you aware of any possible housing situations, resources, agencies, anything like that that could be tapped that additional efforts are being made to find a comfortable place for Mr. Bigley?

MS. STANLEY: Well, we have tapped the one with the mental health, and that worked for a very short period of time. I'm not real familiar with Section 8 housing, and I don't know if Mr. Bigley would qualify for that, but that's the only other one that I can think of in terms of housing assistance for him.

THE COURT: Mr. Gottstein, I know Mr. Bigley has issues concerning medication. There is -- I think you're familiar with -- I can't think of what the name of the place is, but the place that's down by Anchor Point that's sort of a group housing arrangement that --

MR. GOTTSTEIN: Ionia, I think you're referring to.

THE COURT: I think that's it. I have had that come up a couple of times at API where people have addressed that as a possible discharge place.

Has that ever been explored for Mr. Bigley, do you know?

MR. GOTTSTEIN: It's really a place for families.

THE COURT: That's what I understood.

MR. GOTTSTEIN: And so I don't think that that would really be available. I think from my perspective, it's really very hard to segregate the medication issue from all of this, because it's such a

-- something to which he objects so vehemently to, and so I think that -- and in the testimony of Paul Corneals that is submitted from May 15th, I think, he -- maybe I didn't submit that. I submitted his affidavit, but in any event, that that's a big part of, in his view, of the problems that he is having in the community is that he feels that everybody wants him to take medication that he didn't want.

Of course, these programs tend to require it. And so I think that all of these futile efforts to get him to take medication is really inhibiting the progress in these other areas.

And I think that some really creative work, you know, ought to occur on how to address these problems. For example, there is an agency called Choices that has worked with him in the past, and, you know, and they have various requirements that, you know, and potential impediments to working with them, but I don't think they are necessarily insurmountable.

And there may be other programs too, such as -- I don't know how much Assets has really been dealt with, for example, or looked to.

But I think the point is that -- the other point is is that at this point, that without having support for Mr. Bigley in the community, which

basically, in my view, with a lot of experience with Mr. Bigley, really just means having someone with him.

And that that would go a long way towards relieving not only Mr. Bigley's problems, but, you know, kind of the difficulties that other people in the community have with him, so I think that a comprehensive look at those issues is really what's necessary.

THE COURT: A comprehensive look at what issues? You said have somebody with him, and we talked about the Assets program, but --

MR. GOTTSTEIN: And finding housing that realistically is going to be sustainable. Those are the kind of two big issues, I think.

THE COURT: My impression from what Mr. Hughes' comments was was that the public guardian's office is apparently making conscientious, diligent efforts in a difficult case, difficult situation to handle finances and orchestrate housing for Mr. Bigley, so I'm not sure about what kind of a comprehensive review that you're talking about.

MR. GOTTSTEIN: Well, comprehensive approach to working on this. And so I think -- I mean --

THE COURT: Bill, you have to be quiet because we can only record one person's testimony at a time or we're not going to have a clear record when you

talk through it.

Please be quiet, Bill, so we can hear what your attorney has to say.

MR. GOTTSTEIN: Your Honor, I think that raises another point, which is --

THE COURT: I'm still trying to find out what the point was about the comprehensive. I didn't understand what the comprehensive --

MR. GOTTSTEIN: I put it in the submission, but that a program needs to be put together for Mr. Bigley, which I think the guardian is required to do under the statute to effectuate his desires as much as possible, that the guardian is required to assure that he has an abode, and I think that it has not been able to do that.

And then, of course, his physical health and safety as well as, what, care and comfort. And that that -- the guardian -- and I agree that it's a difficult case, but that the guardian has been unable to really fulfill those duties.

And so I think that basically that we need to come up with an approach where the guardian can fulfill those duties, you know, or that the guardianship should be terminated.

THE COURT: I think you and I disagree. My

understanding of when you appoint somebody as a guardian, whether it's an entity such as a public guardian or an individual, that person is authorized by the court order to make decisions about if it includes conservator authority about financial matters, but about placement or health care under a guardianship.

But that there isn't any guarantee in the statute, or that I'm aware of, that says that they guarantee that they will find a suitable abode for this person or they guarantee that it will be an adequate financial arrangement.

I think they have decision-making authority, and that includes decisions about where a person would live or those arrangements, but I know there are some cases where, because of the limited resources or the nature of the person's disability, that there is not a solution, but they do the best they can in those circumstances.

So if there is -- I think if there is a citation or a reference that you have where it says that --

MR. GOTTSTEIN: Yes. AS 1326 150 (c)(1). It states, "The guardian shall assure that the ward has a place of abode in the least restrictive setting consistent with the essential requirements for the

regard's physical health and safety."

THE COURT: That may be different from what Mr. Bigley wants though.

MR. GOTTSTEIN: Well, then -- but then in section A, "Shall encourage the ward to participate to the maximum extent of the ward's capacity."

I think basically the idea is -- "Shall encourage the ward to participate to the maximum extent of the ward's capacity in all decisions," and I think that he has expressed, you know, very clear desires with respect to a number of things, and I think that the guardian is required to, you know, try and achieve those consistent with, you know, the duties adherent in decision-making power, but still the ward's desires are very definitely to be taken into account.

THE COURT: I would agree with that. My understanding is Mr. Bigley's position is that the public guardian has been deficient in that regard and that he is requesting guardianship terminated or is not requesting it be terminated?

MR. GOTTSTEIN: Yes. He is very clear he wants the guardianship terminated.

THE COURT: And the reason that you're arguing is because they have been deficient in complying with that statute?

MR. GOTTSTEIN: Well, I mean, as his attorney, of course, I try and represent his position. And so he is very clear that he wants the guardianship terminated. He believes that he doesn't need a guardian, that he can handle his own money and all of that sort of thing.

And what I'm bringing to the court is the guardian's responsibility with respect to the various aspects of it, and that that should be worked on.

And I think that if the guardian can't fulfill its duties, that guardian should be terminated.

THE COURT: Thank you. Mr. Friend, a comment that you have?

MR. FRIEND: Yeah, and, actually, the court touched on some of it, so I apologize for what's redundant, but my understanding is that there is a guardianship petition and then there is a hearing contested or not and then the guardian is appointed with the authority to make decisions on behalf of the ward.

And that the ward can then, or another interested party, request a review, and I would think that that would have to be based on either a change of circumstances or some misconduct of the guardian for not fulfilling their duty.

But since he can't do what's not there.

There shouldn't be a review hearing about services not being in place. That's a different issue. And so, you know, unless there is a change of circumstances, just merely wishing that the guardianship be terminated, we have already had that hearing, and there was a chance, I'm sure, to appeal the decision.

And if there were any limitations on the guardian's duties, which there often are in terms of medication or housing or whatnot, those are addressed at that time, and there is a finding on that.

If the limitations aren't put on it, then the guardian has the discretion. It's inappropriate, I think, to ask the guardian or to say that there is a disagreement with the guardian's, you know, position on medication or something if there is no evidence of misconduct or neglect or a change of circumstances.

I understand, although I'm not fully, I don't have the full picture, I know there is some Supreme Court cases pending in relation to Mr. Bigley, and I think those address the medication issues, and certainly a legal decision on one of those could be a change of circumstances.

But until then, it just seems like it's another way to hear the same arguments that are probably in front of another court.

THE COURT: Thank you. How we have always handled these, it's been my experience, is that when we appoint a guardian, it's of indefinite duration, so we don't call it long term. We call it as long as that's necessary.

And that any interested party has the right to request a review during that term of appointment. And they file that request either with the court form or their own form or by motion, and that the court reviews that.

Then the standard that we apply is if the court finds there is good cause, it schedules a review hearing and makes the appointments and we end up where we're at today.

I don't recall, and frankly I don't know that we have limited our reviews to cases where we found that there has been a change of circumstances, not like a child custody case. We have certainly scheduled reviews when there is an issue about whether the guardian is complying with their fiduciary duties or deficient some way.

But what we have looked at is if there is good cause. And in this circumstance, Mr. Bigley's case I think hadn't been reviewed for a considerable time, the guardianship case, and we had a series of reviews in

his case. Time had gone by and Mr. Bigley had requested, said that they took his money, so we determined that that was sufficient reason to schedule a review and come back and see if -- look at an accounting, if there were any issues concerning money that we needed to address Mr. Bigley's case.

So that's what led us here, and that's sort of the process we apply when deciding about a review.

MR. HUGHES: I guess that I would just comment that I think that the examples I gave were just things I think are good cause, and so I would just ask that we certainly want him to be able to have it reviewed any time that there is good cause.

Given the fact that it seems like there is an underlying disagreement that the guardian was appointed in the first place, I would just ask that their requests for reviews be somewhat specific, and, obviously, when they request a review, we have an opportunity to object to it or to oppose it and then it's the court's discretion whether there is good cause to set on a hearing.

But I just for the record would like to note that it appears to the state that I don't think that good cause is necessarily being shown if it's just that they don't want the guardian without, you know,

something that --

THE COURT: I don't think that -- I don't think it's the regular practice in the probate court that if Mr. Bigley requests a review that that request that he files is circulated to all the parties and we wait a specific time to see if there is any objections to the request.

I think the usual practice is I think it's routed to the probate master, who looks at it and looks at the case file and determines if there is a good reason to have a hearing, then notices a hearing, and then sends that notice out to the parties.

So if that were to happen in the future and there is a matter that we were going to schedule it for review, and you had opposition to the review, I think you can file it at that time and we would address that motion before the hearing, but I wouldn't count on getting a copy of the request for review before a hearing notice.

MR. HUGHES: Right. And I guess I'm a little procedurally off base. The same basic point, you know, just as long as -- I think certainly this came about before I came into the AG's office that I would have filed a request to be more specific about the funds so that we could have a meaningful hearing, and that's

just what I'm getting at.

THE COURT: Thank you. Ms. Rabinowitz, any comment that you have?

MS. RABINOWITZ: No, Your Honor. Just as indicated, we'll be filing some kind of a motion or response to -- we'll be filing some type of response to the visitor's report and the recommendations she makes there in.

I mean, we have -- the guardian has explained the financial situation. If he wants to speak more to some of the issues Mr. Gottstein raised about the housing, it's not that efforts haven't been made, it's what services are available. That's the issue.

I don't know if you want to speak more to housing.

MR. HUGHES: No, other than we have tried to engage Mr. Bigley almost on a daily basis through him directly and also through his attorney for options, and there hasn't been much -- many other options, realistic options coming from that direction.

I mean, Mr. Bigley is upset that I haven't made funds available for him to travel to Cuba or to California or to the Starship Enterprise, but those are not realistic options that I can entertain.

MS. RABINOWITZ: I believe that some of the

providers, one of the providers Mr. Gottstein mentioned, Choices, is not willing to serve him anymore.

MR. HUGHES: What they are telling me now is that they don't have staff and that they also are not able to serve Mr. Bigley at the rate that they are reimbursed for serving him.

MR. GOTTSTEIN: Your Honor, if I may. I think -- I view that as something really to be worked on as to how to -- you know, how to come up with something, whether it's Choices or someone else, but, you know, I have talked with Choices too and I think that's accurate that they would need to be in a position to hire staff and to have compensation, you know, that pays for the services that they provide.

And so -- and there may be other things that really need to be worked out if it were Choices, but it could be Choices or someone else or something.

But I guess my point is is that I would think -- I think it's fair to say that the current situation really is not working very well and that -- and I don't think it's really that the guardian hasn't been trying, but I think that there really needs to be, A, a fundamental shift on this medication issue, that that's a big problem of it, and that a solution needs to be found and that it's just not sufficient to say, oh,

we can't do it, because if they can't really fulfill their duties, then the guardianship should be terminated.

THE COURT: I have the impression from Mr. Hughes' comments that he individually, and his office, hasn't quit on Mr. Bigley. I appreciate your comment that they were working on things.

I haven't heard anybody say that Mr. Bigley's case isn't a difficult case. I think they are making reasonable and diligent ongoing efforts to try and find satisfactory housing for Mr. Bigley, to try and find a financial arrangement that is more comfortable for him. That's what we're expecting them to do in that representative capacity.

The solutions are difficult and hard to find, and whatever help that they can get from you or from the mental health trust or from any resource, ultimately benefit Mr. Bigley.

We're not making a decision today about medication. That's not part of this review. Mr. Bigley's decisions concerning medication may effect him dramatically, resources that are available for him, but his choice concerning medication isn't the issue today.

It's just whether the public guardian who is

appointed to make decisions for him is aware and working on his issues and trying to solve some problems for Mr. Bigley.

At least it appears today on review that they are doing that. So the court is not going to change any portion of the protective order at this time.

The hearing submission was filed with the court. Ms. Rabinowitz indicated that the public guardian wished to respond. I'll invite anybody else that wants to respond, but my position at this time is that the guardianship order that's in effect would remain in effect and that if there is a new request for review based on these other issues, that the court will address that request when it's filed.

I'm not scheduling any specific thing like mediation or a time to get together and talk further about Mr. Bigley either with the parties or the court. It sounds like there was a settlement agreement. The parties are still in communication, and that having a further hearing on these issues is not going to improve things for Mr. Bigley, at least not at this time.

The standard the court applies when you have a hearing and make a decision about whether we're going to terminate a guardianship is that, to terminate all the protective appointments, the court makes the

determination the person is no longer incapacitated, doesn't need a protective appointment.

Mr. Bigley, you've got to be quiet for a minute or two.

That wasn't the issue today. If Mr. Bigley has somebody that he is proposing as a substitute guardian, the court would certainly consider that request.

So I'm going to conclude this review. The hearing submission would be admitted for the purposes of filing with the court, and if there is a response then that will be filed too, but I'm not going to enter any different orders at this time other than just the one that said the matter came on for review and Mr. Hughes has accounted about the financial information that we have and that the court doesn't find at this time that there is reason to terminate the appointment based on financial matters, or to change the order based on that specific request for review.

Any questions about that, or is that clear enough that we understand?

Thank you all for your attendance and patience today. We'll recess our hearing and excuse the parties.

Thank you.

TRANSCRIBER'S CERTIFICATE

I, SONJA L. REEVES, hereby certify that the foregoing pages numbered 1 through 42 are a true, accurate and complete transcript of proceedings in Case No. 3AN-04-00545PR transcribed by me from a copy of the electronic sound recording to the best of my knowledge and ability.

_____ _____

DATE SONJA L. REEVES, TRANSCRIBER

MEDICATION DOCUMENTATION ON THIS SIDE OF FORM TO INCLUDE:

1. **Routine medications not administered or administered at a different time.**
2. **STAT medications given.**
3. **Notification of medical staff (specify which one) for out of parameter vital signs, oxygen saturation, serum glucose, etc.**
4. **Administration site of all IM or SQ medications.**

DATE	TIME	PROGRESS NOTES	INITIALS	DATE	TIME	PROGRESS NOTES	INITIALS
9/22	2135	Pt refused offer of ordered Alanzapine	RE				
7-22	Noc.	PPD Refused	MC				
9·23	~~2200~~ 0000	"I don't have to take anything I don't want"	ABL				
9/23	2100	Refused Olanzapine	RE				
9·24	0900	Refuses	ABL				

ALASKA PSYCHIATRIC INSTITUTE
LEGAL STATUS RECORD

DO NOT WRITE ON THIS SHEET
THIS STATUS RECORD IS MAINTAINED AND UPDATED BY HEALTH INFORMATION MANAGEMENT SERVICES
COMMUNICATE INFORMATION REGARDING STATUS TO LEGAL TECHNICIAN

DATE	STATUS	TYPE OF DOCUMENT / STIPULATIONS	ORDER EXP
09/22/2008	JP-EXP	ADM via Ex Parte Order recommended for approval by Master Lack	
		rec'd Pet. for Init. of Invol. Commit. filed by Candi Siciliano, LPC	
		Notice of Rights given	
		Notice of Resp. Arrival sent to Anchorage Court	
09/24/2008	NONE	DISCHARGED	
		Notice of Release sent to Anchorage court	

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

AT Anchorage

In the Matter of the Necessity for the Hospitalization of:

William S Bigley
Respondent.

Case No. 3AN-08- 1148 PR

NOTICE OF RELEASE

To: Superior Court at Anchorage, Alaska.

XX Released after evaluation. Respondent was admitted to API for evaluation on 09/22/08 at 1649 and was discharged from the facility on 09/24/08 at 1200 because the evaluation personnel did not find that respondent met the standards for commitment specified in 47.30.700.

☐ Release After Commitment Period. Respondent was committed for treatment on _____ for _____ days.

Respondent was released on _____, . _____

☐ Certificate of Early Discharge. Respondent was committed for treatment on _____, or _____ days.
I certify that on _____, respondent was discharged early because:

☐ Respondent is no longer gravely disabled or likely to cause serious harm as a result of mental illness.

☐ _____

_____

I request the court to enter an order officially terminating the involuntary commitment.

9/25/08
Date

Signature

PJ Whittington, Legal Office
Print Name and Title

MC-410 (12/87)(st.2)
NOTICE OF RELEASE

AS 47.39.720
AS 47.30.725 (b)
AS 47.30.780

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
AT _____

In the Matter of the Necessity for the Hospitalization of:

William Bigley,
Respondent.

Case No. 08-11487PR

PETITION FOR INITIATION OF INVOLUNTARY COMMITMENT

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

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

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

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

Facts in support of this request are as follows:

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

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

-Pt has been trespassing @ office of Public advocacy He has been demanding, yelling, cussing, & intimidating to staff. He admits to this writer he threatened them.
- Pt is homeless & can not identify where to get safe food or housing. Can not identify reasonable plan says he'll fly to HI tonight but ø money or ticket. He has been given money by gaurdian for food/housing but it is gone & Pt has neither. He is not able to care for self
- Pt is diagnosed Schizophrenia, paranoid type He refuses medications. Police were called. They are holding him but charges not being pursued. gaurdian wants mental hygiene

Case No. 08-1148PR

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

9/22/08
Date

Candice Siciliano LPC
Petitioner's Signature

Candice Siciliano LPC
Type or Print Name

4020 Folker St Anch
Petitioner's Address

301-2800
Petitioner's Phone

Verification

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

Subscribed and sworn to or affirmed before me at Anchorage, Alaska on 9-22-08 (date).

(SEAL)

Clerk of Court, Notary Public or other person authorized to administer oaths.
My commission expires: [illegible]

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

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

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

Clerk: _____

File

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

AT Anchorage

In the Matter of the Necessity)
for the Hospitalization of:)
)
William Bigley
Respondent.) Case No. 3AN 08-1148PR
)
) NOTICE OF RESPONDENT'S
ARRIVAL AT EVALUATION FACILITY

To: CLERK OF COURT

Anchorage, ALASKA

Please take notice that respondent arrived at

API

on 09-22-08 at 1649

9/22/08
Date

Signature

PJ Whittington, Legal Office
Printed Name

Title

Superior Court at
notified by telephone on
at
This notice sent to Anchorage court on

PJ Whittington, Legal Office
Name and Title

Distribution:
Original to court
Copy to evaluation facility

MC-400 (12/87) (st.2)
AS 47.30.715
NOTICE OF RESPONDENT'S ARRIVAL AT EVALUATION FACILITY

ALASKA PSYCHIATRIC INSTITUTE

DATE / TIME	ORDER	NURSE SIGNATURE
DATE 9/22/08 TIME 1245	Olanzapine/Zyprexa 10 mg. P.O. G H.S! TO/RB Dr. Peter/K Elizarde RN 9/23/08 0844 on behalf of Dr Peter	Noted 9/22/08 @1700 K Elizarde RN
DATE 9/23/08 TIME 0950	Ensure vanilla or Chocolate 4x per day. Regular double portions S. Khoo, MS 9/23/08 1115 TO/RB Dr. Peter / Adma Krayn RD	Andrea B Gilbert RN 9.23.08 1100 LD
DATE 9/23/08 TIME 10:00 called RB	Pantoprazole ER 40 mg po daily. Jul. D. Hill MD 10/6/08 1138	Andrea B Gilbert RN 9.23.08 1000
DATE 9/24/08 TIME 1050	d/c when transportation available.	Andrea B Gilbert RN 9.24.08 1100
DATE TIME		

BIGLEY, WILLIAM S
09/22/2008 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
AT ANCHORAGE

In the Matter of the Necessity for the Hospitalization of:	)	
Bigley, William, Respondent.	)	Case No. 3AN-08-1148pr
	)	EX PARTE ORDER (TEMPORARY CUSTODY FOR EMERGENCY EXAMINATION/ TREATMENT)

FINDING AND CONCLUSIONS

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

ORDER

Therefore, it is ordered that:

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

SEP 22 2008

Date

Superior Court Judge

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

Clerk:tek

Recommended for Approval
9/22/08
2:15pm

Magistrate

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

SOCIAL SERVICE FOLLOW-UP: [X] CMHC [ ] ANMC (USPHS) [ ] Private [ ] Corrections [ ] Veterans [ ] DFYS [ ] Alcohol/Drug

Name of Person Notified: Johathan Hughes Date Notified: 9/24/08

Discharge Living Arrangement: Code: 05 Local Hotel

Name of Referral Source Notified: (See page 4) OPA - Paradise Inn Date Notified: 9/24/08

Pt will discharge back to his housing in town. Pt has stabilized on unit and is denying any thoughts of suicide or homicide. Pt is not threatening toward staff and says he is ready to discharge. Pt is encouraged to comply with all local and state laws to avoid future incarcerations

Contact Person: Jonathan Hughes Phone: 269-3500

Follow-up Appt. at: Clinic & Address:

Pt is not on medications at this time, refuses all follow-up

With: care.. API to provide OPA money. Date: Time:

Client's Address: Paradise Inn - 3001 Spenard Rd. Anchorage, AK Phone: 563-8770

Clinical Social Worker's Signature: [signature] LCSW Date: 9/24/08

SUMMARIES FOR FOLLOW-UP

1. Copies of:
   - [X] DRO
   - [ ] CTC Packet

TO: — Sent: Date/Initial

- [ ] CMHC ____ /____
- [ ] PHS/ANMC ____ /____
- [ ] VA ____ /____
- [ ] DFYS ____ /____
- [X] Other: OPA - 269-3535 9-24-g
- [ ] Patient/Escort to Hand Carry ____ /____

2. Copies of:
   - [ ] Admission Workup
   - [ ] Multi-Disciplinary Assessment
   - [ ] Discharge Summary
   - [ ] Rehab Referral
   - [ ] Social History
   - [ ] Physical Exam
   - [ ] HIV/TB Test Results
   - [ ] Labs
   - [ ] Other ____

TO: — Sent: Date/Initial

- [ ] CMHC ____ /____
- [ ] PHS/ANMC ____ /____
- [ ] VA ____ /____
- [ ] DFYS: ____ /____
- [ ] Other: ____ /____

3. **I hereby authorize the Alaska Psychiatric Institute to release the above information to the designated agencies to ensure continuity of my health care. I understand specific reference may be made to psychiatric conditions, HIV testing and results, and any related diagnosis and medical condition(s), which may be recorded in my health record. Exchange of information ensures continuity of care between providers.**

Patient's/Guardian's Signature Date Witness' Signature Date

4. Patient/Guardian refused/unavailable to authorize release of information, but referral information is considered necessary for patient's welfare and continued continuity of health care (A.S. 47.30.845).

[signature] 9/24/08

Physician Signature Date

Patient Identification

09/22/2008 00-56-65
01/15/1953

BIGLEY, WILLIAM

DISCHARGE RELEASE ORDER

API Form #06-9038 Rev. 06/02 Replaces all previous editions.

BIGLEY,WILLIAM S 00-56-65

Cont Note #5707

Patient refused H&P at this time.

Electronically signed by:
JDS_JULIAN_D_SMITH, Health Pract. II

5708 Admission Date:09/22/2008 Patient # 00-56-65
09/24/2008 @ 13:50:04 Patient Response -
Progress Note Discharge Planning SW

Pt was discharged today back to his housing at the Paradise Inn. SW contacted pt's OPA guardian, Jonathan Hughes to inform him of discharge. Guardian reported that he has paid for pt's week stay at the hotel and he can return there. Guardian questioned how pt would obtain food and SW reported that this would need to be worked out at this agency. SW agreed to send pt with additional ensures that he was drinking while on unit. Pt was discharged via cab to the Paradise Inn without incident. Electronically signed by:
MSN_MALINDA_S_NATANEK, LCSW

mc

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

AT Anchorage

In the Matter of the Necessity for the Hospitalization of:

William S Bigley
Respondent.

Case No. 3AN-08- 1148 PR

NOTICE OF RELEASE

To: Superior Court at Anchorage, Alaska.

XX Released after evaluation. Respondent was admitted to API for evaluation on 09/22/08 at 1649 and was discharged from the facility on 09/24/08 at 1200 because the evaluation personnel did not find that respondent met the standards for commitment specified in 47.30.700.

☐ Release After Commitment Period. Respondent was committed for treatment on _____ for _____ days.

Respondent was released on _____, . _____

☐ Certificate of Early Discharge. Respondent was committed for treatment on _____, or _____ days.
I certify that on _____, respondent was discharged early because:

☐ Respondent is no longer gravely disabled or likely to cause serious harm as a result of mental illness.

☐ _____

_____

I request the court to enter an order officially terminating the involuntary commitment.

9/25/08
Date

Signature

PJ Whittington, Legal Office
Print Name and Title

MC-410 (12/87)(st.2)
NOTICE OF RELEASE

AS 47.39.720
AS 47.30.725 (b)
AS 47.30.780

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
AT ANCHORAGE

In the Matter of the Necessity for the Hospitalization of:	)	
Bigley, William, Respondent.	)	Case No. 3AN-08-1148pr
	)	EX PARTE ORDER (TEMPORARY CUSTODY FOR EMERGENCY EXAMINATION/ TREATMENT)

FINDING AND CONCLUSIONS

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

ORDER

Therefore, it is ordered that:

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

SEP 23 2008

25 Sept 08
Date

Craig Stowers
Superior Court Judge

I certify that on 9/25/08
a copy of this order was sent
to: AG, PD, API, RESP

Clerk: tek alk

Recommended for Approval
9/22/08
3:15pm

LACC
Magistrate

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA AT _____

In the matter of the necessity)
for the hospitalization of:)
)
_____,) Case No. 08-1176 PR
_____ Respondent.)

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 Hospital or _____ as required to carry out the Order listed below:

☑ Ex Parte Order (Temporary Custody for Emergency Examination/Treatment)
☐ Order for Screening Investigation
☐ Order for Involuntary Commitment to _____
☐ Petition for Initiation of Involuntary Commitment

Respondent (Full name) William Bigley Date of birth 1/15/53
Sex M Race AN/AI Height 5' Weight 110 Hair Brown Eyes Brown
SSN _____ ID/Driver's License No. _____ State _____
Do you know the respondent's location? ☐ No ☑ Yes Telephone number 269-0078
Address Anch Jail MIC Med Unit City Anchorage Zip AK
Physical Characteristics (clothing, scars, other identifiable marks) Pt currently in jail
Are there weapons at the residence? ☑ No ☐ Yes Kind? _____
Is respondent on medication? ☑ No ☐ Yes Kind? _____
Does respondent have a history of violence? ☐ No ☑ Yes Explain Assaultive when psychotic
Is there anyone at the residence? ☐ No ☑ Yes Relationship? Staff

Information provided by Bodie Sciuano Telephone No. 272-3800
Contact person MIC Med Unit Telephone No. 269-0078

RETURN OF SERVICE

I hereby certify _____, a State Trooper or Peace Officer, picked up the respondent at _____, in _____,
(Address, street number, rural route, milepost, etc.) (City)
Alaska, in the _____ Judicial District, _____, 19____, and transported the respondent to Alaska Psychiatric Hospital or _____. The documents were served at Alaska Psychiatric Hospital or _____ on
_____, _____, _____, 19_____.
(Name) (Title) (Date Served)

Return Date _____

Ronald L. Otte, Commissioner
Department of Public Safety
By _____
Printed Name _____
Title _____

AST 12-343 (Rev. 6/96) (cs)
State Trooper Directions for Service

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
AT _____

In the Matter of the Necessity for the Hospitalization of:

William Bigley,
Respondent.
DOB 1/15/53

Case No. 08-1176PR

PETITION FOR INITIATION OF INVOLUNTARY COMMITMENT

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

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

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

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

Facts in support of this request are as follows:

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

2. The facts which make the respondent a person in need of (a screening investigation) (hospitalization for evaluation) are: - Pt arrested again for Trespassing on 9/28/08, just a couple days after getting out of API (on exparte). Pt's charges dropped & he is in jail now on 24hr mental health hold that expires today.
- He is diagnosed Schizophrenia, Paranoid type.
- He was seen by this writer last week, he is even further decompensated today since he has had no meds @ API, jail, or community
- Jail gaurds could not let him out of his cell due to concern of safety, "interviews" done through window. Bill was unable to follow simple directions. He was beligerant, cussing, said twice things about killing. When asked if he wanted to hurt someone he said yes. He was pacing on window. He had periods of yelling unintelligable sounds repeatedly & did not seem like he could stop or control this (almost barking).

- He was unable to answer questions & appears psychotic.
- He appears to be both a danger to others & gravely disabled.

Case No. _____

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

9/30/08
Date

Candice Siciliano LPC
Petitioner's Signature

Candice Siciliano, LPC
Type or Print Name

4020 Folker St
Petitioner's Address

312-2800
Petitioner's Phone

Verification

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

Subscribed and sworn to or affirmed before me at Anchorage, Alaska on 9-30-08 (date).

SEAL OF THE TRIAL COURTS OF THE STATE OF ALASKA THIRD JUDICIAL DISTRICT

(SEAL)

Clerk of Court, Notary Public or other person authorized to administer oaths.
My commission expires: [illegible]

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

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

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

Clerk: _____

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
AT ANCHORAGE

In the Matter of the Necessity for the Hospitalization of:	)	
Bigley, William, Respondent.	)	Case No. 3AN-08-1176PR
	)	EX PARTE ORDER (TEMPORARY CUSTODY FOR EMERGENCY EXAMINATION/ TREATMENT)

FINDING AND CONCLUSIONS

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

ORDER

Therefore, it is ordered that:

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

9-30-08
Date

Superior Court Judge
Gleason
Recommended for Approval

I certify that on 9-30-08 _____
a copy of this order was sent
to: AG, PD, API, RESP

Clerk:tek

Jacquie M Burney 9-30-08
~~Magistrate~~
Master

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

ALASKA PSYCHIATRIC INSTITUTE

TO: Medical Director

As a voluntary patient at Alaska Psychiatric Institute, I, _____, am requesting to leave this hospital before my API physician considers me ready for discharge. I am, therefore, requesting to leave against medical advice (AMA). I understand that my request will be evaluated immediately and I will be discharged AMA or given written notice that involuntary commitment proceedings will be initiated within 48 hours (excluding weekends and holidays per Alaska State Statute Sec 47.30.805).

pt signed AMA form; then tried to talk M Stedman RN

SIGNATURE OF PATIENT — WITNESS

ripped it up

DATE AND TIME — DATE AND TIME 10/1/08 1000

* * * *

Supervising nurse will place the date and time next to the area indicating what action has occurred. If a patient leaves without a physician order he/she is placed on AWOL status.

DATE	TIME		DATE	TIME	
10/1/08	1000	Physician Notified	10/1/08	1030	Discharge order given
		Order given to hold patient			Patient evaluation in writing
		Patient given written notice of "Notification of Commitment"			
		Patient Rights representative notified: ☐ Chaplain ☐ Other _____			

SUPERVISING NURSE'S SIGNATURE — DATE AND TIME

* * * *

This is your notification that commitment proceedings will be initiated within 48 hours (excluding weekends and holidays).

_____, M.D.

DATE AND TIME

I wish to withdraw the above request and agree to remain as a voluntary patient at API. (If commitment procedures have been initiated a voluntary must be signed.)

SIGNATURE OF PATIENT — WITNESS

DATE AND TIME — DATE AND TIME

Patient Identification

BIGLEY, WILLIAM S
09/30/2008 00-56-65
01/15/1953

REQUEST TO LEAVE HOSPITAL AMA

API Form #06-9020, Rev. 05/03
(Replaces Previous Editions)

ORIGINAL: Patient Record - white
COPIES TO: Legal Technician -yellow
Patient (when held) - pink

ALASKA PSYCHIATRIC INSTITUTE

DATE	TIME	ORDER	NURSE SIGNATURE
9/30/08	1206	① Ensure 8 times / day ② double portion [signature]	9/30/08 1230 [signature]
mc			
10/1/08	0930	① D/C 1st degree [illegible] [signature]	10/1/08 1030 [signature]
mc			
10/1/08	10 30	① voluntary admission ② pt to be discharged AMA today [signature]	
mc			
DATE	TIME		
DATE	TIME		

BIGLEY,
WILLIAM S
09/30/2008 00-56-65
01/15/1953

Please write or print legibly.

Please use ball point pen.

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

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

ALASKA PSYCHIATRIC INSTITUTE

Date: 10/1/08 Time: 1200

Escorted: [ ] yes [X] no By whom: Cab To where: Paradise Inn

Destination: Paradise Inn

DISCHARGE SUMMARY

(Address each nursing goal that has not been signed off on patient's treatment plan. Also, document patient's mood/ comments/condition, and any other pertinent information at the time of discharge.)

Pt admitted 9/30/08 on an expedite order. Pt refusing vital signs, labs ordered labwork and UA possible. Pt discharging AMA today. He is not on any medications.

Date: 10/1/08 Signature: [signature] RN

Patient Identification

BIGLEY,
WILLIAM S
09/30/2008 00-56-65
01/15/1953

Nursing Discharge Assessment

API Form #06-14071, Rev. 4/00

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

AT Anchorage

In the Matter of the Necessity for the Hospitalization of:	)	
William Bigley	)	Case No. 3AN 08-1176 PR
Respondent.	)	
	)	NOTICE OF VOLUNTARY ADMISSION

The respondent named above was voluntarily admitted for treatment

on 10-01-08 at Alaska Psychiatric Institute.

The respondent was first admitted for evaluation or treatment on

09-30-08, at 1213

10/01/08
Date

Signature

PJ Whittington, Legal Office
Printed Name/Title

Distribution:

Original to court
Copy to facility

MC-415 (12/87) (sm.1)
AS 47.30.725 (b)
NOTICE OF VOLUNTARY ADMISSION
G:\HIMS\legal\Forms\notice_voluntary.doc

Alaska Psychiatric Institute

I, William Bigley make application for voluntary admission to the Alaska Psychiatric Institute under the provisions of the pertinent statutes of the State of Alaska (Chapter 30, Section 47.30.670). I understand that I may be hospitalized at the Alaska Psychiatric Institute for 48 hours after requesting a discharge (excluding weekends and holidays), during which time the Medical Director or designee will decide if I need continued hospitalization and if so, petition the court under Section 47.30.700. I agree to comply with all hospital rules and regulations. I have been informed of my rights under the provisions of AS 47.30.825 thru AS 47.30.865. I have also received a copy of the API patient rights. As a voluntary patient, I authorize the Medical Director or designee, to administer to me such medical and psychiatric treatment, including examination, diagnostic procedures, and medications as said physicians may deem necessary.

Nick Lodge
WITNESS

X Bill S Bigley
SIGNATURE OF PATIENT

10/1/08 0900
DATE AND TIME

10/1/08 0900
DATE AND TIME

OR: _____
PARENT OR GUARDIAN
(As Applicable)

_____
DATE AND TIME

_____
RELATIONSHIP TO PATIENT

Patient Identification

BIGLEY, WILLIAM S
09/30/2008 00-56-65
01/15/1953

APPLICATION FOR VOLUNTARY ADMISSION

API Form #06-9045 Rev. 7/92
Replaces all previous editions

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

Name of Potential Patient: William Bigley

Date and Time: 10/7/08

Age: 55 Sex: M Race: AK Native Marital Status: S

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

- ☐ gravely disabled
- ☒ likely to cause serious harm to ☒ self ☐ others

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

Don't really know this.

Pertinent Information: Pt is suicidal - He was jumping in traffic & nearly hit by cars before APD could intervene - He is agitated when approached - He is delusional; Believes he is being slaughtered

I am a:

- ☐ peace officer.
- ☒ psychiatrist / physician currently licensed to practice in the state of Alaska or employed by the federal government.
- ☐ clinical psychologist licensed by the state Board of Psychologist and Psychological Associate Examiners.

Tom Baker
Signature of Peace Officer or Mental Health Professional

Tom Baker
Print Name

Daytime Telephone Number

Providence Dr Anch AK 99508
Mailing Address City State Zip

BIGLEY,WILLIAM S
00435402 01/15/53
08281-00138 M 55Y
DOCTOR,PROVER
ADMIT: ERQ -

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

MC-105 (1/07)(st.3)
PEACE OFFICER/MENTAL HEALTH PROFESSIONAL APPLICATION FOR EXAMINATION
AS 47.30.705

PROVIDENCE ALASKA
MEDICAL CENTER

ACCOUNT#: 0828100138

DATE OF SERVICE: 10/07/2008

Reviewed at hospital
10/8/08 John D. Lopez PA

CHIEF COMPLAINT: Psychosis.

HISTORY OF PRESENT ILLNESS: The patient is a 55-year-old male who suffers from longstanding severe psychosis and medical noncompliance and homelessness. The patient was discharged from API October 1, 2008. The patient was found yelling at traffic and jumping in and out of traffic by the police and was almost hit by a car today and was brought into the emergency room for evaluation. The patient's further history is unavailable due to the patient's condition.

REVIEW OF SYSTEMS: Unavailable due to the patient's condition.

PAST MEDICAL HISTORY: Obtained from previous records of chronic right foot pain, GERD, and anemia, schizophrenia, over 70 API admissions.

PHYSICAL EXAMINATION:
VITAL SIGNS: Reviewed by me on presentation and are normal.
GENERAL: The patient is well developed, well nourished, nontoxic.
HEENT: EOMI. PERRL. Moist mucous membranes.
NECK: Supple. No masses.
CARDIOVASCULAR: Regular rate and rhythm. No murmurs, rubs, or gallops. Extremities are well perfused.
LUNGS: Clear to auscultation bilaterally with no respiratory distress.
NEUROLOGIC: No focal motor or sensory deficits. The patient is alert but he is telling me that he does not want to talk to me. He does not want to participate in my interview and he wants me to "get the hell out of my room."

EMERGENCY DEPARTMENT COURSE: The patient is stable throughout emergency department stay. BrAC is 0. Ativan 2 mg p.o. and Haldol 2 mg p.o. was voluntarily taken by the patient with significant reduction in agitation. CMP: Normal. CBC: With no significant abnormalities. TSH: In normal range. The patient is stable throughout emergency department stay.

PLAN: Observe in emergency department, attempt for API admission. However, the patient does suffer from chronic psychosis and schizophrenia and medical noncompliance, and the patient's mental illness is very difficult to treat effectively. He is a danger to himself, jumping in and out of traffic, but as the patient is chronically medically noncompliant, the health care community may not have any options to treat the patient's disease.

002893730/tra/D: 10/07/2008 11:59 P/T: PAMC EMERGENCY ADMIT REPORT
10/08/2008 1:39 A
NAME: Bigley, William S DOB: 01/15/1953
ACCOUNT #: A 0828100138 MR#: 00-43-54-02
PHYSICIAN: Thomas E Baker, MD

FINAL DIAGNOSIS: Paranoid schizophrenia.

Preliminary Not Authenticated

Thomas E Baker, MD

cc: Thomas E Baker, MD

002893730/tra/D: 10/07/2008 11:59 P/T: 10/08/2008 1:39 A
PAMC EMERGENCY ADMIT REPORT
NAME: Bigley, William S
DOB: 01/15/1953
ACCOUNT #: A 0828100138
MR#: 00-43-54-02
PHYSICIAN: Thomas E Baker, MD

☐ On No Medications at Home

☐ Unable to Obtain Medication History (Reason): _____

Initial Medication Reconciliation

(Prescriptions, OTC, herbals, patches, inhalers, eye drops & supplements)

USE GENERIC DRUG NAMES WHEN LISTING MEDICATIONS

Prohibited Abbreviations: Abbreviations for Drug Names, U, IU, AU, AS, AD, QD, QOD, trailing zero, lack of leading zero, MS, MS04, MgSO4, µg, Cc.

Drug Name	Dose	Route	Freq	Last Taken Date/Time (Military)	Reason For Use	Reason Discontinued / Comments	Source of Information

NO meds

Medication given in the Emergency Room prior to admit (including one time doses)

Haloperidol	10mg	PO		10 IV 10-7 Psych Agit.			
Lorazepam	2mg	PO		10 IV 10-7 Psych Agit.			

Marcia Cooper RN (Listed by Signature)	10-8-08 (Date)	0310 (Time)
Marcia Cooper RN (Reviewed by Nurse)	10-8-08 (Date)	0310 (Time)
(Reviewing LIP's Signature)	10-8-08 (Date)	0900 (Time)

(Send yellow NCR copy of this page to Pharmacy)

Patient Identification

BIGLEY, WILLIAM S
10/08/2008 00-56-65
01/15/1953

Initial Medication Reconciliation

ALASKA PSYCHIATRIC INSTITUTE

DATE	TIME	ORDER	NURSE SIGNATURE
10/8/08	0900	① Pt to be discharged off to Log AMA ② Benztropine 2mg po, tmis 1	10/8/08 0945
MD			
DATE	TIME	② Provide 12 ensures daily day Period	
MD			
DATE	TIME		
DATE	TIME		
DATE	TIME		

BIGLEY,
WILLIAM S
10/08/2008 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.

ALASKA PSYCHIATRIC INSTITUTE

Date: 10/8/08 Time: 1135
Escorted: [ ] yes [✓] no By whom: ______ To where: Paradise Inn
Destination: Paradise Inn, Anch, AK

DISCHARGE SUMMARY

(Address each nursing goal that has not been signed off on patient's treatment plan. Also, document patient's mood/ comments/condition, and any other pertinent information at the time of discharge.)

Pt admitted 10/8/08 - refusing treatment. Denies SI/HI. Pt will discharge back to his housing Paradise Inn, in Anchorage AK. Pt labile - refusing treatment & meds — [signature]

Date: 10/8/08 **Signature:** [signature]

Patient Identification

BIGLEY,
WILLIAM S
10/08/2008 00-56-65
01/15/1953

Nursing Discharge Assessment

API Form #06-14071, Rev. 4/00

ALASKA PSYCHIATRIC INSTITUTE

TO: Medical Director

As a voluntary patient at Alaska Psychiatric Institute, I, Bill Bigley, am requesting to leave this hospital before my API physician considers me ready for discharge. I am, therefore, requesting to leave against medical advice (AMA). I understand that my request will be evaluated immediately and I will be discharged AMA or given written notice that involuntary commitment proceedings will be initiated within 48 hours (excluding weekends and holidays per Alaska State Statute Sec 47.30.805).

Bill Bigley — SIGNATURE OF PATIENT

Witness — WITNESS

10/8/08 0915 — DATE AND TIME

10/8/08 0915 — DATE AND TIME

* * * *

Supervising nurse will place the date and time next to the area indicating what action has occurred. If a patient leaves without a physician order he/she is placed on AWOL status.

DATE	TIME		DATE	TIME	
10/8/08	0915	Physician Notified	10/8/08	0910	Discharge order given
		Order given to hold patient			Patient evaluation in writing
		Patient given written notice of "Notification of Commitment"			
		Patient Rights representative notified: ☐ Chaplain ☐ Other			

RN — SUPERVISING NURSE'S SIGNATURE

10/8/08 0915 — DATE AND TIME

* * * *

This is your notification that commitment proceedings will be initiated within 48 hours (excluding weekends and holidays).

_____, M.D.

DATE AND TIME

I wish to withdraw the above request and agree to remain as a voluntary patient at API. (If commitment procedures have been initiated a voluntary must be signed.)

SIGNATURE OF PATIENT — WITNESS

DATE AND TIME — DATE AND TIME

Patient Identification

BIGLEY,
WILLIAM S
10/08/2008 00-56-65
01/15/1953

REQUEST TO LEAVE HOSPITAL AMA

API Form #06-9020, Rev. 05/03
(Replaces Previous Editions)

ORIGINAL: Patient Record - white
COPIES TO: Legal Technician -yellow
Patient (when held) - pink

TREATMENT PLANNING NOTE

Alaska Psychiatric Institute

Date, Signature, & Time	Prob #	Treatment Progress note
10/8/08 @ 0900	1,2,3	Pt was admitted on POA from PPER. Pt was cooperative with admission and did not display any behavioral problems. Pt was appropriately dressed and slept throughout the night. Pt has been appropriate on the unit and ate his breakfast without incident. SW to contact OPA guardian for discharge plan.

BIGLEY,
WILLIAM S
10/08/2008 00-56-65
01/15/1953

API Form 06- 9031 Rev. 07/07

RECEIVED
OCT 19 2008

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
AT ANCHORAGE

CASE NO. 3AN-04-0545 PR

In the Matter of:

William Bigley

ORDER OF REFERRAL TO MEDIATION - ADULT GUARDIANSHIP

This matter is pending before the court on a Petition for _____ filed on _____.

☒ A request for mediation has been received. After review of the case, the court finds that this matter is appropriate for referral to mediation.

or

☐ The court has reviewed this case and finds that this matter is appropriate for referral to mediation.

THEREFORE IT IS ORDERED that:

1. _____ is appointed as mediator. The issues referred for mediation include, but are not necessarily limited to:_____
2. Time and date for initial joint mediation session to be scheduled by mediator with the parties so that mediation is completed no later than _____.
3. The mediator will contact the parties for pre-conference meetings. The initial joint mediation session will occur at 303 K Street, Boney Courthouse, unless otherwise directed by the mediator. Please report to Probate Office, Second Floor, Room 280 when you arrive.
4. The mediator is authorized to access confidential information, including the court file.

Attorneys are strongly encouraged to attend the joint mediation session. Attorneys may also accompany their clients to the orientation meeting with the mediator. The purpose of the orientation meeting is to explain the process, identify necessary participants and begin to identify issues to be resolved.

The joint mediation session(s), and orientation meetings are private and confidential. No participant in mediation may reveal statements, conduct, notes or the substance of negotiations which occur in mediation to anyone outside of mediation unless the parties agree otherwise. Exceptions to confidentiality will be discussed by the mediator and in the Confidentiality and Mediation Agreement. See Probate Rule 4.5(h).

Mediation is voluntary. Parties fulfill their obligation under this order by participating in an orientation meeting with the mediator and, unless excused by the mediator, attending the initial joint mediation session. Any party not wishing to continue with mediation after attending the initial joint mediation session may withdraw from the process. The mediator, in consultation with the parties, shall determine if it is appropriate to continue with the mediation.

There are no accommodations for childcare and, unless specifically requested, children may not attend the mediation.

Date: 10/8/08

Superior Court Judge/Master

I certify that on 10.9.08 a copy of this order was sent to: ☒ Respondent's Atty. (Gottstein) ☒ Petitioner's Atty. AG - Kraly & Friend & Russo
☐ Mediator ☐ GAL ☒ Court Visitor ☒ Karen Largent ☒ Other Rabinowitz - OPA
Clerk alk OPA - Hughes

MED-105 ANCH (11/06)
ORDER OF REFERRAL – ADULT GUARDIANSHIP

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
AT ANCHORAGE

In the Matter of the Protective Proceeding of)
)
)
WILLIAM (BILL) BIGLEY)
Respondent/Ward or Protected Person)
) CASE NO. 3AN - 04-00545

REQUEST FOR COURT SPONSORED GUARDIANSHIP MEDIATION

I am requesting a referral to the court sponsored guardianship mediation program.

I am: ☐ Respondent/Ward (or attorney) ☐ Petitioner (or attorney) ☐ Court Visitor ☐ GAL

☑ Guardian or Conservator ☐ Other (family, domestic partner, etc.) and my relationship to the person is Public Guardian with the Office of Public Advocacy.

In order to make the best plan, I think the following people should participate in the mediation:

NOTE: If you need to add more names, please attach an additional sheet.

Name	Relationship	Phone(s) & E-mail Address
Jonathan Hughes	Guardian	269-3566 jonathan.hughes@alaska.gov
Jim Gottstein	Attorney/Respd	2747686james.b.gottstein@gottsteinlaw.co
Stacie Kraly (AAG) &/or	Attorney/API	465-4164 stacie.kraly@alaska.gov
Scott Friend (AAG)	Attorney/API	269-5540 scott.friend@alaska.gov
Mara Rabinowitz	Attorney/Guard	269-3514 mara.rabinowitz@alaska.gov
Elizabeth Russo	Attorney/Guard	269-3545 elizabeth.russo@alaska.gov
Betty Stanley	Court Visitor	333-9480 visitorcrt@aol.com

I think mediation should focus on the following areas or issues of concern:
Terms of Settlement Agreement including, but not limited to; housing, services, finances and budget modifications.
OPA requests that an attorney mediator be assigned.

September 19, 2008
Date

I certify that on 9/19/08
a copy of this request was sent to:
☑ Respondent's Atty.
☑ Petitioner's Atty. ☐ Mediator
☑ Court Visitor ☐ GAL
☐ Dispute Resolution Coordinator, Karen Largent
☐ Other _____

By: _____

Signature
Mara Rabinowitz
Type or Print Name
OPA 900 W. 5th Ave., Suite 525
Mailing Address
Anchorage AK 99501
City State ZIP
(907) 269-3514
Contact Telephone Number(s)

MED-100 ANCH (11/06)(cs)
REQUEST FOR COURT SPONSORED GUARDIANSHIP MEDIATION