Forced Drugging Defense Package

Background

On March 4, 2008, in connection with the MindFreedom Shield Program, PsychRights and MindFreedom International announced a Task Force on Mental Health Legal Advocacy & Activism to help people facing the horrors of forced psychiatric drugging and electroshock. As set forth in the law review article, Involuntary Commitment and Forced Psychiatric Drugging in the Trial Courts: Rights Violations as a Matter of Course, by Jim Gottstein of PsychRights, 25 *Alaska L. Rev.* 51 (2008), "lawyers representing psychiatric respondents interpose little, if any, defense and are not discovering and presenting to judges the evidence of the harm to their clients." In addition to lawyer indifference, most appointed lawyers do not have funding to obtain expert testimony even when they might want to do a good job for their clients.

In trying to address this problem, PsychRights put together a "generic" forced drugging defense package for use around the country, wrapped around certified copies of written testimony (affidavits) of Robert Whitaker[1] and Grace E. Jackson, MD., PsychRights filed in a couple of forced drugging cases. This package is specifically designed for use in Alaska, incorporating Alaska law and adding the written testimony of Loren Mosher, MD., and Ron Bassman, PhD., and the prior testimony of Dr. Jackson, Dr. Loren Mosher and Sarah Porter..

In order to use this, certified copies of the Whitaker and Jackson testimony must be obtained from MindFreedom.

The Affidavit Testimony

As mentioned, but it bears repeating, in order for the written testimony (Affidavits) to be considered actual court testimony, one needs to obtain **certified copies**. Certified copies of the Whitaker, Jackson and Bassman written affidavits may be requested by e-mailing jim.gottstein@psychrights.org; writing to 406 G Street, Suite 206, Anchorage Alaska; calling (907) 274-7686, or faxing (907) 274-9493.

The Generic Pleadings

There are three generic pleadings that have been prepared, plus a Certificate of Service as part of this package:

1. Certificate of Service
2. Motion and Memorandum for Summary Judgment
    a. Order Granting Summary Judgment
3. Motion and Memorandum for Stay Pending Appeal
    a. Order Granting Stay Pending Appeal
4. Notice of Filing Written Testimony

The blank below "In the Matter of" needs to have the name of the person facing the forced drugging petition, the Case No., blank needs to be filled in and the Judicial District blank filled

[1] A version of Robert Whitaker's affidavit with hyperlinks to all of the references (except books) is available at http://psychrights.org/Litigation/WhitakerAffidavit.pdf.

in. Juneau is the Second Judicial District, Anchorage the Third Judicial District, and Fairbanks the Fourth.

(A) Certificate of Service

Copies of everything that is filed needs to be given to the other party(ies) in a case, which is called being "served". The Certificate of Service lets the court know who has been "served" with the documents and is required. A copy of everything needs to be given to the hospital's attorney either in person or by mail and they also want a copy to go to the "Court Visitor."

(B) Motion and Memorandum for Summary Judgment

As a general rule, one is entitled to "summary judgment," if based on written testimony, "there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Once a summary judgment motion is filed with supporting written testimony, the opposing party has to submit sufficient written testimony to create a "genuine" factual dispute(s) that needs to be resolved in order to defeat the summary judgment motion. In other words, if the other side doesn't present sufficient testimony in opposition to the written testimony, the summary judgment motion should be granted. However, the judges in these types of cases tend to ignore the law so don't be surprised if the summary judgment motion isn't granted, even if the other side doesn't come in with any or enough competent testimony. That's the reason for the next pleading, the motion for stay pending appeal. Alaska Rules provide that a proposed order should go with a motion and that has been included.

(C) Motion for Stay Pending Appeal

The motion for stay pending appeal is to try and keep a forced drugging order from going into effect while an appeal is being taken in the event the force drugging petition is granted, ie, the motion for summary judgment fails and the person also loses after the hearing. The grounds for the motion is that the person will face irreparable harm. As with all three pleadings, the written testimony provides the factual basis for this. A copy of a recent Alaska Supreme Court order granting a stay pending appeal based on this testimony is attached to this motion to try and get the trial court to take it seriously. A proposed order is also provided. This order provides that the stay will terminate if no appeal is filed. PsychRights may be able to help in prosecuting such an appeal. No guarantees, though, because PsychRights has limited resources, but it is a possibility.

(D) Notice of Filing Written Testimony

The Notice of Filing Written Testimony is so that in the event the Summary Judgment Motion is denied, the same testimony is technically in front of the court at the hearing. This could be very important in prosecuting an appeal.

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

In the Matter of:	)	
	)	
_____,	)	Case No. _____
Respondent	)	
_____	)	

Certificate of Service

Respondent hereby certifies that on this date, the following were mailed or hand delivered to an Assistant Attorney General and the Court Visitor.

1. This Certificate of Service.
2. Motion for Summary Judgment;
3. Memorandum in Support of Motion for Summary Judgment
4. Order Granting Summary Judgment (proposed)
5. Motion for Stay Pending Appeal;
6. Memorandum in Support of Motion for Stay Pending Appeal
7. Order for Stay Pending Appeal (proposed);
8. Notice of Filing Written Testimony;
9. Affidavit of Loren Mosher, dated March 5, 2003, originally filed in 3AN 03-277 CI.
10. Affidavit of Robert Whitaker, dated September 4, 2007, originally filed in 3AN 07-1064PR.
11. Affidavit of Ronald Bassman, PhD, dated September 4, 2007, originally filed in 3AN 07-1064PR.
12. Affidavit of Grace E. Jackson, MD, dated May 16, 2008, originally filed in 3AN 08-493PR.
13. Transcript of the March 5, 2003, testimony of Loren Mosher, MD, and Grace Jackson, MD, in 3AN 03-277 CI;
14. Transcript of the September 5, 2007, testimony of Sarah Porter in 3AN 07-1064 PR.
15. Transcript of the May 14, 2008, testimony of Grace E. Jackson, MD, in 3AN 08-493PR.

Dated: _____ By: _____

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

In the Matter of:	)	
	)	
_____,	)	Case No. _____
Respondent	)	
_____	)	

MOTION FOR SUMMARY JUDGMENT

Respondent hereby moves for summary judgment denying the petition for involuntary administration of psychotropic medication. This motion is accompanied by a memorandum in support.

Dated: _____ By: _____

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

In the Matter of:	)	
	)	
_____,	)	Case No. _____
Respondent	)	
_____	)	

MEMORANDUM IN SUPPORT OF
MOTION FOR SUMMARY JUDGMENT

Respondent has moved for summary judgment denying the petition for involuntary administration of psychotropic medication under AS 47.30.839.

The following affidavits and other competent written testimony are submitted in support of the Motion:

1. Affidavit of Loren Mosher, dated March 5, 2003, originally filed in 3AN 03-277 CI.
2. Affidavit of Robert Whitaker, dated September 4, 2007, originally filed in 3AN 07-1064PR.
3. Affidavit of Ronald Bassman, PhD, dated September 4, 2007, originally filed in 3AN 07-1064PR.
4. Affidavit of Grace E. Jackson, MD, dated May 16, 2008, originally filed in 3AN 08-493PR.
5. Transcript of the March 5, 2003, testimony of Loren Mosher, MD, and Grace Jackson, MD, in 3AN 03-277 CI;
6. Transcript of the September 5, 2007, testimony of Sarah Porter in 3AN 07-1064 PR.
7. Transcript of the May 14, 2008, testimony of Grace E. Jackson, MD, in 3AN 08-493PR.

I. Discussion

A. Best Interests

Under *Myers v. Alaska Psychiatric Institute*, 138 P.3d 238, 254 (Alaska 2006), the Alaska Supreme Court held AS 47.30.839 was not a constitutionally permissible basis for forcing someone to take psychotropic drugs against their will except as follows:

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

(emphasis added).

The Supreme Court further held:

> Evaluating whether a proposed course of psychotropic medication is in the best interests of a patient will inevitably be a fact-specific endeavor. At a minimum, we think that courts should consider the information that our statutes direct the treatment facility to give to its patients in order to ensure the patient's ability to make an informed treatment choice. As codified in AS 47.30.837(d)(2), these items include:
>
> > (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[.][1]

[1] 138 P.3d 252.

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

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

Robert Whitaker's written testimony establishes that:

> (a) Neuroleptics, also called 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 neuroleptic drugs.
>
> (c) Neuroleptics cause a host of debilitating physical, emotional and cognitive side effects, and lead to early death.
>
> (d) The new "atypical" neuroleptics 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.
>
> (e) Non-medication approaches have been proven far more effective.

Dr. Jackson's May 16, 2008, affidavit confirms the Whitaker testimony, and describes in some detail the brain damage caused by neuroleptics, summarizing it 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.

[2] *Id.*

> 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)

The testimony of Dr. Mosher, who was the former chief of schizophrenia research at the National Institute of Mental Health also confirms that the scientific evidence for the use of these drugs is lacking. He also testified the Dr. Jackson "knows more about the mechanisms of the various psychotropic agents than anyone who is a clinician, that I'm aware of."

The administration of such a drug(s) is not in respondent's best interests and summary judgment should be granted in respondent's favor.

B. Less Intrusive Alternative

With respect to *Myers'* requirement of a less intrusive alternative, the State is constitutionally required to provide an available less intrusive alternative. *Wyatt v. Stickney*,[3] ("no default can be justified by a want of operating funds."), affirmed, *Wyatt v. Anderholt*,[4] (state legislature is not free to provide social service in a way that denies constitutional right). In *Wyatt* the federal courts required the State of Alabama to spend funds in specific ways to correct constitutionally deficient services.

Upon the State invoking its awesome power to confine Appellant and seeking to exercise its similarly awesome power to forcibly drug him against his will, Appellant's constitutional right to a less intrusive alternative arises under *Myers*. Under *Wyatt* the State may not avoid its obligation to do so by adopting a mission that denies Appellant's constitutional right to a less intrusive alternative.

In *Hootch v. Alaska State-Operated School System*,[5] in considering an equal protection claim regarding the right to state funding of local schools, the Alaska Supreme 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 hold, "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." Here, it is respectfully suggested, this Court should not hesitate to order the provision of the available less intrusive alternative to satisfy the constitutional due

[3] 344 F.Supp. 387 (M.D.Ala.1972).
[4] 503 F.2d 1305, 1315 (5th Cir. 1974).

process right to a less intrusive alternative it required in *Myers*. Otherwise, the right is meaningless.[6]

Dr. Jackson's, Dr. Bassman's, Mr. Whitaker's and Sarah Porter's testimony establish there are less intrusive alternatives and such a less intrusive alternative should be ordered by this Court:

II. Conclusion

There being no genuine issue as to any material fact and Respondent being entitled to judgment as a matter of law, Respondent's Motion for Summary Judgment should be granted, denying the petition and ordering the State to provide the following less intrusive alternative:

Dated: _____ By: _____

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[5] 536 P.2d 793, 808–09 (Alaska 1975).
[6] There are likely limits to the right, such as unreasonable cost, but that is not the situation here.

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

In the Matter of:	)	
	)	
_____,	)	Case No. _____
Respondent	)	
_____	)	

ORDER GRANTING MOTION FOR SUMMARY JUDGMENT

Upon consideration of the motion for stay pending appeal in this matter, and any oppositions thereto, it is hereby ORDERED, the motion for summary judgment is GRANTED and the petition dismissed.

Dated: _____ By: _____

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

In the Matter of:	)	
	)	
_____,	)	Case No. _____
Respondent	)	
_____	)	

MOTION FOR STAY PENDING APPEAL

Respondent, in order to avoid irreparable harm should the court issue an order requiring Respondent to take psychotropic medication(s) against Respondent's will (Forced Drugging Order), hereby prophylactically moves for a stay pending appeal. This motion is accompanied by a memorandum in support

Dated: _____ By: _____

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

In the Matter of:	)	
	)	
_____,	)	Case No. _____
Respondent	)	
_____	)	

MEMORANDUM IN SUPPORT OF
MOTION FOR STAY PENDING APPEAL

Respondent, in order to avoid irreparable harm should the court issue an order requiring Respondent to take psychotropic medication(s) against Respondent's will (Forced Drugging Order), has prophylactically moved for a stay pending appeal. The reason this motion is made in advance of such a ruling is Respondent anticipates that should this court issue a Forced Drugging Order, Respondent would otherwise immediately be subjected to such forced drugging and effectively denied his right to seek a stay pending appeal.

This motion should be granted because the State is adequately protected and Respondent faces irreparable harm should the stay be denied as shown by the written testimony of Robert Whitaker, and Grace E. Jackson, MD, establishing:

(a) Neuroleptics, also called 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 neuroleptic drugs.

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

(d) The new "atypical" neuroleptics 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.

and

> Evidence from neuroimaging studies reveals that ***old and new*** neuroleptics contribute to the progressive shrinkage and/or loss of brain tissue. Atrophy is especially prominent in the frontal lobes which control decision making, intention, and judgment. These changes are consistent with *cortical* dementia, such as Niemann-Pick's or Alzheimer's disease.
>
> Evidence from postmortem analyses in lab animals reveals that ***old and new*** neuroleptics induce a significant reduction in total brain weight and volume, with prominent changes in the frontal and parietal lobes.
>
> Evidence from biological measurements suggests that ***old and new*** neuroleptics increase the concentrations of tTG (a marker of programmed cell death) in the central nervous system of living humans.
>
> Evidence from *in vitro* studies reveals that haloperidol reduces the viability of hippocampal neurons when cells are exposed to clinically relevant concentrations. (Other experiments have documented similar findings with the second-generation antipsychotics.)
>
> Shortly after their introduction, neuroleptic drugs were identified as chemical lobotomizers. Although this terminology was originally metaphorical, subsequent technologies have demonstrated the scientific reality behind this designation.
>
> Neuroleptics are associated with the destruction of brain tissue in humans, in animals, and in tissue cultures. Not surprisingly, <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)

This written testimony was the fundamental basis for the Alaska Supreme Court granting a Stay Pending appeal in *Bigley v. Alaska Psychiatric Institute*, Case No. S-13116, Alaska Supreme Court, a copy of which is attached hereto as Exhibit A.[7]

In addition, the testimony of Dr. Mosher, who was the former chief of schizophrenia research at the National Institute of Mental Health also confirms that the scientific evidence for the use of these drugs is lacking. He also testified the Dr. Jackson "knows more about the mechanisms of the various psychotropic agents than anyone who is a clinician, that I'm aware of."

Respondent faces irreparable harm and has raised serious and substantial questions going to the merits and the State is adequately protected. The Alaska Supreme Court has essentially already ruled on this as set forth in the Attached Exhibit A.

For the foregoing reasons, this Court should grant Respondent's Motion for Stay Pending Appeal.

Dated: _____ By: _____

[7] *See*, also, the cross-examination of Dr. Jackson on her written testimony and redirect, available on the Internet at http://psychrights.org/States/Alaska/CaseXX/3AN-08-493PS/14may08bigley.pdf.

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**
	)	

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

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

In the Matter of:	)	
	)	
_____,	)	Case No. _____
Respondent	)	
_____	)	

ORDER GRANTING MOTION FOR STAY PENDING APPEAL

Upon consideration of the motion for stay pending appeal in this matter, and any oppositions thereto, it is hereby ORDERED, the motion for stay pending appeal is GRANTED.

IT IS FURTHER ORDERED, should no appeal be filed within the time allowed to file such an appeal, the stay shall terminate.

Dated: _____ By: _____

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

In the Matter of:	)	
	)	
_____,	)	Case No. _____
Respondent	)	
_____	)	

NOTICE OF FILING WRITTEN TESTIMONY

In addition to being filed in support of Respondent's Motion for Summary Judgment, in the event such motion is not granted, the following written testimony is hereby filed by Respondent as direct testimony in opposition to any extant or future AS 47.30.839 forced drugging petition(s) filed by petitioner in the above captioned action:

1. Affidavit of Loren Mosher.
2. Affidavit of Robert Whitaker.
3. Affidavit of Ronald Bassman, PhD.
4. Affidavit of Grace E. Jackson, MD.
5. Transcript of testimony of Loren Mosher, MD, and Grace Jackson, MD.
6. Transcript of testimony of Sarah Porter.
7. Transcript of testimony of Grace E. Jackson, MD,.

Dr. Mosher is now deceased and his testimony allowable under Evidence Rule 804(a). The other witnesses do not reside in Alaska and allowable pursuant to Evidence Rule 804(b)(1) because Respondent has been unable to procure their attendance and Petitioner not only had the opportunity and similar motive to develop the testimony by direct, cross, or redirect, it exercised such right.

Dated: _____ By: _____

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

In The Matter of the Hospitalization	)	
	)	
of	)	
	)	
FAITH J. MYERS	)	
	)	Case No. 3AN 03-277 P/S
STATE OF CALIFORNIA	)	
	) ss	
SAN DIEGO COUNTY	)	

Affidavit of Loren R. Mosher, M.D.

Credentials:

I am born and raised in California, a board-certified psychiatrist who received an M.D., with honors, from Harvard Medical School in 1961, where I also subsequently took psychiatric training. I was Clinical Director of Mental Health Services for San Diego County from 7/96 to 11/98and remain a Clinical Professor of Psychiatry at the School of Medicine, University of California at San Diego. From 1988-96 I was Chief Medical Director of Montgomery County Maryland's Department of Addiction, Victim and Mental Health Services and a Clinical Professor of Psychiatry at the Uniformed Services University of the Health Sciences, F. Edward Herbert School of Medicine, Bethesda, Maryland.

From 1968-80 I was the first Chief of the NIMH's Center for Studies of Schizophrenia. While with the NIMH I founded and served as first Editor-in-Chief of the Schizophrenia Bulletin.

From 1970 to 1992 I served as collaborating investigator, then Research Director, of the Palo Alto based, NIMH funded Soteria Project – "Community Alternatives for the Treatment of Schizophrenia". In this role, I was instrumental in developing and researching an innovative, home-like, residential treatment facility for acutely psychotic persons. Continuing my interest in clinical research (1990 - 1996), I was the Principal Investigator of a Center for Mental Health Services (CMHS) research/demonstration grant for the first study to compare clinical outcomes and costs of long term seriously mentally ill public-sector clients randomly assigned (with no psychopathology based exclusion criteria) to a residential alternative to hospitalization or the psychiatric ward of a general hospital (the McPath project). This study's findings, comparable clinical effectiveness with a 40% cost saving favoring the alternative, have important acute care implications.

In 1980, while based at the University of Verona Medical School, I conducted an in-depth study of Italy's revolutionary new mental health system. I documented that the new National Health Service supported system of catchmented community care could stop admissions to large state hospitals, enabling them to be phased down and closed. It

was also concluded that where the legally mandated community system was properly implemented there were no adverse consequences for patients or the community.

In addition to over 120 articles and reviews, I have edited books on the Psychotherapy of Schizophrenia and on Milieu Treatment. Our book, Community Mental Health: Principles and Practice, written with my Italian colleague, Dr. Lorenzo Burti, was published by Norton in 1989. A revised, updated, abridged paperback version, Community Mental Health: A Practical Guide, appeared in 1994. It has been translated into five languages. Most recently I founded a consulting company, Soteria Associates, to provide individual, family and mental health system consultation using the breadth of experience described above.

INTRODUCTION:

In many parts of the country thinking about public mental health systems has moved away from the biomedical model, initially to a psychosocial rehabilitation orientation, and more recently to a recovery based model. Each change represents a move toward a more holistic view, increased self-management in treatment, greater emphasis on independent living and community integration and protection of rights of system users. As a whole it means much less hierarchical systems and greater equality of staff and users.

When considering mental health reform it must be recognized that mental health care is a system. Programs making up mental health systems share the following characteristics: They are labor intensive, relationship based and relatively low technology. The system's elements should include: Prompt, accessible, client centered, recovery oriented, quality mental health and rehabilitation services; decent affordable housing; and appropriate, ongoing self-help focused social supports. Because they address basic human needs systems that contain an array of these services have been shown to be both cost effective and voluntarily used. Such systems must be adequately funded but reform must also include attitude change and reorganization into less institutional, human sized programs.

Reform to produce co-ordinated community based systems of care needs guidelines: (1) a shared set of values and (2) common organizational (3) interpersonal and (4) clinical principles. These four elements of a systemic organizational framework can guide the committee's reform deliberations. Because they are non-specific, they are nearly universally applicable.

1. PROGRAM VALUES

- Do no harm
- Treat, and expect to be treated, with dignity and respect.
- Be flexible and responsive
- In general the "user" (client, patient) knows best. We each know more about ourselves than anyone else. This is usually a vast untapped reservoir of valuable information.
- Choice, the right to refuse, informed consent, and voluntarism are essential to program functioning. Without options, freedom of choice is illusory. Involuntary

treatment should be difficult to implement and used only in the direst of circumstances.

- Expression of strong feelings and development of potential are acceptable and expected – and are not usually signs of "illness".
- Whenever possible, legitimate needs (e.g. housing, social, financial etc.) should be filled. Without adequate housing, mental health "treatment" is mostly a waste of time and money.
- Risks are part of the territory; if you don't take chances nothing ever happens.

2. ADMINISTRATIVE PRINCIPLES

- Reliable funding stream
- Catchmented responsibility – no "shift and shaft" allowed
- Responsible, multi-disciplinary, multi-function, mobile teams
- Decentralized authority and responsibility to allow on the spot decision making
- Use of existing community resources
- Multi-purpose mental health/social services centers.
- Non-institutionalization: Residential care (i.e., hospitals and IMD's) is expensive and often creates or reinforces problems. They are, by definition, abnormal environments and should be used sparingly.
- Multi-dimensional outcomes must be monitored and fed back rapidly.
- Citizen/"user" participation is vital for program planning and oversight.

3. RELATIONAL PRINCIPLES

(All help facilitate the development of relationships)

- Positive Expectations
- Atheoretical need to understand – try to find an explanation for what is going on
- Continuity of relationships across contexts
- "Being with"., "standing by attentively" – getting oneself into the other's shoes to better understand "the problem"
- Concrete problem focus (problems, in contrast to diagnoses, generate questions and possible solutions)
- Relational "partnership", doing together (preserves "user" power)
- Expectation of self-help ("users" need not be so in perpetuity)

4. CLINICAL PRINCIPLES

- Contextualization– we all have histories that can only be understood by considering the contexts within which they developed.
- Preservation and enhancement of "user" personal power and control. Mental health professionals do not necessarily know what is best for their clients/patients – their role should be to keep them continually involved as the treatment process unfolds.

- Normalization (Usualization): Culturally sensitive societal norms should be applied when treatment plans are developed. The most "normal", least restrictive, alternative should always be tried first. If you treat people as normal they tend to behave normally.

We have a more than adequate knowledge base to implement reform. More studies and dust gathering reports are not needed. What is needed is the political will, community involvement and financial resources necessary to make change happen.

Loren R Mosher, MD

SUBSCRIBED AND SWORN TO before me this __5th__ day of March, 2003.

Notary Public in and for California
My commission expires: 11-4-04

OFFICIAL SEAL
JANE M. REILLY
NOTARY PUBLIC-CALIFORNIA
COMM. NO. 1279794
SAN DIEGO COUNTY
MY COMM. EXP. NOV. 4, 2004

State of Alaska)
)ss
Third Judicial District)

I, James B. Gottstein, hereby swear that this reproduction of Affidavit of Loren R. Mosher, M.D., to which this is appended, is a true, correct and complete photocopy of the original document, currently in my possession.

Dated: 10/27/2008

James B. Gottstein

SUBSCRIBED AND SWORN TO before me this 27th day of October, 2008.

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

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

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT

IN THE MATTER OF F.M.

3AN-02-00277 CI

_____/

VOLUME I

TRANSCRIPT OF PROCEEDINGS

March 5, 2003 -- Pages 1 through 198

March 10, 2003 -- Pages 198 through 223

HEARING REGARDING BURDEN OF PROOF THAT DEFENDANT IS MENTALLY ILL AND REGARDING ADMINISTRATION OF MEDICATION

BEFORE THE HONORABLE MORGAN CHRISTEN

Anchorage, Alaska
March 5, 2003

APPEARANCES:

FOR THE PLAINTIFF: Jeff Killip
Assistant Attorney General
State of Alaska
1031 West 4th Avenue, Suite 200
Anchorage, Alaska 99501

FOR THE DEFENDANT: James B. Gottstein
406 G Street, Suite 206
Anchorage, Alaska 99501

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4403-41

8:52:51 AM

THE COURT: We're on record in Case No. 3AN-03-277. It's a case regarding Faith Myers. Mr. Gottstein, before I go any further, I'll just state your appearance. Mr. Gottstein is present, for the record, as is Mr. Killip for the State. Your client requested this be an open hearing, is that correct?

MR. GOTTSTEIN: That's correct. She's not here yet, though, and she's supposed to be here. So, I don't know what the hang-up is. Dr. Kletti, wasn't she --?

THE COURT: Right. She has the right to be present.

DR. KLETTI: Right. She was scheduled for transportation to court this morning.

THE COURT: I was told that you all were ready. I didn't realize that you weren't. We need to wait for her. So we'll go ahead and go back off record and do that. Well, actually, maybe I'll take up some housekeeping, first, but we're not going to proceed in substance with her, certainly.

I just have the one exhibit list. Counselor, do you have --

MR. GOTTSTEIN: The respondent's?

THE COURT: Yes. Do you have an exhibit list, Mr.

Killip?

MR. KILLIP: Your Honor, given the accelerated pace, the witnesses just showed up. I had a chance to speak with one for almost an hour yesterday, but there are two more I haven't had a chance to talk with and one of them presented me with some photographs. I don't have an exhibit list that I've generated yet, but I can do it right now.

THE COURT: Okay, that's fine. We can do it when we go off record for a minute. As long as Mr. Gottstein has it and has a chance to take a look, that's fine.

MR. GOTTSTEIN: Your Honor, I would note under AS 47.37.30(a)(6) that the petition must list the prospective witnesses who will testify in support of commitment or involuntary treatment, and only Dr. Hanowell was listed. And I would object to any witness other than the one specifically listed testifying.

THE COURT: All right. The objection is noted, but again, I'm not going to make any substantive ruling until your client gets here. My intention is to stay on record just to get some housekeeping taken care of.

MR. GOTTSTEIN: Can I respond to that, Your Honor?

THE COURT: No, not yet.

MR. GOTTSTEIN: Okay.

THE COURT: Because we're not going to get into

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THE COURT: Mr. Gottstein?
DIRECT EXAMINATION (continued)
BY MR. GOTTSTEIN:
Q Yeah. Dr. Jackson, can you explain why you failed the exam? Or, you were failed, I guess I should say.
A Well, the Board of Examiners does not send you any kind of feedback, but I was subjected to quite intense cross-examination as to why I would not give a patient with psychotic symptoms medication for life. And I had done extensive research up to that point to prepare myself for -- for my philosophy of treatment. And I was not willing to purger myself in the cross-examination process of board certification exam, so I did not pass that exam.
Q What do you mean by that? You were not prepared to purger yourself?
A I could have lied. I could have told the examiners that the woman in the videotaped interview, who had previously had a case of schizophrenia, needed to be on medication for life, which is what they were attempting to get out of me. Because they kept saying, well, she told you that she had previously been on these medicines. Why won't you give them to her now? And I had done a great deal of research and had very good reasons why I would not continue a person, necessarily on life-long medication. But that, apparently, was not the answer that they were

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looking for.
I should say that my passed portion of the exam, which was based on a live patient interview in the morning, was based -- I passed that exam, and the reason for that or the tone of that was actually quite different. My examiners were more psycho-dynamically oriented individuals, and they accepted the fact that a life-long medication strategy was not necessarily in the best interest of all patients.
So, the board certification process, itself, is extremely relative. I would expect to encounter the exact difficulties when I sit for the examination again and I will give the same answers, based on the same scientifically-based knowledge.
THE COURT: I'll accept this witness as an expert and weigh her testimony accordingly.
Q Dr. Jackson, did you prepare a report and sign an affidavit -- well -- excuse me, Your Honor.
THE COURT: That's okay. But could you get closer to the microphone?
Q Yes. Did you notarize a statement -- have notarized a statement in preparation for this hearing?
A Yes, I did.
THE COURT: Mr. Gottstein, I'm sorry to do this to you, but I just got the email that Dr. Mosher is on the

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phone. Do you want me to have him call back in 10 minutes, or what do you want to do?
MR. GOTTSTEIN: Grace, can you? Let's take Dr. Mosher.
THE COURT: That's your preference?
MR. GOTTSTEIN: Yes.
THE COURT: Ma'am, I'm very sorry to do this. We've been trying to get Dr. Mosher on the line, and the witnesses we typically go in order. And he was not available by phone. I've just received an email that he's called back in.
DR. JACKSON: That's absolutely fine.
THE COURT: All right. I appreciate it very much.
DR. JACKSON: Would you like me -- you'll call me back?
THE COURT: Yes.
DR. JACKSON: Okay. Thank you.
THE COURT: You bet. Dr. Mosher, can you hear me?
DR. MOSHER: Yes. Long distant, but I can hear you.
THE COURT: All right. I'll try to speak into the microphone more clearly. My name is Morgan Christen. I'm a superior court judge and I'm assigned to this case. I have you on a speaker phone on an overhead in the courtroom, sir. And Mr. Gottstein has asked that you testify. Are you able to do that at this time?

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DR. MOSHER: Well, I guess. I didn't prepare must, but anyway, I'll do my best.
THE COURT: All right. That's fine. I need to have the oath administered to you. Could you please raise your right hand?
DR. MOSHER: Okay.
THE CLERK: Do you swear or affirm that the information you are about to give in this matter before the court is the truth, the whole truth, and nothing but the truth?
DR. MOSHER: I do.
THE COURT: Sir, could you please state your full name and spell your last name?
DR. MOSHER: It's Loren Mosher, M-O-S-H-E-R-.
THE COURT: All right. Thank you. Mr. Gottstein, you may inquire.
DR. LOREN MOSHER
testified as follows on:
DIRECT EXAMINATION
BY MR. GOTTSTEIN:
Q Dr. Mosher, I can't express my appreciation enough for your willingness to testify after just getting back from Germany yesterday, and I just felt like I wanted to express that.
Your affidavit has just been admitted. And I

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represented that you would have it notarized and send it. Is that true?
A I just did that. It should be there tomorrow afternoon.
Q Thank you. Could you briefly -- because we've got a total of, I think 28 minutes left in this whole hearing, including to hear from Dr. Jackson -- discuss your credentials, please?
A I graduated from Stanford as an undergraduate, Harvard Medical School, Harvard psychiatric training, more training at the National Institute of Mental Health, post-doctoral fellowship in England, professor -- assistant professor of psychiatry at Yale -- I'm sort of going chronologically -- from '68 to '80 I was the chief for the Center for Studies of Schizophrenia, at the National Institute of Mental Health from 1980 to '88 I was professor of psychiatry at the Uniform Services University of the Health Sciences in Bethesda, Maryland. That's a full-time, tenured, academic position. '88 to '96 I was the chief medical director of the Montgomery County Maryland Public Mental Health System. That's a bedroom community to Washington, D.C. From '96 to '98 I was clinical director of the San Diego County Public Mental Health System. Since November of '98 I have been the director and principle in Satiria (ph) Associates, a

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private consulting firm that I formed, and I also hold clinical professorships at the University of California San Diego School of Medicine, and at the Uniform Services University of the Health Sciences in Bethesda, Maryland. So that's briefly my credentials.
Q Dr. Mosher, did you mention being head of schizophrenia research at the National Institute of Mental Health?
A Yeah, I said I was the head of the Center for Studies of Schizophrenia from 1968 until 1980.
Q Okay. I move to qualify Dr. Mosher as an expert psychiatrist, especially in schizophrenia.
MR. KILLIP: Your Honor, just a couple questions.
VOIR DIRE EXAMINATION
BY MR. KILLIP:
Q Dr. Mosher, Jeff Killip with the Alaska Attorney General's Office. I just want to ask you if you are currently board certified in psychiatry?
A I've been board certified since 1969.
Q Okay. And are you currently a member in good standing with the American Psychiatric Association?
A No, I am not. I resigned from the American Psychiatric Association.
Q And do you have a reason for that?
A Yes, I have a reason for it. I felt like they no

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longer represented my interested and the $1,000 a year that I was paying for them was just basically a waste of money, while they pursued their own interests to the detriment of what I consider to be the people they should be pursuing an interest for, and that's their patients. So anyway, I'm not a member. I resigned in December of 1998.
Q So, is it fair to say that you have a philosophical disagreement with their approach, presently?
A Well, yeah. I don't like how they do business.
Q When you say do business, you mean practice psychiatry in the United States?
A Well, we could take up the next half hour on that subject, but basically I feel that they have taken the person out of psychiatry and psychiatry has -- is now a dehumanizing, impersonal, non-individualized specialty that is interested purely in pharmical therapy now. That's big, broad brush strokes, but that's -- obviously that's not true of every single one, but that's my complaint about the organization.
Q Okay.
A There's a -- if you want to read my letter of resignation, you can look on my web site.
Q Okay, thank you.
THE COURT: Any objection?

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MR. KILLIP: No.
THE COURT: All right. This witness will be qualified
Q Thank you, Dr. Mosher. In the first sentence of the introduce of your affidavit on page two, you talk about the biomedical model. I was going to ask you what you mean by that. Have you already answered that, or would you like to expand on that?
A Well, you know, what I mean by that is the phrase is currently being used that, let's take, for example, schizophrenia is a brain disease. Well, that's a perfect example of the medical model -- of the biomedical model. When -- whereas, there is no evidence that schizophrenia is, in fact, a brain disease. And so a hypothesis that schizophrenia is a brain disease, has been converted into a biomedical fact. And I disagree with converting hypotheses into beliefs in the absence of supporting evidence.
Q Okay, thank you. Now, in your opinion, is medication the only viable treatment for schizophrenia paranoid type?
A Well, no, it's not the only viable treatment. It is one that will reduce the so-called positive symptoms, the symptoms that are expressed outwardly for those kinds of folks. And that way they may seem better, but in the long

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run, the drugs have so many problems, that in my view, if you have to use them, you should use them in as small a dose for as short a period of time as possible. And if you can supply some other form of social environmental treatment -- family therapy, psychotherapy, and a bunch of other things, then you can probably get along without using them at all, or, if at all, for a very brief period of time. But you have to be able to provide the other things. You know, it's like, if you don't have the other things, then your hand is forced.

MR. KILLIP: Excuse me, Your Honor. I just would renew our continuing objection about offering test on medical practice in the context of this hearing.

THE COURT: This hearing is going to last 20 more minutes, and I'm going to let Mr. Gottstein use the time.

Q Now, as a hypothetical question, if a woman who had managed -- who has over a 25 year experience with medications and has -- including navaine, paxil, risperdal and zyprexa -- and then has managed to not -- to wean herself from those for a year, would your recommendation be that she be placed back on them, particularly against her will?

A Well, I think she is an absolute saint if she was able to get off of those drugs. Those drugs are extraordinarily difficult to get off of, especially

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zyprexa, which is a thienobenzodiazepine derivative and the thienobenzodiazepine valium-type drugs are very addictive. And so, zyprexa, in particular, is difficult to get off. And if she got off herself -- got herself off of zyprexa, that's quite a remarkable feat in my clinical experience. So I would be loath to put her back onto, especially zyprexa. But, you know, the other -- risperdal is also problematic for getting off. Actually, they all are, it's just a matter of degree. And if she got off for a year, then I would certainly try to do whatever I can to avoid putting her back on. And if she doesn't want them, then that's even -- you know, if you can't negotiate some drug that she may calm down on, like, for example, if she if kind of agitated and anxious -- I don't know this woman. I've never seen her face-to-face, so I can't really speak to her particular problem without having seen her, but if she is, let's say, unhappy, agitated, and so forth, then sometimes short-term use of drugs like valium is quite helpful and it get's people through a crisis without getting them back onto the neuroleptics drugs, the anti-psychotic drugs.

Q Okay, thank you. Now, in your affidavit, you say involuntary treatment should be difficult to implement and used only in the direst of circumstances. Could you explain why you have that opinion?

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A Well, it's just, you know, the degree to which you have to force people to do anything.....

MR. KILLIP: Your Honor, I'm going to object.

A .....is the degree to which it's going to be very difficult to forge a good therapeutic relationship. And in the field of psychiatry, it is the therapeutic relationship which is the single most important thing. And if you have been a cop, you know, that is, some kind of a social controller and using force, then it becomes nearly impossible to change roles into the role -- the traditional role of the physician as healer advocate for his or her patient. And so I think that that -- we should stay out of the job of being police. That's why we have police. So they can do that job, and it's not our job.

Now, if because of some altered state of consciousness, somebody is about to do themselves grievous harm or someone else grievous harm, well then, I would stop them in whatever way I needed to. I would probably prefer to do it with the police, but if it came to it, I guess I would do it. In my career I have never committed anyone. It just is -- I make it my business to form the kind of relationship that the person will -- that we can establish a ongoing treatment plan that is acceptable to both of us. And that may you avoid getting into the fight around whatever. And, you know, our job is to be healers,

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not fighters.

THE COURT: There's an objection to that question. The objection was relevance?

MR. KILLIP: Yes.

THE COURT: Overruled.

Q Now, you say you've never committed anybody. But you've had a lot of experience with -- or, I should say, have you had a lot of experience with people with schizophrenia?

A Oh, dear. I probably am the person on the planet who has seen more acutely psychotic people off of medication, without any medications, than anyone else on the face of the planet today.

Q Thank you.

A Because of the Satiria Project that we did for 12 years where I would sit with people who were not on medications for hours on end. And I've seen them in my private practice, and I see them to this day in my now, very small, private practice. But --

THE COURT: Sir, I think I understand the answer.

A I find that people who are psychotic and not medicated are among the most interesting of all the customers one finds.

Q Thank you, Dr. Mosher.

THE COURT: That's a yes.

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Q Dr you know Dr. Grace Jackson?
A I do.
Q Do you have an opinion on her knowledge of psychopharmacology?
A I think she knows more about the mechanisms of actions of the various psychotropic agents than anyone who is a clinician, that I'm aware of. Now, there may be, you know, basic psychopharmacologists, you know, who do lab work who know more, but as far as a clinician, a practitioner, I don't know anyone who is better-versed in the mechanisms, the actions, the effects and the adverse effects of the various psychotropic drugs.
Q Thank you, Dr. Mosher. I have no questions, but perhaps the State will have some.
MR. KILLIP: Yes, thank you.

DR. LOREN MOSHER

testified as follows on:

CROSS-EXAMINATION

BY MR. KILLIP:

Q Dr. Mosher, is it not your understanding that the use of anti-psychotic medications is the standard of care for treatment of psychosis in the United States, presently?
A Yes, that's true.
Q Okay, so is it fair to say that your viewpoint --

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MR. GOTTSTEIN: Objection, relevance.
THE COURT: Overruled.
Q Would you say that your viewpoint presented today falls within the minority of the psychiatric community?
A Yes, but I would just like to say that my viewpoint is supported by research evidence. And so, that being the case, it's a matter of who judges the evidence as being stronger, or whatever. So, I'm not speaking just opinion, I'm speaking from a body of evidence.
Q Thank you, Dr. Mosher.
THE COURT: Nothing further?
MR. KILLIP: Nothing.
MR. GOTTSTEIN: No, Your Honor.
THE COURT: All right. Sir, I appreciate your testimony very much and want to thank you. It sounds like the lawyers are done with you, so you can hang up.
DR. MOSHER: Okay. Well, good luck and I hope -- what's her name, Ms. Myers?
THE COURT: Faith Myers.
DR. MOSHER: Gets out and without drugs. Thank you.
THE COURT: Thank you, sir. All right. Do you want to try to call Dr. Jackson back?
MR. GOTTSTEIN: Yes, Your Honor.
THE COURT: All right. Dr. Jackson?
DR. JACKSON: Yes?

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THE COURT: Great. We're back on record. This is Morgan Christen again. I have you back on the same overhead speaker.
DR. JACKSON: Yes, ma'am.
THE COURT: What I'm going to do, I think, to save time, is to just remind you that you remain under oath and allow Mr. Gottstein to ask his questions.
DR. JACKSON: Um-hmm. Yes, ma'am.

DR. GRACE JACKSON

testified as follows on:

DIRECT EXAMINATION (continued)

BY MR. GOTTSTEIN:

Q Thank you, Dr. Jackson. Obviously we're down to 10 minutes now, and I appreciate you waiting all day. And I'm going to have to be, obviously, a little bit -- or more than a little bit brief.
Did you -- we were just talking about an affidavit, I think, that you signed, or a report that you swore. Did you do so?
A Yes, that is correct. Yup.
Q And is it -- can I --?
THE COURT: Do I have this? Oh, you're just handing it to me now, okay.
MR. GOTTSTEIN: I was in the middle of that.
THE COURT: I see. I beg your pardon.

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MR. GOTTSTEIN: Exhibit D.
THE COURT: Thank you, sir.
Q What's the title of that?
A This is an analysis of the olanzapine that is zyprexa, the clinical trials, and I've called this A Dangerous Drug with Dubious Efficacy.
Q Okay.
MR. KILLIP: Excuse me, Your Honor. I just wanted to note for the record that we've got about 20+ pages, half of them are stapled upside down. We're probably not going to have a meaningful opportunity to look at this before cross-examination. I just want to make that record.
THE COURT: Yes, I have the same exhibit.
MR. KILLIP: Thank you.
MR. GOTTSTEIN: And I would note that I received nothing from them before anything.
Q I think what I -- does this accurately -- well, obviously it accurately describes the results of your research into the drug olanzapine. Is that correct?
A Yes, that's right.
Q Okay. Have you -- I'm going to try -- I'm trying to get some stuff into the record here, Your Honor. And so -- and then we'll get to more substantive.
Did you send me some information regarding the

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MR. GOTTSTEIN: .....if that's what our decision is.
THE COURT: If you could let me know, I'd sure appreciate it, because I'm --
MR. GOTTSTEIN: Absolutely, Your Honor. I included you in that.
THE COURT: Yeah, I appreciate it. Because, as I said, I'm -- I have a personal appointment out of the office that's actually a medical appointment I scheduled for some months and moved several times, myself, so I'd like to know as soon as I can, so that I can know how to handle that.
And I appreciate what you're both doing, which strikes me as you're both being very, very cooperative and trying your level best to get this done in a timely manner that jumps through all the hoops required by the statute and make sure that I have the information that I need to make the decision.
Is there anything further I can take up today, productively? No?
MR. KILLIP: I don't think so, Your Honor.
THE COURT: All right. Well then, I'll let you both ring off. It's after 5:00 and I've kept you. Thanks very much for your help. I'll have Hilary confirm tomorrow morning about that time, but that should be at least in pencil on your calendars. And I'll let you know if I need

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to speak to you sooner, after I get the report from the court-appointed visitor.
MR. KILLIP: Okay.
THE COURT: Thank you both very much.
MR. KILLIP: Thank you.
MR. GOTTSTEIN: Thank you.
THE COURT: Off record.
(Off record.)
5:03:47

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TRANSCRIBER'S CERTIFICATE

I, Joanne Kearse, hereby certify that the foregoing pages numbered 1 through 222 are a true, accurate, and complete transcript of the hearings that took place on March 5, 2003 and March 10, 2003, In the Matter of F.M., Superior Ct. No. 3AN-03-277 PR, transcribed by me from a copy of the electronic sound recording to the best of my knowledge and ability.

Dated this 7th day of April, 2003.

JOANNE KEARSE

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

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

AFFIDAVIT OF RONALD BASSMAN, PhD

STATE OF NEW YORK)
) ss.
ALBANY COUNTY)

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

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

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

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

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

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

- T.D. Survivor, Washington, DC

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

- T.D. Survivor, New York

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

- T.D. Survivor, Louisiana

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

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

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

*Recovery is the reawakening of hope after despair.

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

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

*Recovery is active coping rather than passive adjustment.

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

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

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

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

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

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

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

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

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

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

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

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[2] The President's New Freedom Commission for Mental Health. Transforming Mental Health Care: Achieving the Promise, Rockville, MD, 2005.

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

[4] Parks, J. Morbidity and mortality in people with serious mental illness. Fifth National Summit of State Psychiatric Hospital Superintendents, May 6-8, 2007.

[5] Breggin, P. Brain damage, dementia and persistent cognitive dysfunction associated with neuroleptic drugs: Evidence, etiology, implications. Challenging the Therapeutic State: Critical Perspectives on Psychiatry and the Mental health System, ed. David Cohen, Journal of Mind Behavior 11.3-4 p. 425-464. 1990.

[6]Bassman, R. Mental illness and the freedom to refuse treatment: privilege or right. Professional Psychology: Research and Practice, Vol.36, No.5, 488-497, 2005.

[7] Bassman, R. The mental health system: Experiences from both sides of the locked doors. Professional Psychology: Research and Practice, Vol. 28, No. 3, 238-242 1997.

[8] Bassman, R. A Fight to Be: A Psychologist's Experience from Both Sides of the Locked Door. Tantamount Press: Albany, New York, 2007.

[9] Bassman, R. Consumer/Survivors/Ex-patients as change facilitators, in Frese, F. ed. The Role of Organized Psychology in Treatment of the Seriously Mentally Ill, New Directions for Mental Health, No. 88, Winter, p. 93-102, 2000.

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

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

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

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

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

Ronald Bassman, PhD

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

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

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

State of Alaska)
)ss
Third Judicial District)

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

Dated: 10/27/2008

James B. Gottstein

SUBSCRIBED AND SWORN TO before me this 27th day of October, 2008.

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

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

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

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

AFFIDAVIT OF ROBERT WHITAKER

STATE OF MASSACHUSETTS)
) ss.
SUFFOLK COUNTY)

By Robert Whitaker

I. Personal Background

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

III. Evidence Revealing Increased Chronicity of Psychotic Symptoms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

V. Harmful Side Effects from Antipsychotic Medications

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

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

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

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

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

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

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

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[26] Shear, K et al. "Suicide associated with akathisia and deport fluphenazine treatment," *Journal of Clinical Psychopharmacology* 3 (1982):235-6.
[27] Van Putten, T. "Behavioral toxicity of antipsychotic drugs." *Journal of Clinical Psychiatry* 48 (1987):13-19.
[28] Van Putten, T. "The many faces of akathisia," *Comprehensive Psychiatry* 16 91975):43-46.
[29] Herrera, J. "High-potency neuroleptics and violence in schizophrenia," *Journal of Nervous and Mental Disease* 176 (1988):558-561.
[30] Galynker, I. "Akathisia as violence." *Journal of Clinical Psychiatry* 58 (1997):16-24.
[31] Van Putten, T. "The board and care home." *Hospital and Community Psychiatry* 30 (1979):461-464.
[32] Weiden P. "Atypical antipsychotic drugs and long-term outcome in schizophrenia." *Journal of Clinical Psychiatry* 57, supplement 11 (1996):53-60.
[33] Keefe, R. "Do novel antipsychotics improve cognition?" *Psychiatric Annals* 29 (1999):623-629.

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

VI. The Research Literature on Atypical Antipsychotics

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

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

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[34] Arana, G. "An overview of side effects caused by typical antipsychotics." *Journal of Clinical Psychiatry* 61, supplement 8 (2000):5-13.
[35] Waddington, J. "Mortality in schizophrenia." *British Journal of Psychiatry* 173 (1998):325-329.
[36] Joukamaa, M, et al. Schizophrenia, neuroleptic medication and mortality. *British Journal of Psychiatry* 188 (2006):122-127.
[37] Healy, D et al. "Lifetime suicide rates in treated schizophrenia." *British Journal of Psychiatry* 188 (2006):223-228.
[38] FDA approval letter from Robert Temple to Janssen Research Foundation, December 21, 1993.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

VII. Conclusion

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

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

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

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

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

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

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

Robert B. Whitaker

Robert Whitaker

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

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

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

State of Alaska)
)ss
Third Judicial District)

I, James B. Gottstein, hereby swear that this reproduction of Affidavit of Robert Whitaker, to which this is appended, is a true, correct and complete photocopy of the original filed in Case No. 3AN 07-1064PR, Superior Court, Third Judicial District, State of Alaska.

Dated: 10/27/2008

James B. Gottstein

SUBSCRIBED AND SWORN TO before me this 27th day of October, 2008.

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

Lisa E. Smith

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

IN THE TRIAL COURTS FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT

AT ANCHORAGE

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

Respondent.
_____/

No. 3AN-07-1064 PR

30-DAY COMMITMENT HEARING

PAGES 1 THROUGH 103

BEFORE THE HONORABLE ANDREW BROWN
MASTER

Anchorage, Alaska
September 5, 2007
9:14 a.m.

APPEARANCES:

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

FOR W.S.B.: James Gottstein
406 G Street, Suite 206
Anchorage, Alaska 99501

Also Present: W.S.B.

MR. BIGLEY: See him in person.
MR. GOTTSTEIN: I do -- I -- I'm trying to accommodate the -- I know the practicalities of everything, but it just seems like we're in the same town, that we ought to be able to do that. I notice that, you know, Dr. Worrall has a lot of papers, and I haven't had a chance to, you know, look and see what -- you know, what he's referring to. It's those sorts of things. We might -- I have a -- I -- I'm -- I'm pretty sure I'll have some questions on the chart and stuff, and it just seems more, ah...
THE COURT: Then he's here right now, we're going to have to proceed with him and Ms. Porter will have to wait, and she can...
MR. BIGLEY: Now, (indiscernible).
THE COURT: She could be telephonic Monday.
MR. GOTTSTEIN: I -- I -- wo -- then, in light of that, then I will withdraw my objection to a telephonic testimony.
MR. BIGLEY: (indiscernible) telephonic.
THE COURT: So, Doctor, you're excused for now and we will contact you some time Monday. You -- and, ah, Ms. Russo...
MR. BIGLEY: (Indiscernible).
THE COURT: ...will work out how we'll contact

you now. Thank you.
All right. So, now...
MR. GOTTSTEIN: Short break?
THE COURT: We don't really have time.
MR. GOTTSTEIN: Well, I gotta get...
THE COURT: Okay. Go -- yeah, we'll go off record.
MR. GOTTSTEIN: Okay.
(Off record - 11:18 a.m.
(On record - 11:30 a.m.)
THE COURT: You can be seated. This is a continuation of the Bigley matter. So, I guess, first we have to have Ms. Porter sworn in. So if you'll just stand there, we'll get you sworn in, please.
*
called as a witness in behalf of the respondent, being first duly sworn upon oath, testified as follows:
(Oath administered)
WITNESS: I do.
THE CLERK: And you can be seated.
MR. GOTTSTEIN: Thank you, Your Honor.
THE COURT: Wait a minute. The clerk has a couple questions she has to ask the witness.
MR. GOTTSTEIN: Oh, I'm sorry.
THE CLERK: Would you please state your full

name, spell your last name, and give a mailing address.
MR. GOTTSTEIN: Certainly. It's Sarah Frances Porter. The Porter is spelled P-O-R-T-E-R. And the mailing address would be 112 Manly Street. That's M-A-N-L-Y Street, Paraparaumu, which is, P-A-R-A-P-A-R-A-U-M-U, New Zealand. And the postal code is 5032.
THE CLERK: Thank you.
THE COURT: Yes?
MR. GOTTSTEIN: Your Honor, I have a quick administrative matter. I need to get a transcript of today's hearing prepared, and I was discussing with the clerk how to -- and there might be a delay to get a copy. I was wondering if we could make sure that we could expedite getting the CD over so that I can -- and then ask them to expedite getting a copy made for me.
THE COURT: Okay. So, like, tomorrow morning some time we can...
THE CLERK: (Indiscernible).
THE COURT: I guess -- so we would have to call your office when it's available for pickup.
MR. GOTTSTEIN: That's perfect, Your Honor.
THE COURT: Okay. And, of course, for Ms. Russo, too.

MS. RUSSO: Uh-huh (affirmative).
MR. GOTTSTEIN: Yeah.
THE COURT: Okay. So we'll -- as soon as my office can call tomorrow morning and say it's ready for pickup, we'll do that. Okay?
MR. GOTTSTEIN: Okay.
THE COURT: Thanks.
MR. GOTTSTEIN: Thank you.

DIRECT EXAMINATION

BY MR. GOTTSTEIN:

Q Thank you very much for agreeing to testify, Ms. Porter. We only have 25 minutes, so I'm gonna try and do this expeditiously. But it's important for the court to know your background, education, experience and history as it relates to treating or taking care of, and involvement with people diagnoses with serious mental illness. So if you could just go through that. But, pretty -- you know, kinda quickly, but, also, give a pretty full idea of your experience, please.

A Okay. I've worked in the mental health seat in New Zealand for the last 15 years in a variety of roles. I'm currently employed as a strategic advisor by the Capital and Coast District Health

Board. I'm currently doing a course of study called the Advanced Leadership and Management in Mental Health Program in New Zealand. And, in fact, the reason I'm here is, I won a scholarship through that program to study innovative programs that are going on in other parts of the world so that I could bring some of that information back to New Zealand.

I also have personal experience of using mental health services which dates back to 1976 when I was a relatively young child.

What else would you like to know?

Q Well, a little bit more. Did you run a program in New Zealand?

A Yes. I set up and run a program in New Zealand which operates as an alternative to acute mental health services. It's called the KEYWA Program. That's spelled K-E-Y-W-A. Because it was developed and designed to operate as an alternative to the hospital program that currently is provided in New Zealand. That's been operating since December last year, so it's a relatively new program, but our outcomes to date have been outstanding, and the funding body that provided with the resources to do the

program is extremely excited about the results that we've been able to achieve, with people receiving the service and helping us to assist and seating out more similar programs in New Zealand.

Q You're a member of the organization called INTAR, is that correct?

A I am a member of INTAR, which is the International Network of Treatment Alternatives for Recovery. And I'm also a member of the New Zealand Mental Health Foundation, which is an organization in New Zealand that's charged with the responsibility for promotion of mental health and prevention of mental disability in New Zealand.

Q Okay. Are there -- can you describe a little bit what INTAR is about?

A INTAR is an international network of people who are interested in promoting the knowledge about, and availability of access to alternatives to traditional and mainstream approaches to treating mental distress. And INTAR is really interested in identifying successful methods of working with people experiencing distress to promote mental well being, and, in particular,

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

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

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

Q I won't go into that. Are there members of INTAR who are psychiatrists?

A There are. Indeed. Yes, indeed.

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

A Dr. Peter Stastny is a psychiatrist, Dr. Pat Brechan (ph), who manages the mental health services in West Cork, Ireland, and also in parts of England, as a psychiatrist.

MR. BIGLEY: He's a scientist?

A Yep.

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

A Absolutely, there are. And that's quite a strong theme, in fact, for -- for that group, and

I believe that it's based on the fact that there is now growing recognition that medication is not a satisfactory answer for a significant proportion of the people who experience mental distress, and that for some people...

MR. BIGLEY: That's the scientist.

A ...it creates more problems than solutions.

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

A I do.

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

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

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

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

MR. BIGLEY: (Indiscernible).
A And we're just now beginning to develop alternatives. They'd offer people real choice and options in terms of what is available instead of medication that might enable people to further address the issues which are raised by the concerns related to their mental state.
Q And I think I understood you to say that the program that you run along that line has had very good outcomes, is that correct?
A It has. The outcomes to date have been outstanding. The feedback from services users and from other people working with the services -- both, peoples families and the clinical personnel working with those people has supported the approach that we have taken.
Q And is -- and I think you said that, in fact, it's been so impressive that the government is looking at expanding that program with more funding?
A Indeed. And, in fact, right across New Zealand they are now looking at what can be done to create -- make resources available to set up...
MR. BIGLEY: (Indiscernible).

A ...more such services in New Zealand.
MR. BIGLEY: (Indiscernible).
Q Is there a philosophy that you might describe in terms of how -- that would go along with this kind of alternative approach?
A The way that I would describe that is that it's -- it's really about relationships. It's about building a good therapeutic relationship with the person in distress and supporting that person to recognize and come to terms with the issues that are going on in their life, in such a way that builds a therapeutic alliance and is based on negotiation, rather than the use of force or coercion, primarily...
MR. BIGLEY: (Indiscernible).
A ...because we recognize that the use of force and coercion actually undermines the therapeutic relationship and decreases the likelihood of compliance in the long term with whatever kinds of treatment or support has been implicated for the person. So we have created and set up our service along the lines of making relationship and negotiation the primary basis for working with the person and supporting the person to reflect on and reconsider what's going on to

create what might be defined as a crisis, and to devise strategies and plans for how the person might be with the issues and challenges that they face in their life.
MR. BIGLEY: (Indiscernible).
Q Now, you mentioned -- I think you said that coercion creates problems. Could you describe those kind of problems?
A Well, that's really about the fact that these growing recognition -- I think worldwide, but particularly in New Zealand, that coercion, itself, creates trauma and further distress for the person, and that that, in itself, actually undermines the benefits of the treatment that is being provided in a forced context. And so our aiming and teaching is to be able to support the person to resolve the issues without actually having to trample...
MR. BIGLEY: (Indiscernible).
A ...on the person's autonomy, or hound them physically or emotionally in doing so.
Q And I think you testified that would be -- include people who have been in the system for a long time, right?
A It does, indeed. Yes.

Q And would that include people who have been coerced for a long time?
A In many cases, yes.
MR. BIGLEY: She didn't (indiscernible).
Q And -- and have you seen success in that approach?
A We have. It's been phenomenal, actually. Jim, I've been -- personally, I -- I had high hopes that it would work, but I've...
MR. BIGLEY: (Indiscernible).
Q ...been really impressed how well, in fact, it has worked, and how receptive people had been to that approach.
MR. BIGLEY: (Indiscernible).
A Now, are there some -- I want to talk a little bit about other consequences of coercion. For example, can you describe some of the things that happen to people when they -- when they're forced?
MS. RUSSO: Your Honor, I'm objecting to this line of questioning. She hasn't -- she's being asked to offer an opinion, but she hasn't been offered as an expert yet. I don't know what Mr. Gottstein is hoping to offer Ms. Porter as an expert in, but, I -- I think we're getting ahead of ourselves in this.

MR. BIGLEY: (Indiscernible).
THE COURT: Okay. So, Mr. Gottstein, your response to Ms. Russo's...
MR. GOTTSTEIN: Well, I think we can do it now. I would offer Ms. Porter as an expert in the provision of alternative mental health...
MR. BIGLEY: (Indiscernible).
MR. GOTTSTEIN: ...treatment as an alternative to the mainstream standard of care.
MR. BIGLEY: (Indiscernible).
A If I could add something.
THE COURT: Wait a minute. I have to deal with the attorneys first.
Ms. Russo?
MS. RUSSO: Can I voir dire Ms. Porter?
THE COURT: Yes. Go ahead.
MS. RUSSO: Thank you.

VOIR DIRE EXAMINATION

BY MS. RUSSO:
Q Ms. Porter, you said you were in Alaska to study other systems. You won a scholarship?
A Yes.
Q And what specifically were you -- how long have you been in Alaska?
A For a relatively short time. I arrived here

on Monday and I'm here until Saturday. So I've only got five days in this area.
MR. BIGLEY: Take me with you.
A But what I...
MR. BIGLEY: Take me with you. Take me with you.
A What I wanted to also mention is that the work that we had been doing in New Zealand, in terms of -- particularly with the...
MR. BIGLEY: (Indiscernible).
A ...specific (indiscernible) of reducing the use of force is based on some of the work that was done by SAMHSA, in terms of the reduction of seclusion and restraint, and the material that they produced about that.
MR. GOTTSTEIN: Your Honor, maybe she should say who SAMHSA is?
Q Yes. That was the next question.
A It's the Substance Abuse and Mental Health organization in America that's also done things like the new Freedom Commission. The director is Terry Kline, who, I understand is appointed by President Bush.
MR. BIGLEY: I know him, too (indiscernible).
A And he -- he actually came out to New Zealand

to visit our service four weeks ago and was very impressed with the work that we're doing here. And, in fact, there's talk...
MR. BIGLEY: (Indiscernible).
A ...about bringing us back to the United States to talk to people over here about the way that we're working and providing different kinds of services that are more supportive of peoples autonomy and requiring...
MR. BIGLEY: (Indiscernible).
A ...less use of force. And what they found in the research that they did about reducing restraint and seclusion was, not only did it increase the therapeutic outcomes for the clients, but it improved the work -- satisfaction for the staff working with people and reduced the cost of the services of...
MR. BIGLEY: (Indiscernible).
A ...time taken off because of injuries associated with people being hit while they're trying to seclude or manager people through the use of force, so.
Q And who have you met with since -- or, what is your, sort of, I guess, agenda for meeting with people while you're here?

A I've met with all kinds of different people. I actually attended a conference in Ottawa, which is called the International Initiative in Mental Health Leadership. And there was a number of different people there, including...
Q If I'm gonna -- just stop, since we are on limited time, and...
A Yeah.
Q ...we want to get as much of your testimony as possible. In -- in Alaska...
MR. GOTTSTEIN: Your Honor, can she be allowed to answer the question?
THE COURT: I'm going to allow Ms. Russo to continue.
Q I'm trying to direct you towards just specifically...
MR. GOTTSTEIN: I'm sorry.
Q ...in Alaska, in Anchorage.
MR. BIGLEY: Saved my life.
Q Who have you met with?
A Different people. Andrea, Jim...
Q Andrea who?
A Schmook.
Q Schmook. Okay.
A Yeah. You might know her. I believe she's

part of the organization...
Q Uh-huh (affirmative).
A ...that you work with.
Q Yep.
MR. BIGLEY: (Indiscernible).
A Eliza Ella and Tead Ella, and -- oh, I'm struggling to think of the names now. I feel on the spot.
MR. GOTTSTEIN: You got to meet Cathy Creighton (ph), right?
A Yep. That -- those people, as well. Also, while I've been in the United States and Canada, I have met with...
MR. BIGLEY: (Indiscernible).
A Some. Yep.
MR. BIGLEY: (Indiscernible).
A And met with Sherry Meade (ph), Kelly Slater, John Allen, who is the director of the Office of Recipient (indiscernible) in New York. Mat Mathai (ph), Amy Colsenta (ph), Isaac Brown, and Dan Fisher.
Q And have you had -- besides Ms. Schmook, have you talked with anybody from API, or...
A No, I haven't. But I'd be very interested to know if you've got thoughts on that, who I should

talk to.
Q Okay. And in your conversations, I guess, with Ms. Schmook, or with the other people in Anchorage -- have you been made aware of what treatment options are available for individuals with mental illness in Anchorage?
A Some, yes. I would say I -- I wouldn't proclaim that I've got a full and perfect picture, but I've certainly been made aware of some of the options that are available here in Alaska, and some of the -- the history of the state and the way mental health services have evolved in this area, which is very interesting, by the way.
Q Yeah. Probably. And, so...
MR. BIGLEY: (Indiscernible).
MS. RUSSO: Your Honor, I would object to Ms. Porter's qualifications as an expert in alternative mental health treatment, in regards as to how it specifically relates to this case. I don't know -- if she just stated she doesn't have the full picture. She's heard some of what's available in Alaska, but she doesn't have the full picture of what we're facing in Anchorage, dealing with this particular situation.
THE COURT: Okay. Mr. Gottstein, your

response?
MR. GOTTSTEIN: Well, I can ask a couple other questions, but I think -- I'm -- that might be an okay limitation. But I'd also like to ask:
DIRECT EXAMINATION CONTINUED
BY MR. GOTTSTEIN:
Q Are you familiar with an organization called CHOICES?
A Yes, I am.
Q Could you describe what you know about them?
A CHOICES does case management for people in the area -- supporting people to -- actually, it's different kinds of services. I know that Paul works at CHOICES, and that -- other parts of services that they -- and with API, and other kinds of housing and mental health providers here.
Q And would you say -- describe CHOICES philosophy as consistent with the INTAR approach?
A I think it probably is, yes. Because CHOICES stands for Consumers Having Ownership In the service...
Q Creating Effective...
A Yes. Creating Effective Services. So, yes. Absolutely.

Q Okay. Now, you said -- okay. Absolutely. Okay.
MR. GOTTSTEIN: So I think she certainly, at least, has knowledge of that option.
THE COURT: Ms. Russo, do you want to comment further?
MS. RUSSO: I rely on what I said earlier, Your Honor.
THE COURT: All right. I'm going to find that -- I really do not find that Ms. Porter can qualify as an expert witness in this case, at this time, because...
MR. BIGLEY: I'm murdered.
THE COURT: ...I'm not -- to be honest, certain exactly what she's being...
MR. BIGLEY: What...
THE COURT: ... -- other than her giving...
MR. BIGLEY: (Indiscernible)...
THE COURT: ...what I regard as a non-expert opinion as to what might be offered here, but not necessarily being very knowledgeable as to Mr. Bigley's situation.
MR. BIGLEY: (Indiscernible).
THE COURT: Ms. Porter's been here just a couple days, leaving in a couple days. I'm just not

convinced that I can regard her as an expert witness as to available alternative treatments in Anchorage, which I think...
MR. BIGLEY: (Indiscernible).
THE COURT: ...is the thrust of what she's being offered.
MR. GOTTSTEIN: No, Your Honor.
THE COURT: No?
MR. GOTTSTEIN: No. I think that she has testified some to that, but I believe that -- as I put it in my brief, that Mr. Bigley is entitled to alternatives that could be made available. And so she's really being offered as a witness as to that. As -- you know...
MR. BIGLEY: (Indiscernible).
MR. GOTTSTEIN: ...as well as what she knows about choices, but that's what she's being offered as.
MR. BIGLEY: You're killing me here.
THE COURT: Ms. Russo, any other comment?
MS. RUSSO: Your Honor, I -- with all due respect to Ms. Porter, and the work that she's done and is doing, I don't -- the -- the alternatives to which Mr. Bigley can present evidence as, have to be realistic in this state. And I don't know that, at this particular point in time, we're at a point --

we've got -- I'm sure Mr. Gottstein will be calling people from CHOICES to testify as to exactly what, in particular, they do in their relationship with Mr. Bigley. I'm just not sure her testimony will be relevant to the...
MR. BIGLEY: The president will find out.
MS. RUSSO: ...issue before the court.
MR. BIGLEY: President of the United States. Is there a problem?
MR. GOTTSTEIN: Your Honor, basically, if she's given her testimony -- I mean, that's the testimony that I'm offering.
MR. BIGLEY: (Indiscernible). They get on board right now. Th -- (indiscernible) called me and Bush called me. (Indiscernible).
MR. GOTTSTEIN: Sh-sh.
THE COURT: So it's not gonna be -- so, Mr. Gottstein, there's not gonna be any further examination by you?
MR. GOTTSTEIN: I -- I think at this point -- I mean, we're four minutes from when we have to leave. I do have a couple more questions, yes. But, ah -- but she's already described by the efficacy of other approaches with people that are in Mr. Bigley's type of situation. And I could re-ask her those questions, but

I don't see any need to.
MR. BIGLEY: (Indiscernible).
THE COURT: Okay. Well, I guess -- I'm looking at the Rules of Evidence 702, Testimony by Experts. It says, "If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence, or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise."
So, actually, I think that -- giving, maybe a broad reading of this rule,...
MR. BIGLEY: I can see if...
THE COURT: ...I'll allow Ms. Porter to testify as an expert in the area of alternative treatments, but, not necessarily...
MR. BIGLEY: (Indiscernible).
THE COURT: ...in Alaska, but, what may be -- what her -- what may be available in other places, just -- just -- just that, and then, we'll see where we head with other witnesses.
So, I guess, Mr. Gottstein -- and I'm using the computer clock on the bench. It has 11:54. That's a little quick. So we have a little more time.
MR. GOTTSTEIN: Okay. Thank you. Thank you,

Your Honor. So, I think most of the testimony I was gonna elicit has already come in on voir dire.
Q But I did want to talk about some of the effects of coercion. Could you describe that. And I could prompt you some, but that may be -- let's do it without that, first.
MR. BIGLEY: (Indiscernible).
A I think generally speaking, coercion is unhelpful and counterproductive in terms of fooling a therapeutic relationship with somebody in need of care. And that, actually, often the effects of coercion can, themselves, be detrimental and compound the problems faced by a person with experience of serious mental illness, which is why I think there is growing moves internationally to find other ways of working with people to address the kinds of issues and challenges that people face.
Q Does coercion, in your opinion, create reactions that are then regarded as symptoms?
A Oftentimes that's the case, Jim. Particularly, we are -- like, in the case of people being required to take medication that they might feel is not helpful or even worse, possibly a harmful to themselves, sometimes that

can be regarded as symptomatic. Like, I've certainly witnessed a number of cases where people have formed the view that they are being poisoned by medication. But when they express t his fear, that that, itself, has been regarded as a symptom of illness, and (indiscernible) the justification for treatment, which becomes a very vicious circle and a bit of a Catch 22 from service user's perspective.

Q Are there other symptoms, you think - or, reactions that you think are caused by coercion?

A Ah...

Q Let me -- let me -- is it common for people who are coerced to be labelled "paranoid"?

A Yes. Often. Because people can think that things are being done to them, which, it would appear from that person's perspective, to be the case, but often that could be misinterpreted as "paranoid" by service, and then, again, used as further justification for requiring the person to accept treatment.

Q Can you give an example?

A Well, for instance, if a person believed that services wanted to take, say, a blood sample to check whether or not the person had the

therapeutic levels of medication in their blood stream, the person might think that the blood test was being required as a way for the services to get them, or trick them into taking more medication. And that can happen and is reasonably common. Certainly, in New Zealand, I would imagine it would be the same in other parts.

Q And would that -- then, would that reaction be -- would that often be labelled "paranoia"?

A It would, because -- but I think that's, again -- it's a product of different (indiscernible), where services would say some things as -- you know, potentially being a benefit to the service user, where the service user might say that it's to their detriment. So that's, again, different perspectives of the same thing. But from the service users perspective, it's a difficult issue and it might well be perceived as paranoia on the part of the person. Which, again, gets labelled as a symptom and treated as such, so it becomes, again, a self fulfilling situation.

MR. GOTTSTEIN: I could ask some more questions, but I think I'll let Ms. Russo use the rest of the time for cross examination.

THE COURT: Ms. Russo.

MS. RUSSO: Thank you.

CROSS EXAMINATION

BY MS. RUSSO:

Q Just a couple questions. Mr. Porter, before today, had you met Mr. Bigley?

A No, I had not met Mr. Bigley before today.

Q And have you had a chance to spend any time with Mr. Bigley today?

A I haven't.

Q And you're whole approach -- does the -- does the recipient of the -- does the service user -- do they have to be willing to accept the services, in order for your approach to work?

A It's certainly helpful for that approach to work. If the person is unwilling for the approach to work, then it's least likely to succeed.

Q Okay. and so what happens when the person is not willing to work with the people who want to work with him?

A We'd need to negotiate around options and consequences and that's generally the approach that we take.

Q And you had said at the very beginning or your

testimony that, I think, your approach -- let me see if I can refer to my notes. Is that -- that -- your approach, you didn't believe that forced medication -- and correct me if I'm giving your testimony wrong, but that it was -- that it wouldn't work for a significant portion of the population. Did you mean all of the population, or did you mean that...

A That forcing people to take medication would not work for most people.

Q Most people. But there may be outliers?

A I would say in rare and exceptional cases, there might well be. Because, again, these -- in my view, there's no absolutes. It's like saying -- and the same way as you can't say, medication is a good answer for everybody. There are some people for whom medication is helpful. But I think that generally speaking, I'm not certain what your legislation requires here, but in New Zealand, the requirement is that even people subjected to compulsory treatment, it is only able to be and provided without the consent of the person for the first 28 days. And the rational for that is that it's expected that after 28 days of use of medication, that the

person themselves would be able to recognize the benefit of it and then voluntarily agree to continue taking it. And so that's certainly a safeguard that's built into the New Zealand legislation. I would imagine you would have something similar here, and that would actually -- might provision for the person to be able to make an informed choice, and presumably after 28 days of using a medication, or be it by force, the person themselves would be able to recognize the benefit. But if there isn't a benefit that's able to be perceived by the person, then I would hope that service providers would be able to actually acknowledge that, and work with the person to find some other means of addressing the issues and concerns that are least distressing to the person. Because the unfortunate truth of the matter is that as medication really doesn't work for all people, there are a few people for whom it is a good answer, and it's helpful. But they are a large number for whom it's problematic and uncomfortable and distressing.

Q And are there -- is basically the whole thrust of your work sort of designed to -- to make sure that people are able to live to the best of their

abilities in a community, and to have as full of a life as possible outside of institutionalized treatment?

A Absolutely. And, in fact, the definition of recovery that we use in New Zealand is, recovery means the person being able to live well with or without symptoms of mental illness.

Q Okay. Thank you. Those are all my questions.

THE COURT: Any redirect?

MR. GOTTSTEIN: Yes. Just very briefly.

REDIRECT EXAMINATION

BY MR. GOTTSTEIN:

Q What would be your response to the idea that someone who has been -- you know, coerced into taking -- forced to take medication, isn't competent to decide whether or not it should be continued.

MS. RUSSO: Objection, your Honor. I don't know that there is a basis for giving an opinion on somebody's competency. Maybe I didn't fully understand the question.

THE COURT: Yeah. Mr. Gottstein?

MR. GOTTSTEIN: Well, the idea is that often, when patients complain about medications not working and all these terrible side effects, they're saying,

"Oh, well, they're crazy, so they don't know that it's good for them." And that's basically what is -- if Ms. Porter might have a response to that.

THE COURT: I'm going to allow her to answer.

A Well, to be honest, I'm uncomfortable with what the use of force meant. It's probably been fairly evident from what I've said so far. And I think that the issue of persons capacity to consent, I think is, in fact, progressively moving towards allowing more people to be recognized as being able to consent, and, in fact, they (indiscernible) on the rights of people with disabilities has changed the wording around the peoples capacity to consent, which means that people always had the right to be able to consent or not to treatment, and that a person needs support to be able to make those decisions, that such support be made available through advocacy. But that there is an increasing move to respect the autonomy and the personal choice of the person at the center of treatment, more of the time.

Q So does that mean that even -- that even someone who is psychotic knows what's happening to themselves?

A I believe that people do, Jim, to be honest. I believe that even people who are (indiscernible) have a degree of clarity about what's going on with themselves, particularly in terms of the physical well being, and that the peoples capacity to be able to recognize and make decisions about their own physical and mental self needs to be honored and respected as much as possible, and that in so doing, peoples capacity and competence increases.

MR. GOTTSTEIN: I have no further questions.

THE COURT: Ms. Russo?

MS. RUSSO: None.

THE COURT: All right. Ms. Porter, you're free to go. Have a good flight back.

A I will. Thank you very much.

THE COURT: Thank you.

Okay. So this case is going to be in recess until 1:30 Monday, September 10th, right here. And we can go off record.

END

That the foregoing transcript is a transcription of testimony of said proceedings to the best of my ability, prepared from tapes recorded by someone other than Pacific Rim Reporting, therefore "indiscernible" portions may appear in the transcript;

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal this 7th day of September, 2007.

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

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 ***

This hearing was public.
Jim Gottstein

VOLUME II

TRANSCRIPT OF MOTION HEARING

BEFORE THE HONORABLE SHARON GLEASON
Superior Court Judge

Anchorage, Alaska
May 14, 2008
10:17 A.M.

APPEARANCES:

FOR THE STATE: Timothy M. Twomey, Esq.
Assistant Attorney General
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FOR THE DEFENDANT: James B. Gottstein, Esq.
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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

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

STATE OF NORTH CAROLINA)
) ss.
COUNTY)

Appendix A

Evidence for the Neurotoxicity of Antipsychotic Drugs

The History of Neuroleptics

The modern history of psychiatric drugs dates back to the early 1950s, when derivatives of the synthetic dye and rocket fuel industries were found to have medicinal properties. Following World War II, a wide variety of compounds came to be tested in humans. The antihistamine known as chlorpromazine (Thorazine) is generally regarded as the first "anti-psychotic" drug, responsible for igniting the psychopharmacology revolution. As Thorazine grew in popularity, medications replaced neurosurgery and shock therapies as the favored treatments for the institutionalized mentally ill. (For three excellent reviews on this subject, see Cohen, Healy, and Valenstein).[1-3]

When, in 1955, Drs. Jean Delay and Pierre Deniker coined the term "neuroleptic" to describe Thorazine, they identified five defining properties of this prototype: the gradual reduction of psychotic symptoms, the induction of psychic indifference, sedation, movement abnormalities (parkinsonism), and predominant subcortical effects.[4] At its inception, Thorazine was celebrated as a *chemical lobotomizer* due to behavioral effects which paralleled those associated with the removal of brain tissue.[5] As the concept of lobotomy fell into disfavor, the alleged antipsychotic features of the neuroleptics came to be emphasized. Ultimately, the two terms became synonymous.

Ignorant of the historical definition of neuroleptics as ***chemical lobotomizers***, members of the psychiatric profession have only rarely acknowledged the fact that these dopamine blocking compounds have been, and continue to be, a major cause of brain injury and dementia. Nevertheless, the emergence of improved technologies and epidemiological investigations have made it possible to demonstrate why these medications should be characterized as neurotoxins, rather than neurotherapies.

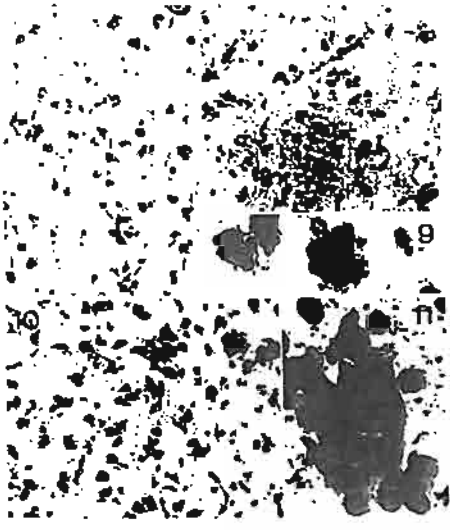
Evidence for Neuroleptic (Antipsychotic) Induced Brain Injury

Proof of neuroleptic toxicity can be drawn from five major lines of evidence:

1) postmortem studies of human brain tissue
2) neuroimaging studies of living humans
3) postmortem studies of lab animal brain tissue
4) biological markers of cell damage in living humans
5) lab studies of cell cultures/chemical systems following drug exposure

Line of Evidence #1: Postmortem Studies in Humans

In 1977, Jellinger published his findings of neuropathological changes in the brain tissue of twenty-eight patients who had been exposed to neuroleptics for an average of four to five years.[6] In most cases, the periods of drug treatment had been intermittent. At autopsy, 46% of the subjects were found to have significant tissue damage in the movement centers (basal ganglia) of the brain, including swelling of the large neurons in the caudate nucleus, proliferation of astrocytes and other glial cells, and occasional degeneration of neurons. Three patients exposed to chronic neuroleptic therapy also demonstrated inflammation of the cerebral veins (phlebitis). An example of the abnormalities is shown below:



This photo demonstrates reactive gliosis (black dots represent scar tissue) in the caudate of a patient who had received neuroleptic therapy. Patients in this study had received the following drug treatments: chlorpromazine (Thorazine), reserpine, haloperidol (Haldol), trifluoperazine (Stelazine), chlorprothixen (Taractan), thioridazine (Mellaril), tricyclic antidepressants, and/or minor tranquilizers.

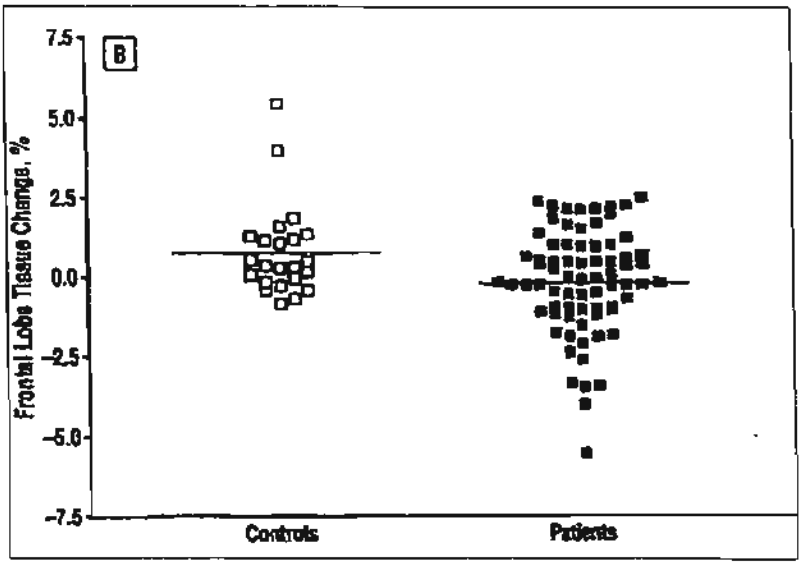
The Jellinger study is historically important because it included two comparison or control groups, allowing for the determination of treatment-related vs. illness-related changes. Damage to the basal ganglia was seen in only 4% of an age-matched group of psychotic patients who had *avoided* long-term therapy with neuroleptics; and in only 2% of a group of patients with routine neurological disease. Based upon the anatomic evidence, Jellinger referred to the abnormal findings as ***human neuroleptic encephalopathy*** (meaning: a drug-induced, degenerative brain process).

Line of Evidence #2: Neuroimaging Studies of Living Human Subjects

Several groups of researchers have documented a progressive reduction of frontal lobe tissue in patients treated with neuroleptics. Madsen et al. performed serial C.T. scans on thirty-one previously unmedicated psychotic patients and nine healthy controls. Imaging was performed at baseline and again after five years.[7-8] During this time, the patients received neuroleptic therapy in the form of traditional antipsychotics (such as Thorazine) and/or clozapine. Findings were remarkable for a significant progression of frontal lobe atrophy in all of the patients, relative to the controls. ***The researchers detected a dose-dependent link to brain shrinkage, estimating the risk of frontal degeneration to be 6% for every 10 grams of cumulative Thorazine (or equivalent) exposure***.

Similar findings have been documented with newer technologies, such as magnetic resonance imaging (MRI). In 1998, Gur et al. published the results of a study which followed forty psychotic patients prospectively for 2 ½ years.[9] At entry, half of these individuals had received previous treatment with neuroleptics, and half were neuroleptic naïve. All patients subsequently received treatment with antipsychotic medications. ***At the end of thirty months, the patients displayed a significant loss of brain volume (4 to 9%) in the frontal and temporal lobes***. For both patient groups, this volume loss was associated with unimpressive changes in target symptoms (e.g., the inability to experience pleasure, restricted affect, and limited speech) and ***with significant deteriorations in cognitive functioning*** (such as attention, verbal memory, and abstract thought).

Researchers at the University of Iowa began a longitudinal investigation of psychotic patients between 1991 and 2001.[10] Enrolling 23 healthy controls, and 73 patients recently diagnosed with schizophrenia, the study design called for a series of MRI exams to be conducted at various intervals (planned for 2, 5, 9, and 12 years). In 2003, the research team published the results from the first interval. Head scans and neuropsychological testing were repeated on all patients after a period of three years of neuroleptic treatment. Several findings were remarkable. ***First, patients demonstrated statistically significant reductions in frontal lobe volume (0.2% decrease per year) compared to the healthy controls***:



These changes were associated with more severe negative symptoms of schizophrenia (alogia, anhedonia, avolition, affective flattening), and with impairments in executive functioning (e.g., planning, organizing, switching). ***Second, almost 40% of the patients failed to experience a remission***, defined by the investigators as eight consecutive weeks with nothing more than mild positive symptoms (delusions, hallucinations, bizarre behavior, inappropriate affect, formal thought disorder). In other words, *almost half of the patients remained floridly psychotic.* ***Third, these poor outcomes occurred despite the fact that the patients had been maintained on neuroleptics*** for 84% of the inter-MRI duration, and ***despite the fact that the newest therapies had been favored***: atypical antipsychotics had been given for 62% of the treatment period. Reflecting upon these disappointing results, the research team conceded:

> "...the medications currently used cannot modify an injurious process occurring in the brain, which is the underlying basis of symptoms...We found that progressive volumetric brain changes were occurring despite ongoing antipsychotic drug treatment." [11]

In 2005, Lieberman et al. published the results of their international study involving serial MRI scans of 58 healthy controls and 161 patients experiencing a first episode of psychosis.[12] Most patients (67-77%) had received prior treatment with antipsychotics for a cumulative duration of at least four months. Throughout the two-year period of follow-up, patients were randomized to double-blind treatment with olanzapine (5 to 20 mg per day) or haloperidol (2 to 20 mg per day). The study protocol permitted the use of concomitant medications, such as minor tranquilizers (up to 21 days of cumulative therapy). Mood stabilizers and antidepressants other than Prozac (which could be used at any time) were allowed only after the first three months of the study. The primary outcome analysis involved a comparison of MRI changes from baseline, focusing upon seven regions of interest: whole brain, whole brain gray matter, whole brain white matter, lateral ventricles, 3rd ventricle, and caudate. ***Haloperidol recipients experienced persistent gray matter reductions throughout the brain***. These abnormalities emerged as early as twelve weeks. ***For olanzapine recipients, significant brain atrophy (loss of gray matter) was detected in the frontal, parietal, and occipital lobes following one year of drug exposure***:

Average change in tissue volume (cubic centimeter) by week 52

	olanzapine	haloperidol	controls
frontal gray	- 3.16	- 7.56	+ 0.54
parietal gray	- 0.86	- 1.71	+ 0.70
occipital gray	- 1.49	- 1.50	+ 0.99
whole brain gray	- 3.70	- 11.69	+ 4.12

In addition to these changes, both groups of patients experienced enlargements in whole brain fluid and lateral ventricle volumes. These disturbances in brain morphology (structure) were associated with retarded improvement in symptoms and neurocognitive functioning.

Line of Evidence #3: Postmortem Animal Studies

Acknowledging the longstanding problem in medicine of distinguishing the effects of treatment from underlying disease processes, scientists at the University of Pittsburgh have advocated the use of animal research involving monkeys (non-human primates). In one such study, the researchers attempted to identify the effects of lab procedures upon brain samples prepared for biochemical and microscopic analyses.[13] Eighteen adult male macaques (aged 4.5 to 5.3 years) were divided into three groups and were trained to self-administer drug treatments. *Monkeys received oral doses of haloperidol, placebo (sham pellets), or olanzapine for a period of 17 to 27 months.* During this time, blood samples were taken periodically and drug doses were adjusted in order to achieve plasma levels identical to those which occur in clinical practice (1 to 1.5 ng/mL for haloperidol; 10-25 ng/mL for olanzapine). At the end of the treatment period, the animals were euthanized. Brains were removed, and brain size was quantified using two different experimental procedures.

A variety of behavioral and anatomical effects were noted. ***First, all animals appeared to develop an aversion to the taste and/or subjective effects of the medications.*** This required creative changes in the methods which were used to administer the drug treatments. ***Second, a significant number of monkeys became aggressive during the period of study*** (four of the six monkeys exposed to olanzapine; two of the six monkeys exposed to haloperidol). One monkey, originally placed in the sham treatment group, engaged in self-mutilatory behaviors. A switch to olanzapine resulted in no improvement. However, when the animal was provided with increasing human contact, a doubling of cage space, a decrease in environmental stimuli, and enhanced enrichment, his behavior stabilized. ***Third, the chronic exposure to neuroleptics resulted in significant reductions in total brain weight compared to controls (8% lower weight for haloperidol, 10% lower weight for olanzapine).*** Regional changes in weight and volume were also significant, with the largest changes identified in the frontal and parietal lobes:

	volume reduction in brain weight (relative to sham controls)	
	olanzapine	haloperidol
frontal lobe	10.4%	10.1%
parietal lobe	13.6%	11.2%

Based upon these results, the researchers concluded that the progressive reductions in brain volume which have been reported in many studies on schizophrenia may reflect the effects of drug treatment. They proposed that further studies be undertaken to characterize the mechanisms responsible for these changes and to identify the precise targets (neurons, glia) of these effects.

Line of Evidence #4: Biological Markers of Cell Damage

Researchers in Austria have been interested in identifying a biological marker which can be used to diagnose Alzheimer's dementia or other forms of degenerative disease prior to death. In 2005, Bonelli et al. published the results of an investigation which involved the retrospective analysis of the cerebrospinal fluid (CSF) from 84 patients who had been hospitalized for the treatment of neurological conditions.[14] Hospital diagnoses included two forms of dementia (33 cases of Alzheimer's dementia, 18 cases of vascular dementia), low back pain (9 patients), headache (5 patients), and neuropathy (4 patients). Researchers evaluated the fluid samples for tTG (tissue transglutaminase), an enzyme which is activated during the process of apoptosis or programmed cell death. Medical histories were also reviewed in order to identify pharmaceuticals consumed within 24 hours of the fluid collection via lumbar puncture.

Findings were remarkable for significant relationships between treatment with neuroleptics and elevations in tTG, particularly for females and patients with Alzheimer's dementia. When specific medications were reviewed, five antipsychotics (***including three of the so-called atypicals: melperone, olanzapine and zotepine***) were associated with above average levels of tTG:

tTG levels for patients receiving antipsychotic medications	
melperone	14.95 ng/dL
zotepine	8.78 ng/dL
olanzapine	8.50 ng/dL
flupentixol	7.86 ng/dL
haloperidol	7.30 ng/dL
average tTG for entire patient group:	**4.78 ng/dL**

Based upon these results, the research team drew the following conclusions:

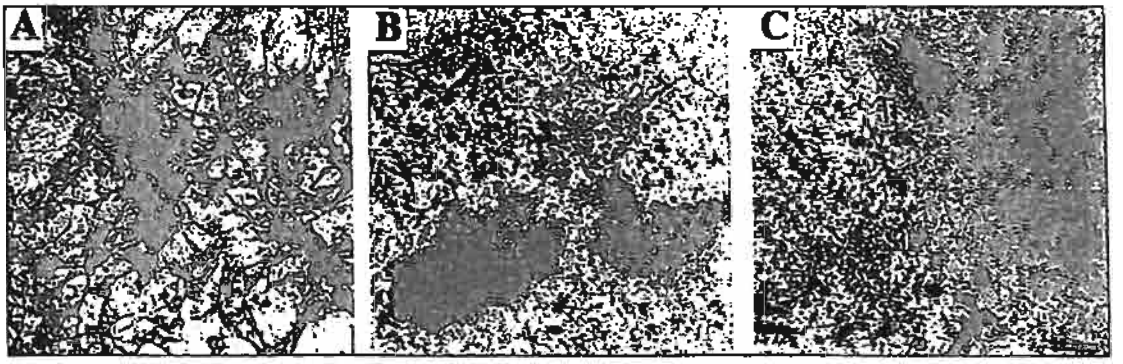
> "...our study failed to show a difference in neurotoxicity between atypical and typical neuroleptics, and we should be careful when using neuroleptics as first-line drugs in Alzheimer's dementia patients...Because the level of cerebral apoptosis of non-demented patients on antipsychotics appears to be indistinguishable to [sic] Alzheimer's dementia patients without this medication, the question might arise as to whether neuroleptics actually induce some degenerative process...In conclusion, we suggest that typical and atypical neuroleptics should be strictly limited in all elderly patients, especially in females and all patients with Alzheimer's dementia." [15]

While there were limitations to the Austrian study, it remains the only existing investigation of cell death in living subjects – none of whom received neuroleptics for mental illness. Furthermore, although the study failed to address possible relationships between apoptosis and antipsychotic exposure in terms of *dose* and *duration of treatment*, the implications extend far beyond the geriatric population. In fact, the finding that neuroleptic medications (and other psychiatric drugs) induce the process of apoptosis has inspired the oncology community to research these chemicals as adjuvant treatments for cancer. In other words, many psychiatric drugs are lethal to rapidly proliferating cells. To the extent that these chemotherapies are lethal to normal as well as cancerous tissues, there exists an urgent need for medical professionals and regulatory authorities to properly characterize the full effects of these toxins.

Line of Evidence #5: Lab Studies of Isolated Cells or Tissues

In vitro studies refer to research conducted upon tissue samples or isolated chemical systems obtained from lab animals or humans. In one such project, researchers in Germany exposed cell cultures to varying concentrations of haloperidol (Haldol).[16] The experiment involved the removal of hippocampal neurons from embryonic rats. Some of these neurons were then incubated with the neuroleptic and or its active metabolite (reduced haloperidol), while a control group of neurons remained drug free. Following a twenty-four hour period of incubation, neurons exhibited a dose-related reduction in viability, relative to the control:

drug concentration	Haldol	Reduced Haldol (drug metabolite)
1 uM	27% cell death	13% cell death
10 uM	35% cell death	29% cell death
100 uM	96% cell death	95% cell death



Examples of neuronal cell loss (death) following incubation with Haldol

A: normal neurons (dark) from unmedicated hippocampal brain tissue
B: 100 uM of Haldol: severe loss of cell bodies and neuron extensions.
Note: Dark patches at bottom of slide represent abnormal cells which have rounded up and detached from the culture dish.
C: 10 uM of Haldol: moderate loss of neurons and neuronal extensions.

Although this particular investigation involved a non-human species (rats), its results were medically concerning. First, the study employed Haldol concentrations which are clinically relevant to humans. In common medical practice, psychiatric patients are exposed to doses of Haldol which produce blood levels of 4 to 26 ng/mL. Brain levels are five to forty times higher. This means that psychiatric patients are indeed exposed to Haldol concentrations (1.4 to 2.8 uM) identical to the low levels that were tested in the German study. Second, the potential toxicity of Haldol in humans may be far greater than that revealed here, based upon the fact that this experiment was time limited (24 hour incubation only). Third, the neurons sampled in this experiment were taken from the key brain structure (hippocampus) associated with learning and memory. The possibility that Haldol kills neurons in this area (even if limited to 30%) provides a mechanism of action which accounts for the cognitive deterioration that is frequently observed in patients who receive this neuroleptic.

Dementia

Several teams of investigators have documented the problems associated with the use of neuroleptics in patients with pre-existing dementia. In a study which enrolled 179 individuals diagnosed with probable Alzheimer's disease, subjects were followed prospectively for an average of four years (range: 0.2 to 14 years).[17] Symptoms were evaluated on an annual basis, and changes in medication were carefully observed. Over the course of the investigation, 41% of the subjected progressed to severe dementia, and 56% of the patients died. Using a statistical procedure called proportional hazards modeling, the ***researchers documented a statistically significant relationship between exposure to neuroleptics and a two-fold higher likelihood of severe neurobehavioral decline***.

In England, a longitudinal investigation followed 71 demented patients (mean age: 72.6 years) over the course of two years.[18] Interviews were conducted at four-month intervals, and autopsy analyses of brain tissue were performed on 42 patients who expired. Main outcomes in this study were changes in cognitive functioning, behavioral difficulties, and (where applicable) postmortem neuropathology. ***The research team discovered that the initiation of neuroleptic therapy was associated with a doubling of the speed of cognitive decline***. This relationship was independent of the degree of dementia or the severity of behavioral symptoms for which the medications may have been prescribed.

While the methodology could not definitively prove that the drugs were the cause of mental deterioration, the study clearly demonstrated their inability to prevent it. The researchers concluded that:

> "an appropriate response at present would be to undertake regular review of the need for patients to continue taking neuroleptic drugs, pursuing trials without medication where possible. This study highlights the importance of understanding the neurological basis of behavioural changes in dementia so that less toxic drugs can be developed for their treatment." [19]

In 2005, an United Kingdom team of investigators performed autopsies on forty patients who had suffered from dementia (mean duration: four years) and Parkinsonian symptoms (mean duration: three years) prior to death.[20] Based upon a postmortem tissue analysis of the brain, exposure to neuroleptics (***old and new***) was associated with a four-fold increase in neurofibrillary tangles, and a 30% increase in amyloid plaques in the cortex of the frontal lobes. Due to the fact that the prevalence of symptoms did not vary between patients who received neuroleptics and those who remained neuroleptic free, the abnormalities detected appeared to be a result of the pharmaceutical agents, rather than a pre-existing disease. Most importantly, the findings suggest that all of the antipsychotics (***old and new***) are capable of inducing or accelerating the pathological changes (plaques and tangles) which are the defining features of Alzheimer's disease.

To review:

> Evidence from postmortem human analyses reveals that older neuroleptics create scarring and neuronal loss in the movement centers of the brain. These changes are an example of *subcortical* dementia, such as Parkinson's or Huntington's disease.
>
> Evidence from neuroimaging studies reveals that ***old and new*** neuroleptics contribute to the progressive shrinkage and/or loss of brain tissue. Atrophy is especially prominent in the frontal lobes which control decision making, intention, and judgment. These changes are consistent with *cortical* dementia, such as Niemann-Pick's or Alzheimer's disease.
>
> Evidence from postmortem analyses in lab animals reveals that ***old and new*** neuroleptics induce a significant reduction in total brain weight and volume, with prominent changes in the frontal and parietal lobes.
>
> Evidence from biological measurements suggests that ***old and new*** neuroleptics increase the concentrations of tTG (a marker of programmed cell death) in the central nervous system of living humans.
>
> Evidence from *in vitro* studies reveals that haloperidol reduces the viability of hippocampal neurons when cells are exposed to clinically relevant concentrations. (Other experiments have documented similar findings with the second-generation antipsychotics.)

Shortly after their introduction, neuroleptic drugs were identified as chemical lobotomizers. Although this terminology was originally metaphorical, subsequent technologies have demonstrated the scientific reality behind this designation. Neuroleptics are associated with the destruction of brain tissue in humans, in animals, and in tissue cultures. Not surprisingly, this damage has been found to contribute to the induction or worsening of psychiatric symptoms, and to the acceleration of cognitive and neurobehavioral decline.

Appendix B

Successful Alternatives to Antipsychotic Drug Therapy [21-22]

In a paper entitled "The Tragedy of Schizophrenia," psychologist and psychotherapist, Dr. Bert Karon, challenges the prevailing notion that psychosis remains a largely incurable brain disease which is best modified by pharmacotherapy. Mindful of the fact that "there has never been a lack of treatments which do more harm than good," Karon explicitly contends that humane psychotherapy remains the treatment of choice for schizophrenia, and he understands why this has always been so.

Karon reminds his readers that history provides important lessons for contemporary practitioners. The Moral Treatment Movement in the late 18th century emphasized four essential elements in the care of the mentally ill:

- respect for the patient (no humiliation or cruelty)
- the encouragement of work and social relations
- the collection of accurate life histories
- the attempt to understand each person as an individual

When these imperatives were applied in the asylums of America and Europe, the rates of discharge reached 60-80%. This was far better than the 30% recovery rate which occurred about a century later, in the era of pharmacotherapy.

Although the Moral Treatment Movement was replaced by the tenets of biological psychiatry in the late 1800s, its elements were incorporated in the theory and practice of various psychosocial therapies. For reasons which were largely political and economic, however, the consensus in American psychiatry came to denigrate the use of these Moral Treatment offshoots – particularly, in the treatment of psychosis.

Academic opinion leaders in the field of psychiatry now contend that there is insufficient evidence to support the use of psychotherapy as a major or independent intervention for psychosis. This perspective is contradicted by a rich (but suppressed) history in the published literature, and by the success of many ongoing programs, some of which are summarized below.

The Bockoven Study

This study compared the prognoses of 100 patients who were treated at Boston Psychopathic Hospital between 1947 and 1952; and 100 patients who were treated at the Solomon Mental Health Center between 1967 and 1972. Patients were similar in the severity of their symptoms, but the earlier cohort received treatment that was limited to psychosocial therapies. In contrast, the 1967 cohort received medication, including neuroleptics. Five-year outcomes were superior for the earlier cohort: 76% return to community and a 44% relapse in terms of re-hospitalization. In comparison, the 1967 cohort experienced an 87% return to the community, but a 66% rate of rehospitalization. The investigators concluded that medications were associated with higher numbers of relapsing patients, and a higher number of relapses per patient.

The Vermont Longitudinal Study of Persons With Severe Mental Illness

In 1955, a multidisciplinary team of mental health care professionals developed a program of comprehensive rehabilitation and community placement for 269 severely disabled, back wards patients at the Vermont State Hospital. When none of these patients improve sufficiently through two or more years of neuroleptic therapy, they were offered a revised plan of treatment. The intensive rehabilitation program was offered between 1955 and 1960. Subsequently, patients were released to the community as they became eligible for discharge, receiving a variety of services that emphasized continuity of care. At a long-term follow-up performed between 1980 and 1982, 68% of patients exhibited no signs of schizophrenia, and 45% displayed no psychiatric symptoms at all. Most patients had stopped using medication (16% not receiving, 34% not using, and 25% using only sporadically). A subsequent analysis revealed that all of the patients with full recoveries had stopped pharmacotherapy completely. (In other words, compliance with antipsychotic drug treatment was neither necessary, nor sufficient, for recovery.)

The Michigan State Psychotherapy Project

Between 1966 and 1981, Drs. Bert Karon and Gary VandenBos supervised the Michigan State Psychotherapy Project in Lansing, Michigan. Patients were randomly assigned to receive about 70 sessions of psychoanalytically informed psychotherapy, medication, or both over a period of 20 months. By the end of treatment, the psychotherapy group had experienced earlier hospital discharge, fewer readmissions (30-50% fewer days of hospitalization), and superior improvement in the quality of symptoms and overall functioning. The poorest outcomes occurred among the chronically medicated, even when drugs were combined with psychotherapy.

The Colorado Experiment

In 1970, Drs. Arthur Deikman and Leighton Whitaker presided over an innovative treatment ward at the University of Colorado. Occurring just 20 years after the advent of the neuroleptics, the Colorado experiment attached a priority to psychosocial interventions during the inpatient care of 51 patients diagnosed with severe mental illness. Individual and group psychotherapies were delivered in the spirit of the Moral Treatment Movement, motivated by a spirit of collaboration, respect, and a desire to understand behaviors as expressive of meaning. Furthermore, psychotherapies were used with the goal of restoring pre-psychotic abilities and independent functioning, rather than with the more limited goal of blunting symptoms in order to justify rapid discharge. *Medications were used as interventions of last resort.* After ten months of experimentation, the researchers made the following discovery: compared to "treatment as usual" (neuroleptics and supportive therapy), the recipients of intensive psychotherapy experienced lower recidivism (fewer readmissions after discharge) and lower mortality.

The Soteria Project

Between 1973 and 1981, Dr. Loren Mosher (then Director of Schizophrenia Research at the National Institute of Mental Health) presided over an investigational program in Northern California. Over the course of nine years, the Soteria project involved the treatment of 179 young psychotic subjects, newly diagnosed with schizophrenia or schizophrenia-like conditions. A control group consisted of consecutive patients arriving at a conventional medical facility, who were assigned to receive care at a nearby psychiatric hospital. Soteria was distinguished by an attitude of hopefulness; a treatment philosophy which de-emphasized biology and medicalization; a care setting marked by involvement and spontaneity; and a therapeutic component which placed a priority upon human relationship. Most significantly, Soteria involved the minimal use of neuroleptics or other drug therapies. Two-year outcomes demonstrated superior efficacy for the Soteria approach. Although 76% of the Soteria patients remained free of antipsychotics in the early stages of treatment; and although 42% remained free of antipsychotics throughout the entire two-year period, the Soteria cohort outperformed the hospital control group (94% of whom received continuous neuroleptic therapy) by achieving superior outcomes in terms of residual symptoms, the need for rehospitalization, and the ability to return to work.

The Agnews State Hospital Experiment

In 1978, Rappoport et al. summarized the clinical outcomes of 80 young males (aged 16-40) who had been hospitalized in San Jose at Agnews State Hospital for the treatment of early schizophrenia. Following acceptance into a double-blind, randomized controlled study, subjects were assigned to receive placebo or neuroleptic therapy (chlorpromazine). Treatment effectiveness was evaluated using various rating scales for as long as 36 months after hospital discharge. The best outcomes, in terms of severity of illness, were found among the patients who avoided neuroleptic therapy both during and after hospitalization. Patients who received placebo during hospitalization, with little or no antipsychotic exposure afterward, experienced the greatest symptomatic improvement; the lowest number of hospital readmissions (8% vs. 16-53% for the other treatment groups); and the fewest overall functional disturbances.

Finland – Acute Psychosis Integrated Treatment (Needs Adapted Approach)

In 1992, clinicians in Finland launched a multi-center research project using Acute Psychosis Integrated (API) Treatment. Keenly aware of the problems associated with antipsychotic drug therapy, the research team adopted a model of care which emphasized four features: family collaboration, teamwork, a basic therapeutic attitude, and adaptation to the specific needs of each patient. The initial phase of the project enrolled 135 subjects (aged 25-34) experiencing a first episode of psychosis. All were neuroleptic naïve, and all had limited or no previous exposure to psychotherapy. Three of the six participating treatment facilities agreed to use antipsychotic medications sparingly. The experimental protocol assigned patients to two groups with 84 receiving the Needs Adapted Approach, and 51 receiving treatment as usual. Two-year outcomes favored the experimental treatment group: fewer days of hospitalization, more patients without psychosis, and more patients with higher functioning. These outcomes occurred despite the fact that the Needs Adapted group consisted of more patients with severe illness (diagnosed schizophrenia) and longer durations of untreated psychosis, and despite the fact that 43% of the Needs Adapted subjects avoided antipsychotics altogether (vs. 6% of the controls).

Subsequent refinements to the Needs Adapted Approach have expanded upon these initial successes.[23-25] In a series of papers describing outcomes for what has evolved to be known as the Open Dialogue Approach, the Finnish clinicians have achieved the following five-year outcomes for first-episode, non-affective psychosis:

82% rate of full remission of psychotic symptoms
86% rate of return to studies of full-time employment
14% rate of disability (based upon need for disability allowance)

The results of the Finnish experiment stand in stark contrast to the results of the prevailing American standard of care, which currently features a 33% rate of lasting symptom reduction or remission; and, at most, a 40% rate of social or vocational recovery.[26]

Pre-Therapy: A Client-Centered Approach [27]

It has been suggested by many professionals that it is not possible to conduct meaningful psychotherapy with any individual who is deep in the throes of a psychotic process. Pre-Therapy refers to a client-centered form of psychotherapy which reaches through psychosis and/or other difficulties (such as cognitive limitations, autism, and dementia) in order to make contact with the pre-verbal or pre-expressive Self. Drawing upon the principles of the late Carl Rogers and developed by American psychologist, Dr. Garry Prouty, Pre-Therapy emphasizes the following treatment philosophy and techniques:

unconditional positive regard for the client:
"the warm acceptance of each aspect of the client's world"

empathy: "sensing the client's private world as if it were your own"

congruence: "within the relationship, the therapist is freely and deeply himself or herself"

non-directiveness: "a surrendering of the therapist to the client's own intent, directionality, and process"

psychological contact: exemplified by the therapist's use of contact reflections, an understanding of the client's psychological or contact functions, and the interpretation of the client's contact behaviors

Although Pre-Therapy has not been promoted or publicized within the United States, it has been used successfully around the world to assist regressed or language-impaired individuals in regaining or improving their capacity for verbal expression. (It has even been used to resolve catatonia successfully, without the use of drug therapy.) [28]

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DATED this 16th day of May, 2008, in WILMINGTON, North Carolina.

Grace E. Jackson MD

Grace E. Jackson, MD

SUBSCRIBED AND SWORN TO before me this 16th day of May, 2008.

Notary Public in and for North Carolina
My Commission Expires: 8/12/12

State of Alaska)
)ss
Third Judicial District)

I, James B. Gottstein, hereby swear that this reproduction of the written testimony of Grace E. Jackson, MD, to which this is appended, is a true, correct and complete photocopy of the original filed in 3AN 08-493PR, Superior Court for the State of Alaska, Third Judicial District at Anchorage.

Dated: 10/27/2008

James B. Gottstein

SUBSCRIBED AND SWORN TO before me this 27th day of October, 2008.

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

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