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

In The Matter of the Necessity for the)
Hospitalization of _____,)
Respondent,)
Petitioner)
Case No. _____

OBJECTIONS TO MASTER'S REPORT

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COMES NOW, _____, by and through his counsel, the Law Project for Psychiatric Rights (PsychRights®) and objects to the Probate Master's report/recommendations issued in the above captioned matter on September 24, 2007.

II. FACTUAL BACKGROUND

A. Respondent's History

Prior to 1980, Respondent was successful in the community, he had long-term employment in a good job, was married with two daughters.[1]

In 1980, Respondent's wife divorced him, took his two daughters and saddled him with high child support and house (trailer) payments, resulting in his first hospitalization at the Alaska Psychiatric Institute (API).[2]

[1] Appendix to Pre-Hearing Brief (Appendix) 157-64. Approximately 80 per cent of the Appendix was struck by the Probate Master and removed from the official court file, by Order dated September 14, 2007 (Order Striking Respondent's Case). On September 28, 2007, these documents were resubmitted with Respondents Offers of Proof filed the same date (Offers of Proof).
[2] Appendix 157.

When asked at the time what the problem was Respondent said "he had just gotten divorced and consequently had a nervous breakdown."[3] He was cooperative with staff throughout that first admission.[4]

At discharge, his treating psychiatrist indicated that his prognosis was "somewhat guarded depending upon the type of follow- up treatment patient will receive in dealing with his recent divorce." [5]

Instead of giving him help in dealing with his recent divorce and other problems, API's approach was to lock him up and force him to take drugs that, for him at least, do not work, are intolerable, and have harmful mental and physical effects.[6]

This pattern was set by his third admission to API as described in the Discharge Summery for that admission:" The medication seemed not to have noticeable favorable effects throughout the first several hospital weeks, despite the fact that there were a variety of unpleasant Extra Pyramidal Symptoms (EPS)."[7] The Discharge Summary of this admission also states:

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[3] Appendix 157.
[4] Appendix 161.
[5] Appendix 164.
[6] The Affidavit of Robert Whitaker describes what the scientific research reveals regarding the lack of effectiveness of these drugs for many, if not most, the way they dramatically increase the likelihood of relapses and prevent recovery, and the extreme physical harm caused by these drugs. Mr. Whitaker's affidavit was struck and removed from the official court file by the Probate Master in his Order Striking Respondent's Case, and was resubmitted with Respondent's Offers of Proof.
[7] Appendix 329. Extra Pyramidal Symptoms, are involuntary movements resulting from the brain damage caused by these drugs. In the early 1980's, the standard of care was that the "therapeutic dose" had been achieved when Extra Pyramidal Symptoms appeared.

> On 3/26/81, a judicial hearing determined that there would be granted a 30 day extension during which time treatment efforts would continue, following which there would be a further hearing concerning the possibility of judicial commitment. Mr. _____ was furiously angry that he was deprived of his right to freedom outside the hospital, but despite his persistent anger and occasional verbal threats, he never became physically assaultive, nor did he abuse limited privileges away from the locked unit.
>
> After the first six hospital weeks he continued to believe that he had some special mission involving Easter Island - drug addicts and alien visitors to the Earth. When these views were gently challenged he became extremely angry, usually walking away from whoever questioned his obviously disordered thoughts.[8]

Twenty-Three years and over Fifty admissions later, the Visitor's Report of May 25, 2004 in his guardianship case, reports, "when hospitalized and on medications, [Respondent's] behaviors don't appear to change much . . . . Hospitalization and psychotropic medication have not helped stabilize him."[9]

On March 23, 2007, at discharge from his 68th admission to API, Dr. Worrall, summarized his condition after having "potentially reached the maximum benefits from hospital care," by which, he has consistently testified solely means forcing Respondent to take psychiatric drugs against his will, that Respondent was "delusional" had "no insight and poor judgment, . . . paranoid and guarded." [10] In other words, even after he had been given the drugs against his will and achieved "maximum benefit" therefrom, he was still "delusional" had "no insight and poor judgment, . . . paranoid and guarded."

In the public jury trial in Case No. 3AN 07-247 PR in which API sought to involuntarily commit Respondent and receive authorization to forcibly drug Respondent

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[8] Appendix 329.
[9] Sealed Appendix, p3.
[10] Appendix 335.

for 90 days, Dr. Worrall, his treating physician then as well in this proceeding, testified as to API's plan as follows:

> [W]hat we would do is stabilize him, which is going to take about three weeks, and then release him on an early release and hope that he keeps taking his medications. And eventually, if we are able to consistently utilize this process and we're -- where everybody is consistent, outpatient and the hospital, he's going to learn that he needs to take his medication. And he's going to take it and he's going to stay out. But it requires that consistent process, and that's what we're trying to do.[11]

Prior to the Alaska Supreme Court's ruling in *Wetherhorn*, Dr. Worrall's plan was to have Respondent continuously on an involuntary commitment under the unconstitutional "gravely disabled" standard definition contained in AS 47.30.915(7)(B), pump him full of long-acting Risperdal Consta, administer other psychotropic drugs, such as Seroquel and Depakote, give him an "Early Release" under AS 47.30.795(a), knowing he would quit them once discharged and then order him returned pursuant to AS 47.30.795(c) when he wasn't drugged to their liking.[12]

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[11] Tr. 4/3/07:275 (3AN 07-247 PR). Under Alaska statutes, an initial commitment is for 30 days and respondents do not have the right to a jury trial. AS 47.30.735. There may, however, be a constitutional right to a jury trial, which has not been litigated. Prior to the end of such a commitment, the hospital can file for a 90 day commitment, for which respondents do have the statutory right to a jury trial. AS 47.30.745(c). Before the end of the 90 day commitment, the hospital may file for a 180 day commitment for which respondents have the right to a jury trial. AS 47.30.770. The hospital may then file for successive 180 day commitments. *Id.*

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

The Office of Public Advocacy (OPA) was appointed Respondent's conservator in 1996 or so in Case No. 3AN-99-1108.[13]

On April 14, 2004, API filed a petition for temporary and permanent guardianship.[14] On June 30, 2004, OPA was appointed Respondent's temporary full guardian and on December 26, 2004, permanent full guardian.[15]

After being appointed, the Guardian unilaterally, without consultation with the Respondent, decided Respondent should become Medicaid eligible even though Respondent did not want Medicaid Services.[16]

Because Respondent's income was above the Medicaid limit, the Guardian established an irrevocable trust, known as a "Miller Trust," with the Guardian as trustee without discussing this with Respondent or certainly obtaining his consent.[17]

This removed a substantial percentage of Respondent's income as available for general financial support.[18] Respondent is eligible for free medical care as an Alaska Native and doesn't need Medicaid to be eligible for such services.[19]

The Guardian has filed a number of *ex parte* petitions to have the Respondent committed in order to have him forcibly drugged against his will.[20]

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[13] Sealed Appendix, page 2.
[14] Sealed Appendix, pp 6-9.
[15] Appendix 196-209. OPA will hereinafter be referred to as Guardian when acting in that capacity.
[16] Tr. 4/3/07:216 *et. seq.* (3AN 07-247 PR).
[17] *Id*.
[18] *Id*.
[19] Tr. 4/3/07:208. (3AN 07-247 PR).
[20] *See*, e.g., Tr. 4/3/07:202 (3AN 07-247 PR).

This includes "insisting" Respondent is gravely disabled under the "unable to survive safely in freedom" standard recently enunciated in *Wetherhorn v. API*, 156 P.3d 371, 379 (Alaska 2007), when his treating psychiatrist, Dr. Worrall, did not believe his survival was in jeopardy.[21]

B. Prior 2007 Involuntary Commitment and Forced Drugging Proceedings

30-Day petitions for commitment and forced drugging were filed on February 23, 2007 under Case No. 3AN-07-274 P/S, a hearing held before the Probate Master on February 27, 2007, and approved by the Superior Court on March 2, 2007. However, copies of the approval were not mailed until March 15, 2007, and in between, on March 6, 2007, the Public Defender Agency filed objections to the Probate Master's report.[22]

Respondent was given an "early release" under AS 47.30.795(a), and then illegally "ordered to return," under AS 47.30.795(c), prior to the expiration of the 30-day commitment for not taking Depakote as prescribed.[23] This put Respondent back in API before the expiration of the 30-Day commitment order and on March 21, 2007, a 90-day continuation petition was filed.[24]

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[21] Appendix 212.
[22] The Court may take judicial notice of these proceedings.
[23] The order to return was illegal because it was based solely on Respondent failing to take Depakote and AS 47.30.795(c) only allows someone to be ordered to return if it is determined, the person is a danger to self or others or gravely disabled. Dr. Worrall did testify that there were other reasons (Tr. 4/3/07 3AN 07-247), but this testimony is contradicted by all of the written evidence (Appendix 220, 221 & 224).
[24] Appendix 225-6.

On March 22, 2007, PsychRights, which had not represented Respondent at the 30-Day Petition hearing, filed an entry of appearance on behalf of Respondent,25 electing, among other things, a jury trial.26

Respondent won the jury trial, which he had elected in open court to make public, and was released from incarceration at API and therefore no Forced Drugging order could be granted.27 More specifically, the jury failed to find that API had met its burden of proving Respondent's mental condition would be improved by the course of treatment, and he was released on April 4, 2007.28

Yet another 30-day commitment petition was filed on May 14, 2007, and a forced drugging petition on May 15th, both of which were granted. PsychRights did not represent Respondent. In due course, API filed 90-day petitions for commitment and forced drugging petition. PsychRights did not represent Respondent with respect to those petitions, but testified as a fact witness on his behalf in the public jury trial elected by Respondent. On or around May 22, 2007, the jury found API had not met its burden of proving Respondent was gravely disabled and he was released.[29]

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

Paul Cornils of CHOICES, Inc., an independent case management agency, first began working with Respondent _____ in January of 2007, under contract

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[25] Exhibit to Limited Entry of Appearance, filed herein on August 31, 2007.
[26] The Court can take judicial notice of this proceeding, 3AN 07-247 P/R.
[27] Tr. 4/4/07:446 (3AN 07-247 P/R).
[28] *Id*.
[29] Case No. 3AN 07-598PR. The Court may take judicial notice of this.

with PsychRights, but when the cost of services exceeded $5,000 PsychRights said it could not afford to continue paying and Mr. _____ informed Mr. Cornils he did not want to work with him any more so services were discontinued.[30]

CHOICES began working with Mr. _____ again in July of this year at the request of the Office of Public Advocacy (OPA), Mr. _____'s Guardian, and has continued to do so.[31]

According to Mr. Cornils, Respondent is so angry at being put under a guardianship that he takes extreme measures to try to get rid of his guardianship, and as a result, he is mostly refusing to cooperate in virtually any way with the Guardian.[32]

Mr. Cornils cites as an example that Respondent rips up checks from the Guardian made out to Vendors on his behalf, trying to force the Guardian to give him his money directly and as part of his effort to eliminate the guardianship.[33]

According to Mr. Cornils, Respondent has also refused various offers of "help" from the Guardian, such as grocery shopping in a similar attempt to get out from under the guardianship.[34]

Mr. Cornils further testified that Respondent exhibits the same types of behavior to him, but CHOICES/Mr. Cornils have a different approach, which involves negotiation

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

and discussion, does not involve coercion and where the natural consequences of Respondent's actions are allowed to occur.[35]

D. 2006/2007 Guardianship Proceedings

On December 6, 2006, represented by PsychRights, Respondent filed a petition in his guardianship proceeding, Case No. 3AN 04-545 PG, to

(1) Terminate the Guardianship.

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

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

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

(5) Amend the powers of the Guardian to eliminate the authority to consent to mental health treatment.[36]

After numerous proceedings, this resulted in a settlement agreement on July 20, 2007, which (a) established some parameters for the administration of the guardianship and (b) provided Respondent with a clear path towards terminating his guardianship (Guardianship Settlement Agreement).[37] As relevant here, the Guardianship Settlement Agreement provides:

> 4.2. Increase of Discretionary Funds. It is recognized the amounts available for food and spending money (Discretionary Funds) are low and efforts will be made to find housing acceptable to Respondent which will increase the amount of Discretionary Funds. To that end, the Guardian shall make its best efforts to

[35] ¶G of Paul Cornils Affidavit.
[36] Sealed Appendix p. 18.
[37] Sealed Appendix, p 10-17.

obtain subsidized housing for Respondent that will allow an increase in Respondent's Discretionary Funds. …

6. Mental Health Services. Respondent has largely been unwilling to accept mental health services. Some services that Respondent may hereafter, from time to time, desire are identified in the subsections that follow. Others may be identified later. To the extent Respondent, from time to time, desires such services, the Guardian and API will support the provision of such services, including taking such steps as may be required of them to facilitate the acquisition thereof to the best of their ability.[38]

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

6.3. Other Services. Additional "wrap-around" or other types of services Respondent, from time to time, desires.

7. Involuntary Commitment Proceedings . The Guardian will make a good faith effort to (a) avoid filing any initiation of involuntary commitment petitions against Respondent under AS 47.30.700. In making such efforts, the Guardian will explore all available alternatives, including notifying and requesting the assistance of Respondent's counsel herein, James B. Gottstein.

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

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

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

E. *Ex Parte* Application and Order in this Case

As it looked like a new round was going to begin and prior to the *Ex parte* Application in this case being filed against Respondent, PsychRights, tried to get to the Court notice of (a) its objections to various aspects of the way these types of proceedings were being processed by the court system, and (b) when and to what extent it would represent Respondent. On August 28, 2007, at the end of a series of e-mails as things were escalating, in order to present to the Court Respondent's objections to the way these proceedings are conducted and to notify it of the circumstances in which PsychRights would represent Respondent, Respondent's counsel wrote to James Parker, the head of OPA's guardianship section, attaching a memorandum he had written to a subcommittee of the Probate Rules Committee appointed by the Chief Justice of the Alaska Supreme Court on August 17, 2007 (Memo), in pertinent part, as follows:

> The first topic I discuss is how *Ex Parte Orders* are being illegally granted as a matter of course (In an e-mail to the subcommittee I suggested steps should be taken immediately to address the situation rather than wait for the rule promulgation process to run its course).
>
> Section 2 of the memo discusses that AS 47.30 respondents have the right to counsel of their choice.
>
> This is to formally advise you (and Ms. Russo) that should OPA file a petition for the initiation of involuntary commitment in the near future I will represent Mr. B. If CHOICES were to do so, I probably wouldn't, although I almost certainly would represent him with respect to a forced drugging petition This is also to formally demand that if OPA files such a petition that it file a copy of this e-mail and the attached memo with the petition. I am also, by copy to Mr. Cornils, of CHOICES, requesting that this e-mail and memo accompany any petition it might file as well. In addition, by copy to Ms. Russo, I am requesting that should a petition be filed against Mr. B by anyone else, including one under AS 47.30.705, that this e-mail and the memo be immediately filed in the proceeding and served

> on any lawyer appointed by the court. These requests are not time limited. The bottom line with respect to *Ex Parte Orders*, is they are not legal unless the prospective harm is so imminent that it justifies dispensing with meaningful notice and meaningful opportunity to be heard.[39]

(emphasis added).

While Mr. Cornils attempted to comply, he apparently got confused and attached the prior e-mail so the above was not included with the *Ex Parte* Application filed by Mr. Cornils, but the memo was attached to the *Ex Parte* Application.[40] The Probate Master automatically recommended appointment of the Public Defender Agency to be Respondent's attorney with respect to commitment, without enquiring as to PsychRights representation even though he knew PsychRights had previously represented him in 3AN 07-247 P/R.

The form of *Ex Parte* Order recommended by the Probate Master was given to the Anchorage Police Department prior to being signed by the Superior Court and Respondent was picked up and taken to API thereunder.[41]

III. COURSE OF CURRENT PROCEEDING[42]

The next day, August 30, 2007, Petitions for 30-day commitment (Involuntary Commitment) and involuntary administration of psychotropic medication (Forced

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[39] Appendix, p.1.
[40] *See Ex Parte* Application filed in this matter, which has the formal title of Initiation of Involuntary Commitment Proceedings.
[41] Appendix 22.
[42] Only those proceedings relevant to the issue of a less intrusive alternative are set forth herein. Thus, for example, the pending issues of (a) Respondent being unrepresented with respect to his involuntary commitment, (b) the motions to dismiss based on due process and failure to state a claim upon which relief can be granted, and (c) opening the court file to public inspection are not set forth herein.

Drugging) were filed against Respondent, a hearing set for both at 1:30 pm the next day, August 31, 2007, and the Public Defender Agency appointed to defend Respondent against the Forced Drugging Petition.[43]

A. August 31, 2007, Hearing

In the morning of August 31, 2007, PsychRights filed (1) a Limited Entry of Appearance with respect to representing Respondent as to the Forced Drugging Petition only, (2) a Motion to Dismiss the Petition for failure to provide sufficient notice of what was being alleged, and (3) a Challenge to Employment of Probate Rule 2(b(3)(D).

At the hearing on August 31, the Probate Master conducted the hearing on the Involuntary Commitment with Respondent represented by the Public Defender Agency. Respondent elected to have the hearing open to the public and to have it in a real courtroom downtown.[44] The Probate Master recognized Respondent's right to have the hearing open to the public, but denied the election to have it moved from behind the locked doors of API. The hearing on the Involuntary Commitment Petition appears to have gone fairly normally at the conclusion of which the Probate Master stated he was recommending the Involuntary Commitment Petition be granted and the reasons therefor.

The Probate Master thereupon took up the Forced Drugging Petition. There was an extended discussion of the status of representation, with PsychRights ultimately being

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[43] The August 30, 2007, Notice of 30-Day Commitment Hearing does not specify the attorney as they normally do, but as indicated, the Public Defender Agency was appointed in the *Ex Parte* Order.

[44] The recording quality of this hearing was so poor the court reporter was unable to provide a true, accurate, and complete transcript of proceedings. However, Respondent believes the description of the August 31, 2007, hearing here is accurate.

recognized as representing Respondent with respect to the Forced Drugging Petition, but confusion over who was representing him with respect to subsequent proceedings under the Involuntary Commitment Petition.

Respondent's request to be given notice of the basic facts supporting the Forced Drugging Petition under *Myers v. Alaska Psychiatric Institute*[45] was denied on the grounds that Respondent should know to what API's psychiatrist was going t testify.

Over API's strenuous objections, Respondent was allowed a one and a half business day continuance before commencement of the hearing on the Forced Drugging Petition.[46] In response to API's protestations that it needed to forcibly drug Respondent because he was disruptive, the Probate Master said the hospital could utilize AS 47.30.838 in an emergency and read the requirements of that statute.

B. September 4, 2007, Pre-Hearing Brief Filed

First thing in the morning on September 4, 2007, the day before the time set to begin the hearing on the Forced Drugging Petition, Respondent filed a Pre Hearing Brief, supported by an extensive Appendix of documents and the separate written testimony of Ronald Bassman PhD, and Robert Whitaker.

As pertinent here, relevant portions of the Pre-Hearing Brief stated:[47]

> As noted above, the psychiatric drugs the Guardian and API insist Respondent be forced to take against his will do not eliminate his psychiatric symptoms, or even substantially reduce them. At least

[45] 138 P.3d 238 (Alaska 2006).
[46] This also included the Labor Day Weekend.
[47] The footnotes in this section are from the Pre-Hearing Brief, but the footnote numbers are not.

Risperdal, Seroquel, Zyprexa and Depakote are also known to cause psychosis in a not small percentage of those taking it.48

These drugs are also very harmful, with a recent study concluding that each increment of neuroleptic increases the mortality rate by 2.5 times in a 17 year period and that people taking three of them are more likely to die than survive during such period.49 They cause a myriad of serious harms, including Tardive Dyskenesia and other Extra-Pyramidal Symptoms, diabetes and other metabolic problems and even kill people outright, perhaps most often by Neuroleptic Malignant Syndrome.50

The current forced psychiatric drugging regime Respondent assumes API is trying to impose on Respondent,51 includes three psychiatric drugs, two of which are such neuroleptics.

The current standard of care, with the introduction of the "second generation" neuroleptics and increasing "polypharmacy," has resulted in the average shortening of life of people in the public mental health system going from 10-15 years to 25 years.52

When Respondent complains the drugs are very harmful to him and damaging his brain and body, which is true, this complaint is labeled as delusional and proof of lack of insight as to his illness, his competency to decide whether or not to accept or reject the drugs, and of the need for forced drugging.53 Similarly, a statement such as "they are drawing my blood to get me," would be labeled paranoid even though it is clearly true that Anchorage Community Mental Health did draw his blood as a

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[48] Appendix 227-326.
[49] Whitaker and Bassman Affidavits.
[50] Whitaker Affidavit.
[51] At the August 31, 2007 hearing, Respondent orally moved for an order requiring API to provide the factual basis supporting its Forced Drugging Petition, which the Probate Master denied based on API's argument that Respondent should already know what the basis is. Respondent believes this is an outrageous denial of due process, and has necessitated Respondent prepare for as many eventualities as he possibly could in the short time allotted. It also exemplifies just one of the many ways in which involuntary commitment and forced drugging respondents' rights are grossly violated as a matter of course. If forced drugging petitions are to be decided on any sort of expedited schedule, the Petitions should provide meaningful notice that allows a meaningful opportunity to respond.
[52] Bassman Affidavit.
[53] Expected testimony of Dr. Worrall.

precursor to ordering him returned to API. Respondent's expressed anger at the Masters during the hearing is also completely understandable in light of the Kangaroo Court nature of the proceedings where no meaningful defense is presented. It is well known that patients are regularly lied to by hospital staff, including the psychiatrists and even that psychiatrists regularly lie in court.54

The Guardian's treatment of Respondent has led to an irreconcilable conflict, with Respondent taking extreme measures to try to get out from underneath the Guardian's oppressive yoke.55

As a result, Respondent is mostly refusing to cooperate in virtually any way with the Guardian.56

For example, the Respondent rips up checks from the Guardian made out to Vendors on his behalf, trying to force the Guardian to give him his money directly and as part of his effort to eliminate the guardianship.57

The Respondent has also refused various offers of "help" from the Guardian, such as grocery shopping in a similar attempt to get out from under the guardianship. 58

These actions have then been labeled as psychiatric symptoms and used by the Guardian to justify having the Respondent locked up and forcibly drugged against his will. 59

The Guardian has decided it is better for Respondent to be locked up and forcibly drugged than to allow Respondent to decline the intolerable

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[54] See, eg.M. Perlin, The ADA and Persons with Mental Disabilities: Can Sanist Attitudes Be Undone?, Journal of Law and Health, 1993/1994, 8 JLHEALTH 15, 33-34; and Torrey, E. Fuller. 1997. Out of the Shadows: Confronting America's Mental Illness Crisis. New York: John Wiley and Sons. 151, 152. However, counsel wishes to expressly state that [he] has no reason to think Dr. Worrall has done so, although he does believe Dr. Worrall does not accurately portray the benefits and harms of the medications. Counsel does not believe Dr. Worrall is lying about this; just that he has been misled as is described below.
[55] Expected testimony of James Parker and Paul Cornils.
[56] Expected testimony of James Parker and Paul Cornils.
[57] Expected testimony of James Parker and Paul Cornils.
[58] Expected testimony of James Parker and Paul Cornils.
[59] If disputed, expected testimony of James Parker, or otherwise can be established at a continued hearing.

medication and eliminate the serious mental and physical harm caused by these drugs.60

As Dr. Bassman quoted in his affidavit" Albert Einstein once said that the definition of insanity is doing the same thing over and over again and expecting different results."

This definition of insanity applies to API's 27 years of forced drugging inflicted on Respondent in over 70 admissions, as well as to the Guardian's participation in inflicting this very harsh regime on Respondent for a lesser, but still significant period of time. There are other ways.

(1) Dr. Mosher's Testimony in *Myers*

The Pre-Hearing Brief at §III.A., also submitted testimony from Loren R. Mosher, MD, from the *Myers* case.[61]

Dr. Mosher, board certified psychiatrist who received his undergraduate degree from Stanford, and medical degree from Harvard Medical School, and the former Chief of the of the National Institute of Mental Health's (NIMH) Center for Studies of Schizophrenia testified at the *Myers* trial.[62] While with the NIMH he founded and served as first Editor-in-Chief of the *Schizophrenia Bulletin*. He was Clinical Director of Mental Health Services for San Diego County from 7/96 to 11/98 and was a Clinical Professor of Psychiatry at the School of Medicine, University of California at San Diego at the time he testified. From 1988-96 he 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.[63] The Superior Court found Dr.

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[60] If disputed, expected testimony of James Parker, or otherwise can be established at a continued hearing

[61] As set forth in ¶9 of Respondent's Offers of Proof, this is admissible under Evidence Rule 804(a)(4) & (b)(1). That API is collaterally estopped from re-litigating what it lost in *Myers*, which was partially based on this testimony of Dr. Mosher was discussed in Respondent's Pre-Hearing Brief at §III, and Offers of Proof at ¶8, and will also be reiterated below.

[62] Dr. Mosher passed away a little over three years ago.

[63] Appendix, pp, 83,97.

Mosher's credentials and experience in the area of schizophrenia particularly impressive.[64]

> Among other things, Dr. Mosher testified to the following:[65]
>
> "There is no evidence that schizophrenia is in fact a brain disease.[66]
>
> 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 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[imony] 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.[67]
>
> 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?[68]

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[64] Appendix, p. 32.
[65] The footnotes within the quoted passages are from the Pre-Hearing Brief.
[66] Appendix, p. 83.
[67] Appendix, pp 83-4.
[68] Appendix, p 84.

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, 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.

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.[69]

CROSS-EXAMINATION

BY MR. KILLIP:

[69] Appendix pp 84-5.

> 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 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.[70]

Dr. Mosher's affidavit in *Myers*, a certified copy of which was filed here, includes additional testimony regarding less intrusive alternatives and the therapeutic importance of not coercing people.

(2) Dr. Jackson's Testimony in *Myers*

The Pre-Hearing Brief, at §III.B., also discussed and included certain testimony by Grace E. Jackson, MD's from the *Myers* case.[71]

> One of the things Dr. Jackson did was analyze documents obtained by Robert Whitaker under the Freedom of Information Act (FOIA)[72] and prepared an analysis of it as pre-filed testimony.[73] With respect to the safety of Zyprexa, Dr. Jackson testified as follows:
>
> > [W]e really do not have any proof that olanzapine is a safe drug. Just to answer, just very briefly, fewer than -- only 12% of

[70] Appendix P. 85
[71] The permissibility of this was addressed in the Pre-Hearing Brief and further addressed at ¶ 10 of the Offers of Proof.
[72] These documents appear at Appendix, pp 100-126.
[73] Appendix, pp 127-151.

> 3,000 patients who were investigated to establish safety, ever stayed on the drug for more than a year. Fewer than 33% were on the drug for more than six months. We're talking about a medication whose safety has been very, very poorly investigated by the FDA.
>
> Q. Do you consider it a dangerous drug?
>
> A. I consider it a very dangerous drug.[74]

Dr. Jackson also talked about how clinical doctors, such as Dr. Worrall have not been getting accurate information to make good prescribing recommendations, which will be discussed in §V [of Pre-Hearing Brief].

A certified copy of Dr. Jackson's prefiled testimony in the *Myers* case was also filed herein with Respondent's Offers of Proof, briefly outlined in §III.O below.

The Pre-Hearing Brief, at §IX, also discussed and presented other written testimony as to the less intrusive alternative requirement of *Myers*.

A. Possible Less Intrusive Alternatives

Myers held:

> *[A] court may not permit a treatment facility to administer psychotropic drugs unless the court* makes findings that comply with all applicable statutory requirements and, in addition, *expressly finds* by clear and convincing evidence that the proposed treatment is in the patient's best interests and *that no less intrusive alternative is available*.[75]
>
> The court may not allow forced drugging when a less intrusive alternative could be made available but the State chooses not to fund them. *Wyatt v. Stickney*, 344 F.Supp. 387, 392 (M.D.Ala.1972) ("no default can be justified by a want of operating funds."), affirmed, *Wyatt v. Anderholt*, 503 F.2d 1305, 1315 (5th Cir. 1974)(state legislature is not free to provide social service in a way that denies constitutional right). In other words, the State may not forcibly drug someone when it could, but chooses not to fund possible less intrusive

[74] Appendix, p. 87.
[75] 138 P.3d at 254, emphasis added.

alternatives. In *Wyatt* the federal courts required the State of Alabama to spend funds to provide constitutionally adequate services in specific detail.

Dr. Mosher's testimony, set forth above, and the Bassman affidavit establish that there are viable alternatives for even the most chronic patient.

B. Existing Less Intrusive Alternatives

Respondent believes that Mr. Paul Cornils, of CHOICES, Inc., who has spent a considerable amount of time with Respondent and was one of co-petitioners for the *ex parte* application filed in this case, will testify that if Respondent was provided adequate housing and "wrap-around" services, he would be much more successful in the community without forcing him to take drugs he doesn't want.[76] It is believed Kamaree Altaffer, API Consumer & Family Specialist,[77] who has spent time working with Respondent both inside and outside of API will testify to substantially the same effect and might offer additional insights into services and approaches that would substantially decrease Respondent's difficulties in the community.

There are less intrusive alternatives and the Court should order the State to provide them so long as the cost is not unreasonable as compared to the over $1,000 per day it costs to have Respondent at API.

In addition, because of the way that being homeless exacerbates Respondent's problematic presentation in the community, the Court should also order the state to allow Respondent to come and go from API as he desires. In light of what API has done to him for so many years, Respondent is unlikely to accept, but it should be available to him. It is expected that Paul Cornils and/or Kamaree Altaffer will provide testimony as to why this makes sense in the

[76] It is also believed that Mr. Cornils will testify that he opposed API filing the Forced Drugging Petition because he felt less intrusive alternatives were available from CHOICES, Inc., but API went ahead in spite of the availability of this less intrusive alternative. If he does so testify, it will directly contradict Dr. Worrall's testimony, although Petitioner doesn't know if Mr. Cornils spoke directly with Dr. Worrall or not.
[77] Ms. Altaffer is being subpoenaed to the hearing, but may not be called due to counsel's concern that she may be retaliated against for truthfully testifying under court compulsion.

> unique situation for Respondent, whom Dr. Worrall has testified is the most, or about the most mentally ill person he has ever treated.

C. Ronald Bassman Written Testimony

Dr. Bassman, through his affidavit, testified to less intrusive alternatives, and included citations to the scientific literature.[78] In particular, Dr. Bassman testified:

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

(citations omitted, italics in original, underlining added)

D. Robert Whitaker Written Testimony

Mr. Whitaker, through his affidavit, citing to the relevant studies, testified as to the scientific evidence regarding the neuroleptics, which include Risperdal, Seroquel, Zyprexa and Haldol, all of which have been administered to Respondent within the last year.[79]

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[78] Dr. Bassman was available for telephonic cross-examination on September 5, 2007, and if API desires to cross-examine him at a further hearing, arrangements will be made to have him available for such cross examination.

[79] Mr. Whitaker was available for telephonic cross-examination on September 5, 2007, and if API desires to cross-examine him at a further hearing, arrangements will be made to have him available.

Portions of Mr. Whitaker's written testimony relevant to this less restrictive alternative phase follow:[80]

> 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).[81]
> >
> > b) Second, researchers have found that if patients abruptly quit taking antipsychotic medications, they are at high risk of relapsing.[82]
>
> 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 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

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[80] The footnotes for the quoted portion are from Mr. Whitaker's affidavit.
[81] Cole, J, et al. "Phenothiazine treatment in acute schizophrenia." *Archives of General Psychiatry* 10 (1964):246-61.
[82] Gilbert, P, et al. "Neuroleptic withdrawal in schizophrenic patients." *Archives of General Psychiatry* 52 (1995):173-188.

over the short term were making patients more likely to become psychotic over the long term.[83]

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.[84, 85, 86] Those findings led NIMH scientist William Carpenter to conclude that "antipsychotic medication may make some schizophrenic patients more vulnerable to future relapse than would be the case in the natural course of the illness."

12. In the 1970s, two physicians at McGill University, Guy Chouinard and Barry Jones, offered a biological explanation for why this is so. The brain responds to neuroleptics and their blocking of dopamine receptors as though they are a pathological insult. To compensate, dopaminergic brain cells increase the density of their D2 receptors by 40% or more. The brain is now "supersensitive" to dopamine, and as a result, the person has become more *biologically* vulnerable to psychosis than he or she would be naturally. The two Canadian researchers wrote: "Neuroleptics can produce a dopamine supersensitivity that leads to both dyskinetic and psychotic symptoms. An implication is that the tendency toward psychotic relapse in a patient who had developed such a supersensitivity is determined by more than just the normal course of the illness. [87]

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

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[83] Schooler, N, et al. "One year after discharge: community adjustment of schizophrenic patients." *American Journal of Psychiatry* 123 (1967):986-95.
[84] Rappaport, M, et al. "Are there schizophrenics for whom drugs may be unnecessary or contraindicated?" *Int Pharmacopsychiatry* 13 (1978):100-11.
[85] Carpenter, W, et al. "The treatment of acute schizophrenia without drugs." *American Journal of Psychiatry* 134 (1977):14-20.
[86] 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.
[87] 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.

ganglia.[88, 89, 90] 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.[91]

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

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

a) In 1994, Courtenay Harding at Boston University reported on the long-term outcomes of 82 chronic schizophrenics discharged from Vermont State Hospital in the late 1950s. She found that one-third of this cohort had recovered completely, and that all who did shared one characteristic: They had all stopped taking antipsychotic medication. The notion that schizophrenics needed to stay on antipsychotics all their lives was a "myth," Harding said.[92, 93, 94]

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

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[88] Gur, R, et al. "A follow-up magnetic resonance imaging study of schizophrenia." *Archives of General Psychiatry* 55 (1998):142-152.
[89] 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.
[90] Madsen A, et al. "Neuroleptics in progressive structural brain abnormalities in psychiatric illness." *The Lancet* 352 (1998): 784-5.
[91] Gur, R, et al. "Subcortical MRI volumes in neuroleptic-naive and treated patients with schizophrenia." *American Journal of Psychiatry* 155 (1998):1711-17.
[92] Harding, C. "The Vermont longitudinal study of persons with severe mental illness," *American Journal of Psychiatry* 144 (1987):727-34.
[93] Harding, C. "Empirical correction of seven myths about schizophrenia with implications for treatment." *Acta Psychiatrica Scandinavica* 90, suppl. 384 (1994):140-6.
[94] McGuire, P. "New hope for people with schizophrenia," *APA Monitor* 31 (February 2000).

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.[95, 96, 97, 98] 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.[99]

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.[100]

* * *

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

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[95] Ciompi, L, et al. "The pilot project Soteria Berne." *British Journal of Psychiatry* 161, supplement 18 (1992):145-53.
[96] 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.
[97] Cullberg J. "One-year outcome in first episode psychosis patients in the Swedish Parachute Project. *Acta Psychiatrica Scandinavica* 106 (2002):276-85.
[98] Lehtinen V, et al. "Two-year outcome in first-episode psychosis according to an integrated model. *European Psychiatry* 15 (2000):312-320.
[99] Seikkula J, et al. Five-year experience of first-episode nonaffective psychosis in open-dialogue approach. *Psychotherapy Research* 16/2 (2006): 214-228.
[100] 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.

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."[101]

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.[102, 103, 104, 105, 106] 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."[107] Letters also poured into medical journals linking risperidone to neuroleptic malignant syndrome, tardive dyskinesia, tardive dystonia,

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[101] FDA approval letter from Robert Temple to Janssen Research Foundation, December 21, 1993.
[102] Rosebush, P. "Neurologic side effects in neuroleptic-naïve patients treated with haloperidol or risperidone." *Neurology* 52 (1999):782-785.
[103] Knable, M. "Extrapyramidal side effects with risperidone and haloperidol at comparable D2 receptor levels." *Psychiatry Research: Neuroimaging Section* 75 (1997):91-101.
[104] Sweeney, J. "Adverse effects of risperidone on eye movement activity." *Neuropsychopharmacology* 16 (1997):217-228.
[105] Carter, C. "Risperidone use in a teaching hospital during its first year after market approval." *Psychopharmacology Bulletin* 31 (1995):719-725.
[106] Binder, R. "A naturalistic study of clinical use of risperidone." *Psychiatric Services* 49 (1998):524-6.
[107] Mattes, J. "Risperidone: How good is the evidence for efficacy?" *Schizophrenia Bulletin* 23 (1997):155-161.

liver toxicity, mania, and an unusual disorder of the mouth called "ra_____it syndrome."

19. Zyprexa, which is manufactured by Eli Lilly, was approved by the FDA in 1996. This drug, the public was told, worked in a more "comprehensive" manner than either risperidone or haloperidol, and was much "safer and more effective" than the standard neuroleptics. However, the FDA, in its review of the trial data for Zyprexa, noted that Eli Lilly had designed its studies in ways that were "biased against haloperidol." In fact, 20 of the 2500 patients treated with Zyprexa in the trials died. Twenty-two percent of the Zyprexa patients suffered a "serious" adverse event, compared to 18 percent of the Haldol patients. There was also evidence that Zyprexa caused some sort of metabolic dysfunction, as patients gained nearly a pound per week. Other problems that showed up in Zyprexa patients included Parkinsonian symptoms, akathisia, dystonia, hypotension, constipation, tachycardia, seizures, liver abnormalities, white blood cell disorders, and diabetic complications. Moreover, two-thirds of the Zyprexa patients were unable to complete the trials either because the drugs didn't work or because of intolerable side effects.[108]

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."[109]

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

[108] See Whitaker, R. *Mad in America*. New York: Perseus Press (2002):279-281.
[109] Geddes, J. "Atypical antipsychotics in the treatment of schizophrenia." *British Medical Journal* 321 (2000):1371-76.

study were unable to stay on antipsychotics owing to the drugs' "inefficacy or intolerable side effects," or for other reasons.[110]

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.[111] This finding was quite startling given that researchers had previously determined that patients medicated with the old drugs had a "very poor" quality of life.

20. There is also growing evidence that the atypicals may be exacerbating the problem of early death. Although the atypicals may not clamp down on dopamine transmission quite as powerfully as the old standard neuroleptics, they also block a number of other neurotransmitter systems, most notably serotonin and glutamate. As a result, they may cause a broader range of physical ailments, with diabetes and metabolic dysfunction particularly common for patients treated with Zyprexa. In a 2003 study of Irish patients, 25 of 72 patients (35%) died over a period of 7.5 years, leading the researchers to conclude that the risk of death for schizophrenics had "doubled" since the introduction of the atypical antipsychotics. [112]

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.

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[110] Lieberman, J, et al. "Effectiveness of antipsychotic drugs in patients with schizophrenia." *New England Journal of Medicine* 353 (2005):1209-1233.
[111] Davies, L, et al. "Cost-effectiveness of first- v. second-generation antipsychotic drugs." *The British Journal of Psychiatry* 191 (2007):14-22.
[112] 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.

E. September 5, 2007, Forced Drugging Petition Hearing

(1) Motion to Strike All of Respondent's Attachments and Affidavits

At the beginning of the September 5, 2007, hearing on the Forced Drugging Petition, API filed a Pre-Hearing Brief of Petitioner and Motion to Strike All Attachments to Pre-Hearing Brief of Respondent.

(2) Dr. Worrall's Testimony on Best Interests and Less Intrusive Alternative

Dr. Worrall, API's psychiatrist, testified on direct examination that the forced drugging would be of very little benefit and the forced drugging he was requesting was directed towards Mr. _____'s behavior in the community:

> It's not going to make him sane. It's not going to make him stop believing that he has, you know, a million dollar jet plane, or other things are going on, that he believes. It's not gonna...remove his delusions or stop his delusions. It's not gonna make him stop being distrustful or paranoid of people, but it's gonna just make the main difference, his ability to communicate and have some more self control so that he could function in the community. Unfortunately, that's -- at this stage in his illness, that's about the extent of the benefit. It's not curable.[113]

Dr. Worrall also testified there is no less intrusive alternative available.[114]

Dr. Worrall's cross-examination was postponed until September 10, 2007 in order to allow the in-court testimony of Sarah Porter, an expert in the area of alternative treatments from New Zealand who was in Anchorage only until the end of the week.[115]

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[113] Tr. 9/5/2007:54.
[114] Tr. 9/5/2007:55

(3) Sarah Porter Testimony

Sarah Porter, who, as mentioned, was qualified as an expert in the area of alternative treatments,[116] testified to the following:[117]

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

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[115] Tr. 9/5/2007:92.
[116] *Id*.
[117] Tr. 9/5/2007:73-81.

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

A There are. Indeed. Yes, indeed.

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

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

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

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

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

A I do.

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

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

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

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

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

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

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

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

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

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

A ...because we recognize that the use of force and coercion actually undermines the therapeutic relationship and decreases the likelihood of compliance in the long term with whatever kinds of treatment or support has been implicated for the person. So we have created and set up our service

along the lines of making relationship and negotiation the primary basis for working with the person and supporting the person to reflect on and reconsider what's going on to create what might be defined as a crisis, and to devise strategies and plans for how the person might be with the issues and challenges that they face in their life. . . .

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

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

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

A It does, indeed. Yes.

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

A In many cases, yes. . . .

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

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

F. API's Criminal Assault on Respondent

The forcible drugging of a person without any legal authority constitutes criminal assault under AS 11.41.200, .210 .220 or .230.

As set forth above, at the August 31, 2007 hearing, the Probate Master advised API that if there was an emergency need to forcibly drug Respondent during the continuance on

the Forced Drugging Petition, it could do so under AS 47.30.838.[118] From the end of the hearing on August 31, 2007 until September 10, 2007, API continued to forcibly inject Respondent with Haldol without justification under AS 47.30.838 existing, nor any of the required documentation placed in Respondent's medical records.[119] By September 9, 2007, it was a mathematical impossibility for there to be compliance with AS 47.30.838, and in order to provide API with as much notice as possible API was served that evening *via* e-

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[118] AS 47.30.838 provides in pertinent part:

> (a) Except as provided in (c) and (d) of this section, an evaluation facility or designated treatment facility may administer psychotropic medication to a patient without the patient's informed consent, regardless of whether the patient is capable of giving informed consent, only if
>
> (1) there is a crisis situation, or an impending crisis situation, that requires immediate use of the medication to *preserve the life of, or prevent significant physical harm to, the patient or another person,* as determined by a licensed physician or a registered nurse; the behavior or condition of the patient giving rise to a crisis under this paragraph and the staff's response to the behavior or condition *must be documented in the patient's medical record*; the documentation must include an explanation of alternative responses to the crisis that were considered or attempted by the staff and why those responses were not sufficient;

(emphasis added).

[119] Original Application for Relief and Emergency Motion for Injunctive Relief filed in the Alaska Supreme Court under Case No. S-12851. The Original Application, including the Appendix filed therewith was served on the Superior Court as required by Appellate Rule 404(b)(2), but removed from the official court file by the Probate Master and returned to counsel by Order dated September 17, 2007, stating:

> There is nothing in the Civil Rules of Procedure, the Rules of Appellate Procedure or the Rules of Administration requiring the submission to the trial court of these documents. Therefore, they are not part of the trial court record and they shall be returned to the Respondent's attorney.

Respondent will be happy to return these if the Court so desires, but otherwise the Court can take judicial notice of them *via* access to the Alaska Supreme Court file.

mail the Original Application and Emergency Motion upon API that were being filed first thing Monday morning, September 10, 2007, at the Alaska Supreme Court.

First thing Monday morning, September 10, 2007, Respondent filed the Original Application and Emergency Motion in the Alaska Supreme Court, under Supreme Court Case No. S-12851, and a companion Motion for Injunctive Relief with a Motion for Expedited Consideration in the Superior Court. The Memorandum in Support of the Motion for Injunctive Relief stated:

> Respondent has moved for the issuance of an injunction against William A. Worrall, MD and the Alaska Psychiatric Institute from administering any psychotropic medication to Respondent _____ on any grounds except as follows:
>
> 1. The enjoined parties may seek to administer psychotropic medication only through court approval.
> 2. In the event the Superior Court grants such approval, such authority shall be stayed for seven days for Mr. _____ to seek review by the Alaska Supreme Court.
> 3. If such review is sought, Mr. _____ may seek a further stay in this court, and the stay granted in 2, above, shall remain in effect until the this court has ruled on his request and, if not granted, Mr. _____ has had seven days from denial to seek further review in the Alaska Supreme Court.
>
> The grounds for this motion is that Dr. Worrall,[120] without restraint by API, is flouting the requirements of AS 47.30.838 as set forth in the Application for Original Relief and Emergency Motion for Injunctive Relief filed in the Alaska Supreme Court, copies of which have also been filed herein.[121]

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[120] Since Respondent filed this, Dr. Worrall has disputed the forced drugging was done pursuant to any order of his. If necessary, a hearing should be held to determine on whose order and under what circumstances this criminal assault occurred.

[121] As set forth previously, the Probate Master removed these from the official Court file and returned them to counsel. They have not been returned by counsel, but counsel will gladly do so if requested.

The Emergency Motion to the Alaska Supreme Court requested:

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

The Alaska Supreme Court ordered a response by 3:00 pm, Monday, September 10, 2007. However, API stopped the illegal forced drugging of Respondent[122] in the morning of September 10, 2007, and submitted an Opposition to the Motion for Injunctive Relief, stating in pertinent part:

> As Mr. _____ has had the statutory allowance of emergency medication, Dr. Worrall stopped the order this morning. See Attachment A. Until there is a final decision on the Petition for the Administration of Psychotropic Medication, Mr. _____ will not receive any emergency medication. Thus, his Motion for Injunctive Relief should be denied.

G. Respondent's Request for a Less Intrusive Alternative/Remedy

In §V of Respondent's Opposition to Motion to Strike All Attachments to Pre-Hearing Brief of Respondent and Presentation of Other Matters, filed September 10, 2007, Respondent requested an Order for a less intrusive alternative as follows:[123]

> AS 47.30.655 provides:
>
> **Sec. 47.30.655 Purpose of major revision.**
>
> The purpose of the 1981 major revision of Alaska civil commitment statutes (AS 47.30.660 and 47.30.670 - 47.30.915) is to more adequately protect the legal rights of persons suffering from mental illness. The legislature has attempted to balance the individual's constitutional right to physical liberty and the state's interest in protecting society from persons who are dangerous to

[122] API states it did not illegally drug him, but it is clear it did.
[123] The footnote in this section is from the original pleading.

> others and protecting persons who are dangerous to themselves by providing due process safeguards at all stages of commitment proceedings. In addition, the following principles of modern mental health care have guided this revision:
>
> (1) that persons be given every reasonable opportunity to accept voluntary treatment before involvement with the judicial system;
>
> (2) that persons be treated in the least restrictive alternative environment consistent with their treatment needs;
>
> (3) that treatment occur as promptly as possible and as close to the individual's home as possible;
>
> (4) that a system of mental health community facilities and supports be available;
>
> (5) that patients be informed of their rights and be informed of and allowed to participate in their treatment program as much as possible;
>
> (6) that persons who are mentally ill but not dangerous to others be committed only if there is a reasonable expectation of improving their mental condition.

(emphasis added).

The expert testimony of Ronald Bassman, PhD, and Sarah Porter described a less intrusive alternative approach to coercion and drugs that has much more favorable outcomes for people, including those who have been subjected to force and coercion, including forced drugging for a very long time, such as Mr. _____. Dr. Worrall testified there were members of API staff who like Mr. _____.

In light of Mr. _____'s current situation, largely created by the actions of API over 27 years, *API should be ordered to provide the following as a less intrusive alternative*, applicable in the community as well as any time he might be involuntarily at API, including beyond the conclusion of this case. Therefore, Mr. _____ is moving for an order requiring the following:

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

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

> 3. Only the Medical Director of API may authorize the administration of psychotropic medication pursuant to AS 47.30.838 (or any other justification for involuntary administration of medication, other than under AS 47.30.839), after consultation with James B. Gottstein, Esq., or his successor.
>
> 4. API shall procure and pay for a reasonably nice two bedroom apartment that is available to Mr. _____ should he choose it.[124] API shall first attempt to negotiate an acceptable abode, and failing that procure it and make it available to Mr. _____.
>
> 5. At API's expense, make sufficient staff <u>available</u> to be with Mr. _____ to try keep him out of trouble.
>
> 6. The foregoing may be contracted for from an outpatient provider.

(Italics added).

In footnote 16 of the Memorandum in Support of Support of Motion for Permanent Mandatory Injunction, Respondent states "Some other form of order besides an injunction may also be appropriate."

H. September 10, 2007 Hearing

At the continued hearing on the Forced Drugging Petition on September 10, 2007, Respondent asked the Probate Master to "so order" API's representation that Respondent would not receive any emergency medication. The Probate Master denied the request.

With respect to the Forced Drugging Petition, API informed the Probate Master it would like to hold the Forced Drugging Petition in abeyance pending an anticipated discharge on Thursday, September 13, 2007, at which point API expected to dismiss the Forced Drugging Petition.

Respondent responded that he felt API should not discharge him without providing sufficient support in the community:

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

> I maybe have kind of a slightly different, either expectation or desire, in terms of the resolution. . . . I think that the State has some obligations to Mr. _____ upon discharge, and what I would like to see is some kind of settlement... that would . . . maximize his chances for not having to go through this again.[125]

I. Motion for Permanent Mandatory Injunction

Concerned the Forced Drugging Petition would be dismissed and the Probate Master would fail to deal with his request under *Myers* that the Court order the less intrusive alternative set forth in §III.G above, Respondent re-filed it as a separate Motion for Permanent Mandatory Injunction, on September 12, 2007 (Motion). Footnote 2 states, "substantially similar relief was originally requested in [Respondent's] Opposition to Motion To Strike All Attachments To Pre-Hearing Brief Of Respondent and Presentation of Other Matters, filed September 10, 2007, and footnote 16, notes, "Some other form of order besides an injunction may also be relevant."

(1) Paul Cornils' Less Intrusive Alternative Testimony

Filed contemporaneously was the affidavit of Paul Cornils, portions of which have been set forth above. Mr. Cornils also testified with respect to the requested relief as follows:

> L. It is my belief that if the CHOICES approach were consistently used with Mr. _____ and there are sufficient community support resources there is a good chance he will be able to live successfully in the community.
>
> M. I understand Mr. _____, through his attorney Jim Gottstein, has moved for an injunction as follows:

[125] Tr. 9/10/07:11-12.

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

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

3. Only the Medical Director of API may authorize the administration of psychotropic medication pursuant to AS 47.30.838 (or any other justification for involuntary administration of medication, other than under AS 47.30.839), after consultation with James B. Gottstein, Esq., or his successor.

4. API shall procure and pay for a reasonably nice two bedroom apartment that is available to Mr. _____ should he choose it. API shall first attempt to negotiate an acceptable abode, and failing that procure it and make it available to Mr. _____.

5. At API's expense, make sufficient staff available to be with Mr. _____ to try keep him out of trouble.

6. The foregoing may be contracted for from an outpatient provider.

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

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

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

Q. With respect to Number 4, housing is a huge issue for Mr. _____. He demands a relatively nice apartment and will choose homelessness over one that does not meet his requirements. Currently, under his Guardianship regime, he is only given about $60 per week for food and $50 per

week for spending money. That is an unreasonably small amount. I don't know if the State should be required to support Mr. _____'s housing to the extent requested by Mr. Gottstein, but it should in a reasonable amount as necessary.

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

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

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

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

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

Mr. Cornils was under subpoena to attend the September 5, 2007 hearing and the continued hearing on September 10, 2007, being at the courthouse to do so. He is available to testify at a further hearing, including for cross-examination as to his affidavit, should such a hearing be held.

J. Order Striking 80% of Respondent's Case and Removing it From the Official Court File

By Order dated September 14, 2007, the Probate Master struck and removed from the official Court file approximately 80% of the written evidence submitted with Respondent's Pre-Hearing Brief.

K. Order Removing Other Documents from the Official Court File.

By Order dated September 17, 2007, stating there is nothing in the Civil Rules of Procedure, the Rules of Appellate Procedure or the Rules of Administration requiring the

submission of a transcript or a copy of the Original Application for Relief in the Supreme Court, the Probate Master had the documents removed from the file and returned to counsel.[126]

L. Dismissal of Forced Drugging Petition.

On September 18, 2007, API notified the Court that Respondent had been discharged on September 14, 2007, and on what looks like September 20, 2007, the Probate Master *sua sponte* recommended the Superior Court dismiss the Forced Drugging Petition, which recommendation was adopted by Order signed September 20, 2007.

M. The Probate Master's Report

Not waiting for a response from API to the Motion for Permanent Mandatory Injunction, on September 24, 2007, the Probate Master issued a Master's Report recommending denial of the Motion for Permanent Mandatory Injunction and imposition of a $250 fine against Respondent's counsel on the grounds the Motion was frivolous.

N. Opposition to Motion for Permanent Mandatory Injunction

API filed its Opposition to the Motion for Permanent Mandatory Injunction on September 24, 2007.[127]

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[126] The Probate Master is clearly in error since Civil Rule 53(d)(1) requires a transcript with his report/recommendations and Appellate Rule 404(b)(2) required service of the Original Application for relief on the trial court.

[127] After receipt of this, the Probate Master issued a Notice dated, September 27, 2007, stating, "No change to the Master's Report is made upon review of the State's opposition and the objection period to the Master's Report is not changed."

O. Offers of Proof

On September 28, 2007, Respondent filed Offers of Proof with respect to the stricken documents and testimony and removed from the official Court file by the Probate Master's September 14, 2007, Order.

P. Reply to Opposition to Motion for Permanent Mandatory Injunction

On October 1, 2007, Respondent filed his Reply to API's Opposition to Motion for Permanent Injunction.

IV.DISCUSSION

AS 47.30.655 provides:

Sec. 47.30.655 Purpose of major revision.

> The purpose of the 1981 major revision of Alaska civil commitment statutes (AS 47.30.660 and 47.30.670 - 47.30.915) is to more adequately protect the legal rights of persons suffering from mental illness. The legislature has attempted to balance the individual's constitutional right to physical liberty and the state's interest in protecting society from persons who are dangerous to others and protecting persons who are dangerous to themselves by providing due process safeguards at all stages of commitment proceedings. In addition, the following principles of modern mental health care have guided this revision:
>
> (1) that persons be given every reasonable opportunity to accept voluntary treatment before involvement with the judicial system;
>
> (2) that persons be treated in the least restrictive alternative environment consistent with their treatment needs;
>
> (3) that treatment occur as promptly as possible and as close to the individual's home as possible;
>
> (4) that a system of mental health community facilities and supports be available;

> (5) that patients be informed of their rights and be informed of and allowed to participate in their treatment program as much as possible;
>
> (6) that persons who are mentally ill but not dangerous to others be committed only if there is a reasonable expectation of improving their mental condition.

(emphasis added). These provisions, especially combined with the Alaska Supreme Court's mandate in *Myers* for a less intrusive alternative, give ample statutory authority for the relief requested.

A. *Myers v. Alaska Psychiatric Institute* Mandates a Less Intrusive Alternative.

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

> [A] court may not permit a treatment facility to administer psychotropic drugs unless the court makes findings that comply with all applicable statutory requirements and, in addition, expressly finds by clear and convincing evidence that the proposed treatment is in the patient's best interests and that *no less intrusive alternative is available*.[128]

API may not avoid its obligation to provide a less intrusive alternative by choosing to not make it available. *Wyatt v. Stickney*, 344 F.Supp. 387, 392 (M.D.Ala.1972) ("no default can be justified by a want of operating funds."), affirmed, *Wyatt v. Anderholt*, 503 F.2d 1305, 1315 (5th Cir. 1974)(state legislature is not free to provide social service in a way that denies constitutional right). In *Wyatt* the federal courts required the State of Alabama to spend funds in specific ways to provide constitutionally adequate services.

Having invoked its awesome power to confine Respondent and having sought to exercise its similarly awesome power to forcibly medicate him against his will "for his own good," Respondent's constitutional right to a less intrusive alternative has sprung into

[128] 38 P.3d at 254, emphasis added.

being. This is what *Myers* holds. *Wyatt* holds that API may not avoid its obligation to do so merely by choosing not to provide the less intrusive alternative, *i.e.*, providing a social service that denies Respondent's right to a less intrusive alternative.

B. Respondent Has Established There is a Less Intrusive Alternative

Dr. Worrall, testified there is no less intrusive alternative available.[129] This was trying to prove a negative, but as set forth above, Respondent has put on overwhelming evidence both as to the effectiveness of less intrusive alternative treatment and its availability.

C. Respondent is Entitled to the Requested Less Intrusive Alternative in the Community

Dr. Worrall, API's psychiatrist, testified the forced drugging would be of very little benefit and the forced drugging he was requesting was directed towards Mr. _____'s behavior in the community:

> It's not gonna remove his delusions or stop his delusions. It's not gonna make him stop being distrustful or paranoid of people, but it's gonna just make the main difference, his ability to communicate and have some more self control so that he could function in the community. Unfortunately, that's -- at this stage in his illness, that's about the extent of the benefit. It's not curable.

API's proposed treatment was intended to allow him to "function in the community." This is exactly what Respondent's less intrusive alternative treatment is designed to do as well, but with a program designed to allow him to be successful in the community in the long term, while respecting his choice not to take psychiatric drugs as mandated by *Myers*.

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[129] Tr. 9/5/2007:55

AS 47.30.655 provides in pertinent part that one of the guiding principles of modern mental health treatment that guided the 1981 revisions to Alaska's civil commitment statutes is "that a system of mental health community facilities and supports be available." This is exactly what Respondent is asking for and required under *Myers*.

API attempts to discharge itself from its obligations to Respondent by discharging Respondent. It has taken the position that if it can't forcibly drug Respondent, it won't provide the less intrusive alternative treatment Respondent has proven is available by discharging him even though it expects that will result in Respondent ending up in jail.[130]

> We're looking at a guy who is going to do time in jail if we don't intervene, which is not a good environment. And in that environment, he's going to be forced to take medications, too, and without the kind of due process that we have here.[131]

In fact, this is exactly what happened, with Respondent being arrested on September 19, 2007, for yelling and disturbing employees in Senator Murkowski's office and failing to leave when requested.[132]

Respondent has been dragged into API to be forcibly drugged more than 70 times, over 27 years, constituting 20% of his life since 1985,[133] only to be discharged with the knowledge he would go off the drugs and the cycle repeated.[134] At API's current daily rate of over $1,000 it currently charges patients for staying there, this amounts to over $6,000

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[130] *See*, Tr. 9/5/2007:57-8 where Dr. Worrall testifies that if they can't drug Respondent he should just be discharged.
[131] Tr. 9/5/2007:47.
[132] *USA v. Bigley*, USDC Alaska Case No. 3:07-MJ-00192-JDR.
[133] Tr. 9/5/2007:56.
[134] Part VI of Pre-Hearing Brief.

per month. Continuing this approach was API's expectation and plan and the requested apartment, for example, would cost under $1,000 per month. It is eminently reasonable and, most importantly, required under *Myers*.

Respondent is similarly entitled to the other relief requested as supported by the Affidavit of Paul Cornils. Mr. Cornils was subpoenaed to attend both the September 5, 2007 and September 10, 2007, and was at the court house on both days. Mr. Cornils can further testify to the reasons why the requested relief should be granted if the Court would like a more full understanding of the rationales behind the less intrusive alternative requests. Mr. Cornils is still available for cross-examination should that be deemed necessary or desirable.[135]

D. Specific Responses to Probate Master's Report

The foregoing lays out the basis for the requested relief. There is relatively little overlap between what Respondent presented and the Master's Report. In other words, the Master's Report fails to address most of Respondent's case, both factually and with respect to the legal grounds for the requested relief, as set forth above. This section shall restrict itself to specific erroneous Findings of Facts and, as seems desirable, erroneous analysis leading to why the proposed Conclusions should not be adopted. However, Respondent will not re-present his case within the context of addressing the specific errors in the Master's Report addressed here.

[135] Counsel is going to be out of state from October 11, 2007, until late October 28, 2007 and from November 13, 2007 through November 17, 2007, and requests no hearings or responsive pleadings be scheduled for when he is out of town.

(1) Erroneous Findings of Fact

Respondent will identify the Probate Master's proposed findings of fact by the same numbered paragraphs as contained in the Master's Report.

¶2. The Involuntary Commitment and Forced Drugging Petitions were filed August 30, 2007, not August 29, 2007.

¶6. It is noted here that the second sentence of paragraph 6 demonstrates API's unwillingness to allow Respondent to "participate in their treatment program as much as possible" as set forth in AS 47.30.655(5), nor that his treatment be tailored to be responsive to his needs.

¶7. Paragraph 7 of the proposed findings fails to acknowledge the reason for requiring the medical director to authorize emergency forced drugging under AS 47.30.838 on any other basis for forced drugging other than an order authorizing it under AS 47.30.839. This relief was requested because of the criminal assault of Respondent by forced drugging without any authority to do so. *See*, §III.F above. In light of API staff being allowed to forcibly drug Respondent with no legal authority to do so, it is eminently reasonable to have the medical director review any such emergency drugging. The point isn't that Respondent's counsel is not a physician, but that he is Respondent's attorney and the consultation request is so counsel can be in a position to (i) suggest other approaches, (ii) intervene with Respondent to address the situation which API feels warrants forced drugging, and (iii) protect Respondent's legal rights, if necessary.

¶9. It is untrue that API has not provided any of its staff for the purpose of assisting former patients out in the community after their release from API. API has made an

exception for Mr. _____ in the past to come in and get Risperdal Consta shots on an outpatient basis. This came out in the April 90-Day petition proceedings and was not technically before the Probate Master, however. A hearing could be held to establish this, or Respondent could submit the deposition testimony on this, but it is somewhat tangential.[136] However, it is untrue that API has not ever provided out patient services in the community after their release from API.

¶10.a. Mr. Cornils' testimony about Respondent's circumstances outside of API is very relevant, as set forth above. In addition to API's approach being directed to Respondent's functioning in the community and therefore testimony on that is entirely relevant, it is also directly relevant to Respondent's care at API.

¶10.b. The Probate Master said Dr. Bassman's testimony was not part of the record because he had ruled it immaterial and ordered it stricken and so it is not part of the record. Dr. Bassman's affidavit was also removed from the official court file, but it has since been returned with Respondent's Offers of Proof. It is part of the record and never should have been removed from the Court's official file. It is not at all clear the Probate Master had the authority to strike the affidavit (as opposed to ruling on its admissibility) and certainly had no authority to remove it from the official Court file.

¶10.c. Ms. Porter's testimony goes directly to the viability of a less intrusive alternative.

[136] In his Report at page 11, the Probate Master prohibited the submission of anything other than objections and proposed orders.

(2) Erroneous Conclusions

Much of the Probate Master's proposed conclusions are addressed elsewhere herein. A few points will be made here, however.

At page 7, the Probate Master states that after Respondent was committed, "the hospital had the right to treat him as it believed necessary." This is exactly what was held unconstitutional in *Myers*.

The next sentence says "there is no evidence that that he was improperly treated." This is also erroneous. He was criminally assaulted by being forcibly drugged without any legal authorization to do so, as set forth in §III.F above. Related to this on page 8, the Probate Master recommends the conclusion that "there is no factual basis justifying [requiring the Medical Director to authorize emergency forced drugging].[137]

The Probate Master then states, "There is no evidence that in the recent 30-day commitment period that any doctor improperly authorized or administered any psychotropic medication to the Respondent." Nothing could be further from the truth. Respondent was criminally assaulted by the improperly authorized druggings between August 31, 2007. It was only stopped in the morning of September 10, 2007, after Respondent served API with his Original Application for Relief and Emergency Motion for Injunctive Relief with the Alaska Supreme Court. The evidence should maybe be reopened to take direct testimony on this flouting of Respondent's rights. Requiring API to consult

[137] Just above that the Probate Master misstates the requested relief. Respondent only requested the relief with respect to purported emergency druggings, or otherwise not pursuant to an AS 47.30.839 order.

with Respondent's attorney is a logical way to avoid such problems in the future and the Court has authority to order it.

At page 9, the Probate Master recommends the conclusion that there is no legal or factual basis for the request for sufficient staff being made available for Respondent to be successful in the community. This is false. Mr. Cornil's testimony provides such factual basis and Respondent's memorandum in support of the motion provides the legal basis. There is additional support here. However, it might be useful to the Court to receive additional testimony from Mr. Cornils as to the rationale and reasons for this and the other relief requested. It should not be forgotten that the motion was filed in haste because Respondent was concerned his request for a less intrusive alternative would be ignored and the petition dismissed without the Probate Master addressing it. This concern was proven to be very well taken. Thus, additional testimony on this less intrusive alternative phase of the proceeding might prove helpful.

With respect to the Probate Master's proposed conclusion that there are no grounds to require API to outsource any of the requested services, at page 10, this is not what Respondent requested. Respondent's proposed order only allows API to outsource this service, not require it.

The Probate Master's proposed conclusion on page 10 that no irreparable injury has been shown is erroneous. There has been a tremendous amount of evidence put on that API's approach has done and is doing irreparable harm to Respondent.

The Probate Master's proposed conclusion at page 11 that the motion is frivolous is erroneous. The Probate Master has ignored the mandate of *Myers* for a less intrusive

alternative. Thus, the recommendation to fine Respondent's counsel $250 is also not well taken.

V. CONCLUSION

For the foregoing reasons, Respondent respectfully requests the Court order API to provide the following less intrusive alternative, whether denominated a permanent mandatory injunction or some other form of order:

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

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

3. Only the Medical Director of API may authorize the administration of psychotropic medication pursuant to AS 47.30.838 (or any other justification for involuntary administration of medication, other than under AS 47.30.839), after consultation with James B. Gottstein, Esq., or his successor.

4. API shall procure and pay for a reasonably nice two bedroom apartment that is available to Respondent should he choose it.[138] API shall first attempt to negotiate an acceptable abode, and failing that procure it and make it available to Respondent.

5. At API's expense, make sufficient staff <u>available</u> to be with Respondent to enable him to be successful in the community.

6. The foregoing may be contracted for from an outpatient provider.

DATED _____, 2007.

Law Project for Psychiatric Rights, Inc.

By: _____
James B. Gottstein, ABA # 7811100

[138] API may seek to obtain a housing subsidy from another source, but such source may not be Respondent's Social Security Disability income.