ALASKA PSYCHIATRIC INSTITUTE

HOSPITAL RECORD

SOCIAL HISTORY

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

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

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

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

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

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

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

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

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

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

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

Patient's religious preference is Nazarene.

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

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

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

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

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

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

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

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

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

Patient: BIGLEY, William S.
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Social History/Page 3

Severity: 4, moderate.

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

Annie Bowen

Annie Bowen, MSW

AB:dh

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

SAU
Randy Gager, NA III
4/15/80

ADMISSION DATA BASE

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

RG/sjb

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

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

SAU
Randy Gager, NA III
4/30/80
R. Gager NAIII

DISCHARGE ASSESSMENT NOTE

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

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Discharge Assessment Note/Page 2

(DISCHARGE) WHAT PATIENT VERBALIZES AS FOLLOW-UP CARE

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

RG/sjb

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

DISCHARGE SUMMARY

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

DATE OF ADMISSION: 4/15/80
DATE OF DISCHARGE: 4/30/80

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

REASON FOR & CONDITION ON ADMISSION: Patient was admitted reportedly having been threatening and bizarre, subject to auditory hallucinations. For example, he mentioned that he had removed a crown from a tooth because it contained a transmitter. On admission, he was guarded and defensive, unwilling to discuss any of these matters, but he did not directly deny them. He simply said he did not want to talk about it. He wanted to see a priest. He reportedly had stated that he killed someone in Sitka, but this was believed to be a delusion. He was very recently divorced and his wife gained custody of his two daughters, ages 4 and 5. On admission, he was very depressed, near tears and made statements, such as "I'm very sad and I hurt." He denied suicidal ideations. His orientation was intact. He denied hallucinations and his insight and judgment were impaired.

COURSE IN THE HOSPITAL: Patient responded well to the unit routine and participated in the ward activities. He was treated with Haldol 10 mg. b.i.d. which was started on 4/15/80 and on 4/17/80 after he developed some extrapyramidal problems, Cogentin 2 mg. p.o. b.i.d. was added. Physical examination did not reveal any significant abnormalities. Laboratory findings included a CBC, which showed an RBC of 5.22, hemoglobin of 15.7, hematocrit of 44.9, and a normal differential. Urinalysis was normal. RPR was non-reactive. A throat culture after 48 hours showed positive staph aureus, sensitive to a number of antibiotics. Patient's depression improved rather rapidly and with no further indication of hallucinations, and delusions, while he was in the hospital. Towards the end of hospital treatment, his affect became pleasant and cooperative. He was interacting well on the unit and was anxious to be discharged.

CONDITION ON DISCHARGE: Patient was markedly improved. He was discharged to the care of his parents.

FINAL DIAGNOSIS:

Axis I: Schizophreniform disorder, 295.40.

Axis II: All disturbances limited to Axis I.

Axis III: None.

Axis IV: Psychosocial stressors: Unresolved and ongoing reaction to divorce, ex-wife has custody of two daughters, pays large child support and trailer payments to ex-wife. Severity: 4, moderate.

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

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

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

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

RA/ojb

Robert Alberts, M.D.
Staff Psychiatrist

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

ALASKA PSYCHIATRIC INSTITUTE

HOSPITAL RECORD

DISCHARGE SUMMARY

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

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

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

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

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

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

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

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

No psychological studies were secured during this hospitalization.

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

The medication seemed not to have noticeable favorable effects throughout the first several hospital weeks, despite the fact that there were a variety of unpleasant EPS side effects. He was transferred to the longer term, locked, adult treatment unit on 3/10/81 because of continuing frank paranoid delusions and threatened angry assaultiveness.

On 3/26/81 a judicial hearing determined that there would be granted a 30 day extension during which time treatment efforts would continue, following which there would be a further hearing concerning the possibility of judicial commitment. Mr. Bigley was furiously angry that he was deprived of his right to freedom outside the hospital, but despite his persistent anger and occasional verbal threats, he never became physically assaultive, nor did he abuse limited privileges away from the locked unit.

After the first six hospital weeks he continued to believe that he had some special mission involving Easter Island - drug addicts and alien visitors to the Earth. When these views were gently challenged he became extremely angry, usually walking away from whoever questioned his obviously disordered thoughts.

Mr. Bigley often was visibly despondent and several times was close to tears as he discussed the forlorn hopelessness of his situation. He was unwilling to relate his despondency to issues other than his forced confinement, and specifically denied that he was still troubled by the recent divorce from his wife. Ludiomil was started in a dosage up to 150 mg. q. d. on 3/26/81. At the same time Haldol was decreased to 40 mg. h.s. After four days of use of Ludiomil, Mr. Bigley's thought processes seemed more fragmented, he seemed more intensely irritable, and angrily demanding, for which reason the Ludiomil was discontinued. Haldol was once again increased to 20 mg. t.i.d., on 4/3/81. Efforts to decrease or discontinue Cogentin were unsuccessful, so that he required relief of EPS with regular use of Cogentin. On 4/27/81 the Haldol was discontinued in favor of what was hoped to be the less sedative Navane 40 mg. h.s. He required intravenous Cogentin on the day after Navane was started, but thereafter, responded well to Navane with less sluggishness and waxy, bodily movements. His spirits improved, that he was able to be quietly pleasant in his interactions with unit staff members for the first time. He had reached maximum benefit from hospitalization, and arrangments were made for discharge.

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

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

FINAL DIAGNOSIS:

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

Axis II: Diagnosis confined to Axis I.

Axis III: No significant diagnosis.

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

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

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

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

Robert Marshall

RM/sjb

Robert Marshall, M.D.
Staff Psychiatrist

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

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

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

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

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

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

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

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

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

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

See what well means on page 2.

Contradicted by page 2

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

Where is documentation of necessity. Myers and/or

ADMITTING DIAGNOSIS:

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

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

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

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

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

FINAL DIAGNOSIS:

Axis I: Schizoaffective Disorder, Bipolar Type.

Caffeine Abuse.

Nicotine Dependence.

Axis II: Paranoid Personality Traits.

Axis III: Gastroesophageal reflux disease, by history.

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

Axis V: GAF: 35.

PROGNOSIS: Poor.

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

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

William A. Worrall, MD
Staff Psychiatrist

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ADMITTING DIAGNOSIS:

Axis I: Schizoaffective Disorder. Bipolar Type.

Caffeine Intoxication.

Nicotine Dependence.

Axis II: No diagnosis.

Axis III: Gastroesophageal reflux disease.

History of anorexia.

Axis IV: Stressors: Other psychosocial and environmental problems.

Axis V: GAF: 20.

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

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

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

William Worrall, MD
Staff Psychiatrist

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

Anchorage Community Mental Health Services

Medical Progress Note

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

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

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
AT _____

In the Matter of the Necessity for the Hospitalization of:

William Bigler,
Respondent.

Case No. 3AN-07-247PR

NOTICE TO OUTPATIENT TO RETURN TO TREATMENT FACILITY WHERE COMMITTED

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

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

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

3-19-07
Date

Signature of Provider of Outpatient Care

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

Scott A. Rassat
Printed Name

Utilization Review Associate
Title

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

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

By: _____
Outpatient Care Provider

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

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

AS 47.30.795(c)

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
AT ANCHORAGE

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

Order

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

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

3/20/07
Date

Superior Court Judge

MICHAEL L. WOLVERTON

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

Clerk:

Recommended for approval on a

March 20, 2007

Probate Master

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA AT _____

In the Matter of the Necessity for the Hospitalization of:

William Eagler, Respondent.

Case No. 3AN-07-247PR

State Trooper Directions for Service

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

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

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

To Serve: RESPONDENT NAMED ABOVE

Address where respondent is at this time 1555 Arctic Blvd. #7

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

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

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

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

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

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

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

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

RETURN OF SERVICE

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

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

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

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

Return Date _____

Commissioner of Public Safety

By _____

Printed Name _____

Title _____

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

ALASKA PSYCHIATRIC HOSPITAL

Report Contact

AT

William S

Reguarding: BIGLEY ,BILL

Date: 03/19/2007

Time: 15:42

Patient Type: Prior Patient

APH No.: 00 56 65

Adult

Person Making Referral:

SCOTT

Agency:

ACMHS

Phone # of Agency:

City/State:

Seeking: Information Only

Contact Type: Telephone Contact

Legal:

Still Pending

Brief Statement of Problem or Situtation

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

RdN
3/20/07

DISTRIBUTION

ORIGINAL: Medical Record Services
COPIES TO:

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

Time Spent on Contact:

Recorded By:
LLS_LAUREL_L_SILBERSCHMIDT, LCSW
BIGLEY ,BILL