IDENTIFYING INFORMATION:

Evaluation is Provided in Reference to:
United States District Court For The District of Columbia
United States of America v. Russell Eugene Weston, JR., Defendant.
Criminal Action No. 98-357
Patient's Name: Russell Eugene Weston, Jr.
Date of Birth: 12-28-56

LEGAL CONTEXT:

Mr. Weston is charged in a six-count indictment for behavior allegedly occurring on July 24, 1998, within the District of Columbia. Count One: On or about July 24, 1998, in the District of Columbia, Mr. Weston did willfully, deliberately, maliciously and with premeditation and malice aforethought, kill Officer Jacob J. Chestnut of the United States Capitol Police while he was conducting his official duties. Count Two: on or about July 24, 1998, within the District of Columbia, Mr. Weston did willfully, deliberately, maliciously and with premeditation and malice aforethought, attempt to kill Officer Douglas B. McMillan of the United States Capitol Police while he was engaged in his official duties. Count Three: on or about July 24, 1998, within the District of Columbia, Mr. Weston did willfully, deliberately, maliciously and with premeditation and malice aforethought, kill Special John W. Gibson of the Untied States Capitol Police while he was engaged in his official duty. Count Four: on or about July 24, 1998, Mr. Weston, during and in relation to a crime of violence for which he may be prosecuted in the Court of the United States that is the murder of Officer Jacob J. Chestnut, knowingly used and carried a firearm, that is a Smith and Wesson .38 caliber revolver. Count Five: on or about July 24, 1998, within the District of Columbia, Mr. Weston during and in relation to a crime of violence for which he may be prosecuted in the Court of the United States, that is attempting to kill Officer Douglas B. McMillan, knowingly used and carried a firearm, that is a Smith and Wesson .38 caliber revolver. Count Six: on or about July 24, 1998, within the District of Columbia, Mr. Weston during and in relation to a crime of violence for which he may be prosecuted in the Court of the United States, that is the murder of the special agent John M. Gibson, knowingly used and carried a firearm, that is a Smith and Wesson .38 caliber revolver.

PURPOSE AND SCOPE OF EVALUATION:

Description of Order Appointing Medical Expert:
Pursuant to this court's August 3, 2000, Order regarding the appointment of a psychiatric expert in this case pursuant to Fed. R. Evid. 706 and 18 U.S.C. S4241, et seq, the Court hereby appoints Dr. David G. Daniel for the purpose of providing the Court with an expert opinion as to whether it is in the defendant's medical interests to administer anti-psychotic medication without his consent.

SOURCES OF INFORMATION: See Appendix

HISTORY OF PRESENT ILLNESS:

The patient is a forty-three year old, unmarried white male high school graduate born in Murphysboro, Illinois on Decemebr 28, 1956, and raised in Valmeyer, Illinois. The full-term pregnancy and delivery were generally unremarkable. A single injection of unknown content was administered by a physician to address an apparent poison ivy dermatitis early in the pregnancy. A brief course of oral medication to address poison ivy may have been administered around the same time. "Morning sickness" was reported to have occurred at no greater intensity than occurred with the patient's sister. No other significant physical ailments or medical interventions were recalled prior to labor. The patient's mother did not use tobacco or alcohol during the pregnancy.
Early developmental milestones (including, for example, "holding onto things," walking and talking) were felt to have occurred at normal time and not dissimilarly from the patient's sister. He did not attend preschool or kindergarten classes and began school in the first grade. His parents felt that having been born in December, he was younger than many other children in his class and that this created problems for him. In elementary school, his parents described his grades as poor to average but noted that he was never held back a grade. He was required to attend the remedial reading class. Socially he was noted to be little different from other children except that he was not as outgoing as his sister. In terms of friendships it was noted that there were few close neighbors. He was noted to be emotionally and socially close to his sister and grandfather.

Early in elementary school while at an amusement facility he was struck by a go-cart type vehicle. He may have been briefly, transiently dazed or confused. He was examined at a hospital and underwent an x-ray procedure. There was no apparent fracture. No long-term change in behavior or motor coordination was noted subsequent to the injury.

In grades 7-9, he was noted to "just make it" (sic), with no significant improvement in grades. He developed some friendships but they closely mirrored his sister's friends. He was very attached to and spent significant time with his grandfather. He played Little League baseball without great success and was considered somewhat awkward. He was noted to have run into the catcher once. In contrast, he was noted to have always been very coordinated with his hands.

His parents felt that a retrospective examination of his high school years suggested unusual thinking. They noted that he was awkward around dating and seemed uncomfortable in his choices of conversational material with the opposite sex. They recollected apparent misconstruing of conversations and behaviors and non-sequiturs. They described an example of an apparent unusual interpretation of another person's behavior by the patient as follows: At a party at his home a female left shortly after using the restroom. The patient was said to have attributed her leaving to his perception that the bathroom needed remodeling. He was said to have been preoccupied with and upset about this for a few days. He was said to see connections between things and insist on their veracity like a "brick wall" (sic).

He had few friends of his own in high school, continuing to rely heavily on his sister's friendships. He continued to enjoy spending time with his grandfather. He may have hunted with his father and grandfather during this period. He learned to handle guns early in life and was around guns not infrequently. He had some success in deer hunting. One time in hunting along a railroad track, he was noted to have left the safety of his gun in the off position. Around late high school or shortly thereafter, he developed an interest in moving to Alaska. He talked about this frequently and studied maps of Alaska. He was not involved in social clubs or organized athletics. He apparently enjoyed talking about things such as automobile transmissions and outdoors topics, including the possibility of moving to Alaska or Montana.

Around 1973, he was said to have been involved in an automobile accident in which he was thrown from the back seat to the front and sustained a black eye. No loss of consciousness, immediate neurological effect, or longer term changes in motor functioning, cognition, or behavior were reported in relationship to the accident.

He was most interested in and apparently did best in woodworking class, drafting and vocational classes. He was skilled in building models. Although he was able to perform the math required for the aforementioned, he had little interest in other more bookish aspects of math. He was also noted to have little interest in English or French classes. Throughout school he was said to be an average to poor student, graduating with a class rank of 47 out of a class of 61, and a grade point average of 76.7 with 70% required for passing. His school records from Balmayer Community Schools from 1962 to 1973 noted grades generally ranging in the C to D area with some F's. Standardized testing records were said to suggest he was functioning in the average or lower level in high school. At some point after he graduated from Balmayer High School in 1974, he was said to have attended two years of drafting courses at Beck Area Vocational Center with attendance inconsistent.

His sister moved to Montana after graduating from high school and the patient developed a strong interest in doing the same. The patient moved to Montana subsequent to graduating from high school, although the exact timeline is unclear. He rented a cabin and was said to change his clothes infrequently, receiving the nickname "Crusty Rusty".

The patient's father recalls that 2-3 years after graduating from high school, the patient began to state that he could have been valedictorian of his high school. His father's recollection from that time is that the patient may have felt that his high school grades actually qualified him to be valedictorian.

Between 1974 and 1983, he worked intermittently at numerous odd jobs, including carpenter's helper, maintenance work, custodial work and prospecting. He did not sustain lengthy periods of employment in any given job. His longest consecutive periods of sustained employment were said to be janitorial work for several months in 1976 and as a general automotive mechanic for several months ending in June of 1980. His parents recollected that he had worked almost a year at Boulder River School. His parents felt that his difficulty in holding sustained employment probably stemmed from his difficulty

in getting along with people and a desire to do very high quality work. He seemed to get along better with elderly people. They noted that he became involved with an elderly man who taught him gold mining techniques in exchange for work but paid him little. The parents felt this relationship was exploitive of their son. The patient came to describe himself as a self-employed miner and prospector of precious metals. The family says that although he "piddled" in a couple of goal mines, they were not a consistent or significant source of income for him.

The family notes that while renting a cabin in Montana, the patient became engaged in an altercation with his landlord, who allegedly beat him with a cane. The events leading up to it are unclear. The landlord allegedly said that the patient took something from her cabin. The patient was said to have stated that the female landlord had made a solicitous request of him. The parents recall that the daughter told them that he was hit about the head and face, and teeth could be heard cracking. There was some sense that this may have been blows directed more toward the cheeks than the head. There is no information to suggest that he was knocked unconscious. The patient's parents thought it plausible that he may have been transiently dazed afterwards. The parents dated this incident to the patient's 20's. The patient's father said that the patient had intended to sue over the incident but missed the deadline despite repeated reminders from his father and that he subsequently blamed his father. After the incident, the patient's parents recollected that he complained of ear problems and blackouts. An 11-12-83 clinical record apparently from a hospital emergency room describes the patient having entered with complaints of assault to the face, and stating that ten days prior he had been hit under the eye with the rounded end of a cane and had since then developed a number of facial symptoms. It was noted that the patient felt he had heard something crunch during the alleged attack. The diagnostic impression was no fracture seen on x-ray of facial bones and cervical spine with final diagnosis of neck strain and face contusion.

An incident the patient's father recollected as having occurred in 1983 and standing out as an example of the patient's peculiar thinking was that while he was actively applying for social security benefits the patient stated that he did not believe in social security.

A January 26, 1984 consultation at St. Elizabeth's hospital in Bellville, Illinois, concluded, "These findings are suggestive of quite generalized polyneuropathy." Laboratory evaluations done at St. Elizabeth's Hospital indicated a folic acid level of 4.9 units per millimeter and vitamin B12 of 296 PG/ML (both values within the normal range provided). A photocopy bearing some resemblance to a report of a thyroid T4 test was illegible.

A letter of March 19, 1984 by P.R. Kini, M.D. states: "My examination is normal and also the EEG". It notes that the EEG was ordered because the patient complained of some light-headedness and partial black-outs. In two places the letter states that the EEG was normal. The EEG report itself, dated 3-6-84 and read by R. Welch, M.D., states, "This record consists of poorly organized eight to ten cycles per second activity and low-voltage fast activity. No focal or paroxysmal features are seen. Hyperventilation did not

change the record significantly. The impression was that the record was within normal limits."

A letter of November 29, 1984, written by Panduranga, R. Kini of Belleville, Illinois noted, "He had EEG and a CAT brain scan, magnetic resonance imaging of his neck, all these studies turned out to be normal." "He has multiple injuries to his head and neck dating back to 1966, 1973, 1978, and 1980 but apparently got over these reasonably well."

A letter written by Ronald G. Welch, M. on November 29, 1984, states, "He had an EEG and a CAT brain scan, magnetic resonance imaging of his neck, all these studies turned out to be normal."

A letter of April 26, 1984, written by P.R Kini, M.D., indicated that his neurological examination was normal except for absent reflexes in the lower limbs, which the writer considered consistent with alcoholic polyneuropathy.

A January 7, 1985, evaluation in Valmayra, Illinois, indicated probable EMG and nerve conduction abnormailities in a note dictated by R. Welch, M.D. on 2-18-85. The findings were interpreted as consistent with a diffuse polyneuropathy affecting both upper and both lower extremities.

A January 13, 1985, document signed by the patient is excerpted as follows: "Capitalists have to be dominators and where people and personal safety is concerned in comparison to profit, any company will sacrifice people, personal safety, human rights, or anything that stops profit." "The only law made for those who can get it enforced or can pay to get it enforced. I have been victimized by (illegible) sheriffs who were bought and paid for. I have caught state agencies breaking law for financial reasons and fraud. I have lived (illegible) in other major chemical company that spew (illegible) and toxic chemicals for twenty years." "I have been run over by a car and hurt many times in car accidents and got represented by shyster lawyers paid off by insurance companies under the table. From all the neglect in accidents, abuse from teachers and public officials, my health and safety compromised. I have extreme pain and neuro difficulties. An entire body can not (compete in society?) because of my neck and (psychological?) problems."

EMG and nerve conduction studies were cited in a note dictated by R. Welch, M.D. on 2-18-85: "These findings are consistent with a diffuse polyneuropathy affecting both upper and both lower extremities."

In an evaluation at Washington University on December 19, 1985, by Joseph S. Babinski, M.D., the mental status examination describes no irritability and speech of a normal rate with low volume although somewhat excessive productivity with clear associations. Affect appeared appropriate and stable, and thought content was negative for suicidal and homicidal ideation. The patient was noted to deny psychotic symptoms, including hallucinations, delusions, and ideas of reference. "He does seem to have some generalized suspiciousness and exaggerated sense of self-importance. There are no

grandiose delusions or clear paranoid or jealous delusions. The patient was fully oriented. Intellect was above average. Memory is intact for remote, recent, and immediate recall." In the impression, diagnosis was deferred "but I suspect the patient may have a mixed personality disorder with possibly a combination of paranoid personality disorder and histrionic personality disorder. Additionally, the patient may actually have sociopathic traits, if not antisocial personality disorder, but his intellect is able to misrepresent the truth to such an extent that at present the history obtained does not support a diagnosis of antisocial personality disorder. It does not appear that the patient has schizophrenia or an affective disorder."

An evaluation by Edward L. Eyerman, M.D., dated March 5, 1986, concluded, "I think that this patient has very severe cervical sprain, he has something of a posttraumatic cerebral syndrome as well as he gets light-headed, nauseated and dizzy from head movements even now and sometimes his vision gets blurred. I think that he does have a peripheral sensory neuropathy, probably from combination of heavy metals plus previous alcohol intake. It is hard for me to say whether he has cervical radiculitiis or not, and I think he probably does not, but it is hard to be absolutely sure." Dr. Eyerman indicated that "The patient does have a history of some alcohol intake from about age eighteen to about twenty-three, but he says he hasn't had anything to drink in the past six years." He goes on to say, "Apparently he has been exposed to arsenic and antimony and several other heavy metals. The patient has had considerable work-up buy two neurologists in Belleville and Doctors Welch and Kinney, and he had an EEG which was normal, he has had cervical spine x-rays which were normal, he had magnetic resonance imaging study of the cervical spine which was felt to be normal. However, EMG's in the legs were abnormal showing peripheral neuropathy…"

An evaluation of May 15, 1986, by Sherman Sklar, Psychologist, concluded that the patient had a mixed personality disorder with narcissistic and paranoid features. Sherman Sklar's report included the following excerpts: "The client's MMPI profile shows him to have a rather negative view of other people, that he's suspicious and distrustful of others' motives toward him. He anticipates conflict, anticipates that he will somehow be victimized by others, so that he maintains a constant vigilance and places significant barriers between himself and others in order to protect himself from anticipated harm. This type of complex of attitudes makes the patient prone to a great deal of attention and to keep him on a constant edge of anger for his hostility, is easily stimulated and expressed in a "righteous cause". The client's view of himself as being in an unfriendly environment causes him to focus on himself and his protection to the point where his egocentricity is a dominant feature…." Under mood and affect he was noted to be cheerful and friendly in his interaction with no sign of anxiety, depression, or hyperactivity. Under speech it was noted that there were no signs of a thought disorder. His thinking was described as relevant and his associational process appropriate. However the recurrent themes of conflict and some grandiosity in his thinking were noted. Under thought process, it was noted that there were not any delusions or confused thought processes, it was noted that there was some grandiosity in his thinking where "Every little thing he was engaged in became some kind of major product." A quote states, "For example, in response to the question what his past work activity was, he said

that he had done lawyer work, had done doctor work, was a book writer, and worked for the army corps as an engineer." In discussing these in detail, the patient described his doctor work as relating to work in childcare work or as a custodian; his lawyer work had to do with some of the legal battles that he is involved in from time to time; his book writing work involved thoughts about compiling stories which he will give to a writer which will make him rich; and his work with the Army Corps of Engineers seems to be related to his attending meetings as a private citizen. "It is this flavor of grandiosity that pervades his thinking about his life experience." Under orientation, he was noted to be appropriately oriented to person, time, and place: "He did not show any lapses in reality testing". He showed ability to describe current events appropriately, although there was a description of some of the grandiosity of his thinking in being involved with this. He indicated a good general fund of information. He had great difficulty in doing serial sevens backwards, and he couldn't go backwards from one hundred at all. His responses to proverbs were described as appropriate in that he was able to appropriately explain all of them, described as doing fairly well on similarities and differences with some problems. The diagnostic impression was that of mixed personality disorder, narcissistic personality disorder, and paranoid personality disorder.

On June 24, 1986, an administrative law judge, Mark A. Brown indicated, "The claimant has been disabled since December 19, 1985 under section 1614 (a) (3) (A) for the Social Security Act and the claimant's disability can be expected to last for twelve continuous months." He noted that the application had been filed on December 13, 1984. Also in this opinion he noted that in various evaluations the patient had denied any history of alcohol abuse and stated no alcohol use for four years prior to 1985.

A disability examiner (TAS) and physician reviewer (LC) in a March 24, 1989, note indicated that he had initially been found to be disabled because of asymptomatic polyneuropathy of the lower extremities, cervical strain, and a mixed personality disorder. At that time it was noted that the patient indicated that he was still unable to work because of a chronic sprained neck, blurred vision, posttraumatic cerebral syndrome, tortacollis, diffuse polyneuropathy of the upper and lower extremities, nerve damage, lumbar spine spur formation and interior lipping, personality disorder, paranoia and headaches. It was also noted that the patient stated that he had a broken left foot, sprained left knee, and suffered from more stress.

In an April 5, 1989, request for reconsideration of disability cessation the patient wrote: "I am accusing SSI of deceptive acts and fraud, refusal to give me copies of doctor reports, refusal to reset doctor appointment with non-abusive doctor".

In a letter logged May 1, 1989, the patient wrote, "I, Russell Weston, am asking for a complete copy of my entire file concerning my SSI disability. I am accusing SSI of deceptive acts and fraud, also I'm assessing SSI a $500.00 fine for deceptive behavior and fraud" (some words were respelled for this presentation for clarity).

12/8/89: Evaluation by Barbara G. Kuhlengel, M.D. Psychiatrist:

Understanding and memory were described as not significantly limited. Sustained concentration and persistence were considered not significantly limited for the ability to carry out short and simple instructions, as well as detailed instructions, and the ability to make simple work-related decisions. The ability to maintain attention and concentration for extended periods was considered moderately limited. The ability to perform activities within a schedule and maintain regular attendance and be punctual within customary tolerances was considered moderately limited. The ability to sustain an ordinary routine without special supervision was described as "No evidence of limitation in this category". The ability to work in coordination or proximity to others without being distracted by them was described as moderately limited. The ability to complete a normal work day and work week without interruptions from psychologically based symptoms, and to perform at a consistent pace without an unreasonable number and length of rest periods was considered markedly limited. The ability to interact appropriately with the general public was considered moderately limited; the ability to ask simple questions or request assistance was considered significantly limited. The ability to accept instructions and respond appropriately to criticism from supervisors was considered markedly limited; the ability to maintain socially appropriate behavior and to adhere to basic standards of neatness and cleanliness was considered moderately limited. The ability to respond appropriately to changes in the work setting was considered not significantly limited as was the ability to be aware of normal hazards and take appropriate precautions and the ability to travel in unfamiliar places or use public transportation (all considered not significantly limited). The ability to set realistic goals or make plans independently of others was considered markedly limited.

Excerpts from the functional capacity assessment are: "This man has not been believed to be schizophrenic, but does display a lot of paranoia, hostility, and difficulty assessing reality." "He uses law suits as a means of inflicting pain on others, for what appear to be imagined slights in many cases. He's quite capable of organizing activity, as witnessed by the suits, but any work is interrupted by his quickness to assume others mean him harm, and that he needs to defend himself immediately."

During the early 1990's, the patient was noted to be helpful to his family in dealing with the problems associated with the flooding of the Mississippi river. At the same time, he was noted to be preoccupied with transmission and paint problems with motor vehicles, and in a brief period bought three different vehicles. During the early to mid 1990s he was often preoccupied with details of his automobiles' appearance and performance. At one point he became convinced that the color on the fender of his red pick-up truck was slightly off. He would examine automobiles with a jewelry glass, sometimes having them repainted unnecessarily. He became convinced that another truck had a problem with its transmission. He was said to be able to argue these complaints in a convincing way like "gospel". There was a litigious vein to the complaints.

His parents note that approximately 10 years ago the patient began to express increasing numbers of illogical ideas that seemed to worsen and worsen in intensity and frequency over time. For example "8-10" years ago he became "obsessed" around the details of an apparent kidnapping and remained preoccupied with this concern for years. He ultimately

concluded that the kidnap victim was Chelsea Clinton and developed an elaborate set of beliefs that defied normal logic and natural laws, including accepted concepts of time and aging. He developed an elaborate explanation to support his views. He began to redevelop his ideas about his own past with delusionally grandiose themes. Elaborate paranoid themes grew in prominence. These views persisted and grew despite overwhelming logic and factual contradictions. He sometimes acted on the paranoid themes by taking protective measures (sometimes bizarre) and grandiose themes that led others to feel harassed or frightened by his attention. He was said by his parents to become unable to comprehend age and time.

During the mid-1990's he developed the notion that he had secret information that made him a target of the government and he became terrified. He carried a satchel that he said contained these secrets. He felt President Clinton had sent Navy Seals to get him and that the President wanted him killed. He felt that rocking on the porch might be protective (make him a more difficult target). He was interviewed by the Secret Service.

An emergency crisis note from human support services of 4-21-96 indicates that the police and secret service were worried that the patient was delusional and may have made threats against the President. This problem started when Russell said that he saw a man in the field pointing a gun at him in the house for three days. Previously he had sent material to CNN about the Unabomber.

The patient's parents noted that in 1996 that patient seemed preoccupied with stories about the Unabomber and would sometimes stay up all night watching the television and drink coffee all day. He would express the belief that the cabin being shown was his own cabin, and the police were taking his things. Around this time, he accused his parents of planting a bomb in a cable box in his room.

On 5-20-96 he presented to the Emergency Room of St. Peter's Community Hospital in Helena, Montana, complaining of palpitations. The next morning on a radio talk show he had discussed a radioactive chip in his tooth. Later that day (5-21-96), he presented to the emergency room requesting toxicology screening and HIV testing to support his notion that he had been chemically poisoned by the government. Subsequently, he was hospitalized voluntarily from 5-21-96 through 5-22-96 at St. Peters Community Hospital in Helena, Montana. He complained of being harassed by numerous government officials, including President Clinton, being poisoned by an airplane, and having had a radioactive chip implanted in his jaw, which apparently allowed him to communicate with the ambassador of Russia. He was noted to be alert and cooperative, friendly and talkative, "without true pressure", with an incongruous affect in that he smiled regardless of the content of his speech. His speech was coherent and grammatical but tangential and at times loosening of associations were noted. He displayed "grossly intact orientation, attention, recent and remote memory and average intelligence". Bizarre and non-bizarre delusions were prominent. No homicidal or delusional ideation was noted. The physician had the impression that the delusional system had been present "perhaps 10 years". The diagnostic impression was "Schizophrenia, paranoid type (provisional diagnosis). He was not felt to meet commitment criteria and the patient declined medication and follow-up.

A report by the Secret Service Intelligence Division dated 5-28-96 discussed the patient. The report type was "harassment" and noted that the patient had left messages for a woman named Sandy Brown to the effect that she worked in the office of the President and he wanted to talk and meet with her. He then sent her flowers. In the interview the patient was described as delusional, making statements to the effect that this Sandy Brown worked for the office of the President and that someone in the National Security System had told him that this was her. The patient was said to have made mention of filing a criminal indictment on the President and that he thinks that the Clinton administration is trying to get him back for implicating the President in this indictment.

He purchased an expensive new suit in late July 1996 and traveled to the Washington, DC area to be interviewed for a job at CIA headquarters. Both a videotape and U.S. Attorney's office transcript were reviewed of an interview the patient initiated and participated in at the headquarters of the Central Intelligence Agency in Langley, Virginia in 1996. In the videotape the patient seemed engaged with the interviewer, although his facial expression is difficult to discern. He nodded frequently as he spoke. The affect did not seem euphoric or extremely unregulated. He used relatively few gestures. He sometimes motioned with his hand to make a point. There seemed to be a good deal of initiative and spontaneity. The speech was loquacious, but not classically pressured to a marked extent. There was a repetitious quality in which the conversation frequently returned to systematized bizarre delusional themes with paranoid and grandiose features. The patient seemed to be able to maintain his attention to the interview, and there was no obvious response to internal or external stimuli, or obvious marked distractibility. He seemed to have difficulty, however, shifting his focus from one subject to another.

Selected quotes from the content of the patient's conversation in the 1996 interview at CIA headquarters are: "Okay it started out"[pause] "first off in the Eisenhower Administration. I am a clone. Do you understand what I mean by clone?"

"No, that is called Scalar Magnetic Resonance" [pause] "it's what it's called. You've got to continue to write" [pause] "In other words, what it means is, is that when people are born before they're born, they are bombarded with a microwave." "Inside the microwave, there's a Scalar electromagnetic wave that is hidden inside that wave, which is" [pause] "you know, magnetic in nature." "And what it does is, is it essentially mutates the cells"; "that's what it does" [pause] "changes their molecular structure". My father was traveling on the highway. He was hit by that interactive beam. His radio became interactive. He was told to recover a prototype watch that had been" [pause] "stolen from the United States Government. And that was around 1952" [pause] "was when that was".

"In the movie that John F. Kennedy was making, there were three actors in the movies that were chosen"; "me, myself, which is Rusty Weston. Sandy Brown is her name. Her father is Dubutio Herb Brown (phonetic). He is a songwriter." "And a third actor in it is Bill Clinton."

“Say, how do you get a job at the CIA anyway? I’ve worked as an operative for the last thirty-three years”.

The videotape of the interview at CIA headquarters illustrates systemized bizarre delusional content and illogical thinking in the absence of apparent gross cognitive defects (such as disorientation), delirium, full manic syndrome, major depressive syndrome, or apparent intoxication.

The patient was re-hospitalized on 10-10-96 at St. Peter’s Community Hospital in Helena, Montana. He was referred by the Crisis Response Team after he presented to the police department requesting the arrest of the person he thought was threatening him. He claimed to have been injected with a drug that erased his memories, he noted himself to be a close friend of John F. Kennedy, claimed to be making a movie, claimed to have connections with the CIA and FBI, and that people were trying to harm him. He felt that four months prior, he had been injected with a needle contaminated with noxious substances. The St. Peter’s Hospital emergency room record dated October 10, 1996, indicated that the patient was evaluated by Alex Sirr, M.D. with the chief complaint described as a request for an AIDS and hepatitis test. He was said to have demanded blood tests because he felt that lab technicians five months previously had given him an infection in his arm while drawing blood. He was noted to have pressured speech and refused to leave the emergency room without tests. He requested the police and threatened to bring charges against the hospital. He said that he was the grandson of John F. Kennedy and involved in the assassination and investigation and federal charges would be brought to anyone who interferes with him. He was noted to be mentally agitated and pacing. The diagnostic impression was paranoid schizophrenia. At admission on October 10, 1996, John Tupper, MD diagnosed on Axis I: “Bipolar Disorder, Type I, manic, severe with psychotic features”. He added “rule out schizophrenia, paranoid, Type severe”. On Axis V he provided a global assessment of function (GAF) score of 20. He considered the patient an imminent danger to others, and commitment procedures were initiated. It was determined that he was an imminent threat of injury to others, and required psychiatric treatment in a structured facility.

He was hospitalized involuntarily from 10-11-96 to 12-2-96 at Montana State Hospital . The “Admission Psychiatric Evaluation” of 10/11/96 by Robert L. Jordan, MD provided an admission diagnosis of “Bipolar, manic with psychotic features” on Axis I and on Axis V: GAF=20. He noted that suicidal risk was denied by the patient; and that assaultive risk was also denied; but Dr. Jordan stated, “however, I consider this to be a definite possibility”. He also noted that the patient was afraid his medication might be poisoned.

Excerpts from the hospital progress notes indicate that during the first week of hospitalization he was alert, oriented and cooperative, but disorganized and tangential. On October 11, 1996 he was described as paranoid and delusional, with rambling speech. He discussed a plutonium isotope chip in his tooth that kept him alive. Pressured speech, grandiosity and delusions were noted. On October 12, 1996 he discussed being

programmed through the TV by the FBI including control via the air waves through a chip in his teeth. He described having gone to school with Clinton and a relationship with JFK. On October 13, 1996 he was described as resting quietly all night socializing well with peers, eating well. He refused bedtime medications. On October 14, 1996 he was described as up until around 2:30 AM and pleasant and cooperative. On October 15, 1996 he was described as loud and verbally threatening to staff. He attempted to force his way into an office, became combative with staff kicking and attempting to bite. He punched female and male staff in the face. He was described as delusional and paranoid. Later that day he was released from restraints and seclusion after committing to safety of himself and others. He subsequently refused medication. He was placed in full physical restraints and placed in seclusion and treated with haloperidol 10 mg and lorazepam 2mg intramuscularly. On October 16, 1996, he was noted to have underlying tones of anger, and to behave curtly and abruptly. He responded to questions. He was described by a different writer as friendly and cooperative, played cards with a male peer, and "no behavioral problems were noted". He took his medications. On October 17, 1996, in a "Petition for Long-term Guardianship," Michelle Moran, MD, wrote the following under the heading "Recommendations": "Patient is refusing prescription medications . He is clearly dangerous, yet no order to treat was provided by Helena courts. He presents an ongoing danger to self and others and is incompetent to make rational decisions regarding his future welfare. This is an emergency situation". Under mental status examination he wrote: "In general he is stubborn and controls the conversation. He is unwilling to negotiate or reason and is very fixed in his beliefs. He is well-oriented. His speech is rapid and with pressure. He is moody, easily irritated, defensive, and argumentative. His thought content is notable for delusions, paranoia, and grandiosity, although the form is linear and goal directed." His Axis I diagnosis was Schizoaffective Disorder, Bipolar Type. On Axis V: global assessment of functioning (GAF) was described as "15".

The "progress notes", nursing staff notes, medication records and a discharge summary dated December 3, 1996, from Montana State Hospital described the following additional information relating to his medication regimen and clinical status: on October 11, he was prescribed Risperdal 2 mg po bid; Depakote 500 mg bid; with Haldol 10 mg prn, Ativan 2mg prn. On October 12, he was noted to refuse his Depakote saying it gave him a headache and his Risperdal because it made his heart pound. On October 15, in the context of a physical altercation and verbally threatening behavior he was given Haldol 10 mg IM, Cogentin 1 mg bid. On October 17, Risperdal was discontinued. ("Nurse's Medication Notes" indicate he refused Risperdal 2mg on 7 occasions between October 11, 1996, and October 15, 1996, inclusive.) He continued to express the belief that a government agency was trying to kill him and exhibited high energy, grandiosity and pressured speech. Haldol was discontinued on October 28, 2000, in the context of apparent akathisia and insomnia. (The Medication Administration Record described results of apparent prn use of Cogentin in response to complaints of "EPS" or "restlessness" in mostly positive terms such as "good results", "helpful", "it really helps", "no further co ".)

On October 28, 1996, Trilafon 8 mg po q AM and 16 mg po q 2000 were ordered. On October 30, 1996, due to complaints of sedation and dizziness, Depakote dosage was

distributed as 250 mg q AM, 250 mg q noon and 500 mg hs. Subsequently, he continued to complain of being nervous, antsy and exhibited other restless and pacing behavior. The effects of Cogentin were noted to be apparently transient. The patient also complained of being tired and dizzy. He complained of stiff feelings. Some cogwheeling was noted. He was noted to be pleasant and cooperative and aggressive behavior was noted to be absent. It was noted that the delusions about the CIA and Clinton, for example, remained. On November 8, 1996, his hands were noted to be swollen and edematous. The patient noted that that this had occurred in the past with and without medication. However, the Trilafon was subsequently discontinued because it was felt that it could have been involved in the swelling. The last dose of Trilafon was on November 11, 1996.

Loxitane 10 mg po bid was begun on November 12. A November 12 progress note says: "He believes his mental health is more important than the CIA operations. They leave him money in the candy box on the refrigerator." Staff noted good eye contact and that the patient seemed to enjoy discussing his delusions. On November 12, it was noted that he attended all scheduled groups and activities and had recently started a job in the warehouse... "at which he is reported to be doing well". "Patient stated in group today that he is bipolar, but indicated that he has been aware of this for some time and initiated it on his own, which is not the case. He has made no threats of harm or been physically aggressive since early in the hospitalization. He remains delusional and will discuss his delusions accompanied by pressured speech if encouraged, but does not do so spontaneously as much as formerly. The fact that staff believes his beliefs are delusional and the product of a mental illness has been discussed with him –he does not become angry or agitated, but rather explains in a slightly condescending and grandiose way how he understands that we believe this, but it is not so. Pt is generally improving " (Eileen P. Lapeen, MA, Psychologist).

On November 19, 1996 it was noted that he discussed how upsetting the Valmeyer, Illinois flood was for him. "He agrees to take meds after D/C. Good eye contact and calm, cooperative, pleasant, demeanor described. Described as talkative, without pressured speech, euthymic with linear and goal directed thoughts." "Less intense and more realistic thoughts, goals with ability to accept conflicting input." "Doing well on Depakote, Loxitane, Wants to read about PTSD, buy a book. Stable for DC". (signature appears to be Michelle Moran, MD).

On November 22, 1996 it was noted by Ellen P. Lappin, MA that "Russell continues to do well. Is pleasant and cooperative with both staff and peers. Takes meds willingly. Personal hygiene good. Performs well in work and school placement. Is reported to sleep well. Remains able to discuss his delusional system without becoming angry. Voices no threats toward anyone, specifically denying thoughts of harming anyone when asked. His delusional system, however, remains intact." A note of November 25, 1996, nursing staff noted, "Russ talked about dentists putting a microchip in his tooth, was reminded of his tx plan to not obsessively speak about it. He did not get defensive or aggressive, was easily redirected." On November 26, 1996, it was noted that he was "calm, cooperative, euthymic, not psychotic. Reports less mood lability on meds". (signature appears to be Michelle Moran, MD).

An employment evaluation of November 26, 1996, noted that he "settled in quite nicely to job assignment at the warehouse. Seems to enjoy the entire operation. Has been very helpful to supervisor, helping to unload supplie , stock and setting up orders-Is friendly to others on job and has very good attendance." The November 27, 1996, weekly summary noted, "Russell continues to do well in all areas. Has been especially good this week in group therapy, giving good feedback to others. Attends scheduled activities, … and is helpful, cheerful…. He has made no threats; behavior is appropriate as is affect." (Ellen P. Lappin, MA).

The Montana State Hospital discharge summary indicated an Axis I discharge diagnosis of Schizoaffective Disorder, Bipolar Type. On Axis V, GAF at discharge was 50 (up from 15 on October 17). He was discharged on December 3, 1996, with a 31 day supply of meds. He had expressed plans to stay for 3-5 days in Rinini, Montana to close up his cabin for the winter then drive to Valmeyer, IL, to the home of his parents, before returning to Montana in the spring. Appointments were made at the Waterloo, IL, MHC on December 13 and December 30.

At his follow-up appointment on December 13, 1996 at Waterloo Health Clinic, the patient was noted to be uncooperative, very bizarre, and paranoid. He was not viewed as presenting an immediate risk to others. The patient concluded during this visit that his follow-up treatment was not court-ordered and declined to have further follow-up. He was described as very bizarre and paranoid. It was noted that he taped the session. "He is taking medication; he is able to get that from a doctor outside of our agency, and he is not a harm to himself or others at this point." (However the record does not indicate what evidence formed the basis for the conclusion that the patient was taking his medication. That is, it is unspecified: the conclusion is based on the patient's report rather than a more objective measure such as a count of pills not yet used).

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In a "home video" filmed on December 25, 1997, the patient and his parents, sister, brother-in-law and grandmother are seen opening Christmas day presents and having Christmas dinner. The patient's affect seems somewhat blunted and the expressive gestures somewhat muted. No affective lability is noted. The patient seems somewhat emotionally withdrawn from the proceedings. However, he responds appropriately when given gifts or asked questions. His rapport with the remainder of the group seems to lack emotional depth and to be relatively detached. In the meal he appears preoccupied with the meal itself, rather than interacting interpersonally with the family at the table. His appearance appears to be relatively kempt. The interpersonal interaction by the patient seems somewhat limited and barren in contact. At times he seems to respond to receiving gifts in a warm and cheerful manner. His affect does not appear to be elevated, manic, or inappropriately cheerful, nor does he appear to be depressed, hopeless, or downcast. His speech is relatively scarce and limited to a single or few phrases. No mannerisms or posturing are noted. He does not seem particularly tense. Overt delusional, grandiose, hostile, threatening, or suspicious content is not evident. One gift he received was apparently gun ammunition.

The following are excerpts from notes taken from Mr. Weston's cabin:
"The Assassination of President John F. Kennedy: November 22, 1963". The byline read, "By Russell E. Weston, Jr., favorite son of John F. Kennedy" "Rusty". Excerpts are as follows: "My side of the story starts in May of 1963 with the offer of a movie part. The president is backing the movie along with --- Oil Company. The president states that when he was born, his mother Rose Kennedy heard the angels sing. My Dr. Andrew R. Esposito, stated that when I was born he heard the angels sing. The president was searching, nationwide for such children.

"They were upset, Billy had developed interactive TV system, and the government had confiscated the system, and had paid Billy several thousand dollars for it. Police said that he had been selling cocaine to Coca Cola to pay for expenses involving the TV system. He talked about how the system worked, and then about the graviton. Also about how the violin produced a signal that a TV could pick up. Then he talked about stroking a ruby also produced a TV signal. He said that he was mad about the confiscation of his work and he would kill the president for doing so. He said that he would bring in the man the same way he was getting the coke."

"These documents were the plan for interactive TV, Scalar Electromagnetic Technology as used in radar and microwave transmissions. Also biological weaponry used with microwave transmissions, electromagnetic machines that can influence the brain and nervous system directly. This included the Lida machine can induce a catatonic state into a mammal such as a man or cat, etc.

"The same technology is used to induce dreams, which are not of our own minds, placed there kind of like sending a TV picture to your television."

"Within a very short time, I started not being able to sleep, I became very worried about communists possibly trying to kill me. Then one day I became violently ill, ran a very high fever with "dilioutions." I was given the ion poison in the food, causing a thyroid storm."

Another note was entitled "The Assassination of John F. Kennedy:

" Facts that Pertain to the Assassination by Russell E. Weston, Jr." : "In May of 1963, I was chosen by John F. Kennedy, President of the United States of America, to act in a movie called 'My Favorite Roses'. I was six years old. My cousin is Ralph Weston, a famous war hero from the Korean war. "

"On November 16, 1963 at 1:30pm, Bill Clinton and his stepfather came to my grandfather's television repair shop in Murphysboro, Illinois. They were very upset, the federal government had compensated Bill's interactive television system, and was putting an end to Bill's buying cocaine and selling it to Coca Cola.
Bill Clinton and his stepfather were reported to be in Dallas, Texas shortly before the assassination stating, the same story, by…"

In May of 1998, the patient left home to return to Montana, then returned home again six weeks later. He continued to decline to take his medications, and expressed no insight that he was ill. His parents apparently felt that he had left Montana because he felt land mines were planted around his cabin. In the week prior to July 24, 1998, Mr. Weston was said to be preoccupied with bizarre delusional beliefs, involving "Black heva" and cannibalism. He felt that some of his neighbors were cannibals and cooking a young girl, for instance.

Around that time, while living at his parent's home, the patient apparently became concerned about a number of stray cats living on the property. He apparently received a financial offer to remove some of the cats, and shot several of the cats with a .22 caliber rifle. However, the patient's father apparently was fond of some of the cats, and had named some of them. This led to a difference of opinion within the family, and the patient was advised to find another place to stay within the next ten days. Very shortly thereafter, the patient left his home with a .38 caliber Smith and Wesson revolver and drove to Washington, D.C. He was believed to have left for Washington the night of July 23.

Sally Johnson, M.D.'s note of November 12, 1998 indicates that on July 24, 1998, at approximately 3:40p.m., the patient was alleged to have entered the east front entrance of the United States Capitol Building, and walked up to the U.S. Capitol police officer, Jacob J. Chestnut who was working in uniform at the magnetometer. The patient allegedly took out a handgun, pointed it at Officer Chestnut's head and fired it, hitting him in the head. He then ran past the magnetometer through a hallway, and was confronted by plain clothed United States Officer, John W. Gibson. Weston shot Officer Gibson, striking him in the chest. Officer Gibson was able to return fire before collapsing. Weston fell to the floor and was arrested by responding United States Capitol police officers. During the exchange of gunfire, a female bystander was also wounded. The United States Capitol police officers died as a result of their injuries. The patient was taken by ambulance to D.C. General where he underwent medical treatment for the wounds he received.

The patient is charged in a six-count indictment for behavior allegedly occurring on July 24, 1998, within the District of Columbia. Count one: On or about July 24, 1998 in the District of Columbia, Mr. Weston did willfully, deliberately, maliciously and with premeditation and malice aforethought, kill Officer Jacob J. Chestnut of the United States Capitol Police while he was conducting his official duties. Count two: on or about July 24, 1998 within the District of Columbia, Mr. Weston did willfully, deliberately, maliciously and with premeditation and malice aforethought, attempt to kill Officer Douglas B. McMillan of the United States Capitol Police while he was engaged in his official duties. Count three: on or about July 24, 1998 within the District of Columbia,

Mr. Weston did willfully, deliberately, maliciously and premeditation and malice aforethought, kill Special John W. Gibson of the Untied States Capitol Police while he was engaged in his official duty. Count four: on or about July 24, 1998 Mr. Weston during and in relation to a crime of violence for which he may be prosecuted in the Court of the United States that is the murder of Officer Jacob J. Chestnut, knowingly used and carried a firearm, that is a Smith and Wesson .38 caliber revolver. Count five: on or about July 24, 1998 within the District of Columbia, Mr. Weston during and in relation to a crime of violence for which he may be prosecuted in the Court of the United States, that is attempting to kill Officer Douglas B. McMillan knowingly used and carried a firearm, that is a Smith and Wesson .38caliber revolver. Count six: on or about July 24, 1998 within the District of Columbia, Mr. Weston during and in relation to a crime of violence for which he may be prosecuted in the Court of the United States, that is the murder of the special agent John M. Gibson, knowingly used and carried a firearm, that is a Smith and Wesson .38caliber revolver.

He was seen at D.C. General Hospital on July 24, 1998 at 19:46 in the emergency room. Multiple gunshot wounds to the chest and extremities were with transection of the femoral artery and vein, a fracture of the left femur, fracture of the right humerus and right radial nerve palsy. On July 24, in the emergency room he was noted to be alert and verbal. On July 27, he was noted to have been somewhat confused since extubation, requiring Haldol administration. Haldol was noted to initial control agitation. Psychiatric evaluation was attempted, but the patient was reluctant to answer questions, or give information apparently out of concern that it might incriminate him. Progress notes of August 5, 1998 indicated that he verbalized understanding of the care he was receiving and was alert and cooperative. For the most part the clinical notes describe him as alert and oriented X3, able to follow commands and cooperative. This is illustrated, for instance, in the physical therapy notes on 9-16-98. At discharge from D.C. General on October 10, 1998 he was described as able to voice understanding of instructions and information. A drug screen was apparently obtained on 7-25-98. On the report, were repeated references 'see separate report'. The separate report was not found in the materials I reviewed.

The patient was transferred to the Corrections Corporation of America (CCA) Correctional Training, Correctional Treatment Facility (CTF) in Washington, DC on October 10, 1998. Clinical notes indicate that he was oriented to time, place, person, and situation and cooperative on that day, but refused to answer many questions. He was noted to "be in a fair mood and affect". "He did not exude any looseness of association or delusions". The provisional diagnosis applied by the clinician on October 10, 1998 was Axis I: Dysthymia (300.4), Axis II (799.90). On October 11, he was described as oriented to person, place, time, and circumstance with normal affect and mood, speech normal in tone and structure. He was said to be cooperative with the interview, with normal motor activity. Mood was described as good. On October 12, he was described again as oriented to person, place, time, and circumstance with affect and mood within normal limits, speech normal in tone and structure. He did not endorse suicidal ideation. He claimed that he was experiencing no current thoughts of hurting himself, he stated that he was eating good, his mood was described as fair. The suicide watch was

discontinued, and he was put on "observation only". In another note that day, he was described as cooperative, normal motor activity, and very verbal with impaired concentration. On October 13, he was again described as having no looseness of association, or delusional symptoms, denying any change in mood since he'd been there, eating and sleeping well, with a provisional diagnosis of dysthymia. He denied suicidal ideation. He was described as oriented in time, place, person, and situation, with no abnormality in thought content and process, cooperative with normal motor activity, and it was noted that he "held good conversation". The description of the mood is difficult to read, but may be "jovial" mood. Over the course of October, he was generally described as cooperative, and seemed to speak to others. On October 17, 1998, he said "I didn't get to wash this morning, can you wash my other arm and my back?" He was described as alert and oriented, appeared polite, cooperative, thoughts organized and coherent, behavior appeared normal; no problems observed. On October 31, 1998 he was described as alert, verbal, responsive. Continued through November to be respondent to staff. On November 8, 1998, for instance, he remarked, "Good morning, nurse. May I have the bedpan?" He was considered alert and oriented X3, lying in bed without distress. On 11-29-98, he was quoted as saying, "Good evening, how are you?" He was noted to be sitting up in bed, and reading a novel, alert and oriented X3, not in distress. He frequently was noted to say "Good morning" or "Hello". He was described on 12-30-98 as alert and verbally responsive; he said, "Good evening", for instance. On January 10, 1999 for example, he was quoted as saying "Hello", and to be alert and verbally responsive, sitting up in bed, reading. On January 28, 1999, he was quoted as saying, "I'm getting ready for court today", "Good morning", and he was described as alert and oriented X3.

A videotaped interview between Dr. Philip Resnick and the patient at CTF on January 31, 1999 was reviewed. In this interview the patient appears alert, relatively well groomed and well shaven, he appears to make good eye contact through most of the interview, and engage the examiner, although the examiner can not be seen on the film. There is modulation of his speech as he becomes emphatic, and one can hear his local accent. He appears very spontaneous-he smiles, changes position, he appears to think and reflect on questions, there are some gestures. He appears to have an animated mood, and it does not seem to fluctuate a great deal except in its intensity of animation. He does not appear sad or overly concerned when speaking of matters that are of gravity or consequence. There is a narrowing of the range of fluctuation in his affect. At points in the interview he becomes more animated and energetic, repeatedly seems to smile at the interviewer and engages him. He is occasionally difficult to interrupt, but exhibits relatively little severe classic speech. At the end of the film he appears to react warmly to the interviewer, and attempts to shake his hand. None of the emotional concern or gravity one might expect given the content expressed by the patient in this situation is seen.

He says that he does not perceive himself as mentally ill. He discusses the Blackheva, and cannibalism. He expresses the belief that various people involved in the trial, including the judge, are involved in a conspiracy. He states that he went to Harvard, and

describes time sweeps, the Ruby Satellite System, and a plethora of systemized delusional material.

He notes that if the death penalty were imposed, he would get controlled of the Ruby Satellite System, he does not show a great deal of concern when capitol punishment was discussed. He said that he would only die for three or four seconds, and end up in the great safe of the U.S. Senate where the Ruby Satellite System is controlled.

He discusses the judge giving up control to him, and that he would go easier on the judge.

He discusses the Ruby Satellite System, and time sweeps, time moving forward and reverse, that the system works on a computer system. In regard to capitol punishment, he notes that the system knows that if he were to become deceased, a certain computer program would kick in, that time reverses and sweeps him back to a point where he is no longer deceased, that a transporter system becomes involved and puts him back in control of the Ruby Satellite System. It is noted in the film that this is where he was headed when he went into the Capitol. It is noted that in death he achieves his goal and gets to the safe in the Capitol building and gets control.

He notes that Washington, D.C. is virtually at the point of annihilation, because of the potential effects of the reverse time sweep destroying elements of time that would destabilize the earth and lead to earthquakes that could flatten Washington, D.C.

He notes that this is not the first time he has been charged with these crimes, and what happens now, has happened millions of times before.

When discussing whether the two capitol policemen are permanently dead, the patient notes that it depends on who has control of the Ruby Satellite System. He initially says yes, they are permanently dead. When challenged and reminded that he had initially said something different before, he says that they are being criminally prosecuted for cannibalism, that the Ruby System means they are not permanently dead. He notes that he makes up the rules of the system at his discretion when he has control of the system by deciding if people are dead or not.

The patient is illogical at times, there are non-sequitors and loosening of associations between concepts at times, he expresses intensely systemized grandiose and paranoid delusions. He is somewhat animated and engaging.

On February 3, 1999, before being transferred to the Springfield, Missouri Medical Center for Federal Prisoners, for a forensic evaluation, he was described as alert and oriented, and verbally responsive.

At the U.S. Medical Center for Federal Prisoners Springfield, Missouri staff noted on February 3, 1999 that the patient was unwilling to share much back ground information, psychiatric history, or anything about his legal situation, stereotypically replying ‘On the advice of my lawyers I have no comment’, or similar phrases. He related that he was

willing to discuss his injuries. He would not answer questions about hallucinations or suicidal ideation. He did reply in the negative when asked about homicidal ideation. February 3, 1999 mental status examination by Dr. Wolfson described adequate grooming and hygiene, eye contact normal, motor activity seemed generally normal, given the physical limitations. Affect calm, with a question of affective blunting raised. He was noted to connect relatively well with a nursing staff member who questioned him on medical interviews, and displayed some cheerful and friendly behavior. Flow of thought was described as logical and sequential and the information that he did share was considered coherent and relevant. He had no apparent difficulty in comprehending others conversations. He appeared fully oriented.

A physical exam of February 4, 1999 by Richard R. Swena, M.D. and Antonio J. Alburquerque, PA indicated impressions of status post multiple gunshot wounds to the upper and lower extremities and right chest with limited range of motion to the left leg, radial nerve damage and wrist drop of the right arm, atelectasis at the base of the right lung by chest x-ray, with currently normal breathing, and tinea corpus.
Laboratory evaluations indicated blood chemistries and a thyroid test within the normal range. Hematologic testing revealed a mean corpuscular volume (MCV) of 94.2 and a nonreactive RPR test for syphilis.

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In a psychiatric status report completed by James K. Wilson, M.D. on February 24, 1999 it was noted that the patient was polite and responsive to nursing and correctional staff on subjects other than his psychiatric background, or about his case, and that he consistently differentiated medical discussion which he participated in, from psychiatric discussion and that, with effort, he could be persuaded to discuss neurological questions that could be distinguished from psychiatric questions. In regard to many questions the patient would say either, “Upon the advice of my attorneys I have no comment” or something along those lines.

Mr. Weston was discharged from the U.S. Medical Center for Federal Prisoners Springfield, Missouri on March 2, 1999. Dr. Wolfson who had supervised the patient’s care there gave the patient a diagnosis of probable schizophrenia, chronic paranoid subtype, axis II was deferred with the possibility of a mixed personality disorder with schizoid and paranoid features.

A second videotaped interview between Dr. Resnick and the patient filmed at CTP on March 27, 1999 was reviewed. The patient notes that he declined to talk with Dr. Wolfson, Dr. De Prado, or Dr. Gunta because he considered them to not be legally licensed , and to be involved in illegal black market activities. He includes Judge Sullivan in a related conspiracy. He no longer will talk openly with Dr. Johnson for related reasons. He discusses scalar electromagnetic concepts, time sweeps and cannabalism. He discusses his legal concerns should he discuss thecase with the wrong people

In a report dated April 6, 1999, Deborah K. DePrato, M.D. noted that she attempted to interview the patient on February 21, 1999 at the U.S. Medical Center for Federal

Prisoners in Springfield, Missouri and on March 3, 1999 at the United States Courthouse in Washington, D.C. She noted that the patient responded that on the advice of his attorneys, he would not speak to her. She noted that due to her limited interactions with the patient, she could not render an opinion of his current medical state. She noted that his current differential diagnosis would include Delusional Disorder, Persecutory Type, Personality Disorder (Schizotypal/Paranoid) and Schizophrenia, Paranoid Type. In her last two sentences, she stated that "In the event that the court may find Mr. Weston incompetent", it is significant that Mr. Weston responded well to medication during his one psychiatric hospitalization for treatment. This would indicate that his symptoms would again respond to medication, which would be an important aspect to consider in his ability to be restored to competency.

According to a report previously submitted by Dr. Sally Johnson, an entry of March 18 1999 in the guards logbook noted that up until that point the patient had spent much time reading the bible.

On May 5, 1999 Mr. Weston was admitted to the health services division of the federal correctional institution in Buttner, North Carolina. He was noted to have been admitted to seclusion. The patient was noted to generally answer questions relating to his psychiatric condition with the quote, "I refuse to answer on the advice of my lawyer". Case review of the hospital records indicate that the patient generally took medical medications as prescribed, allowed himself to be given injections of anticoagulant, and that the nurses generally wrote "N" for no on the suicide/homicide/ideation/gesture part of the mental status. He generally appeared guarded, and displayed little content in his conversations with staff. He frequently used head gestures to confirm yes or no answers.

A letter written on May 20, 1999 from Sally C. Johnson, MD to the Honorable Emmett G. Sullivan indicated that Dr. Johnson's opinion remained that Mr. Weston was currently suffering from chronic paranoid schizophrenia and was overtly delusional, manifesting both paranoid and grandiose delusions. She noted that his delusional system seemed to continue to expand. In early May 1999, Dr. Johnson noted that she had seen Mr. Weston and he had expressed delusional ideas about medication treatment, including his belief that he had a secret agreement with the Department of Defense and the CIA about taking medications. A hearing to address the possible administration of involuntary medication occurred on 5-14-99, and the hearing examiner was said to have determined that Mr. Weston met the criteria for involuntary medication. Mr. Weston was said to have expressed his wish to appeal the decision. On 5-18-99, Warden James responded by denying Mr. Weston's appeal. Dr. Johnson noted that in a 5-20-99 individual interview with Mr.Weston, he indicated that he would cooperate with medication if his attorneys advised him so, and if it was so ordered by the court. At the hearing of 5-14-99, regarding involuntary medication administration, the patient was stated to say, "On the advice of my attorney, I can not make any comments or statements or sign any documents". The patient was noted to refuse to provide any other information. The patient was noted to be a forty-two year old single, white male court-ordered for 4241 (D) for restoration of competency. The summary of the history noted that the patient had claimed to be a General in the military or have advanced academic degrees which were

all unfounded. He had been receiving disability for mental illness for ten years. His family and collateral records indicated he has suffered from mental illness for approximately the past twenty years. In 1985, he had his first major mental health evaluation which showed evidence of paranoia and narcissism. He moved between his family home in Illinois and Montana, primarily supported by his grandmother financially. No significant substance abuse history. The psychiatric evaluation in 1999 found grandiosity/paranoia. In 1996, he became more preoccupied with the Unabomber and accused others of plotting against him and trying to harm him. He was evaluated in April of 1996 for possible threats against the president. A month later he was voluntarily admitted to a psychiatric hospital in Helena, with marked persecutory delusional ideation regarding supposed harassment, poisonings against him, with focus on a supposed implant placed in him by a dentist, also bizarre delusions about President Clinton. He was first diagnosed with schizophrenia at that time. In October of 1996, he was readmitted to the hospital in Helena with extensive bizarre paranoid ideation with threats to harm others. He was committed to a state hospital and treated with Haldol, Risperidone, Depakote, and Ativan. He had to be involuntarily treated with Haldol, and was, at least at one point, assaultive to staff. He was discharged December 1996 on Loxitane and Depakote, but remained noncompliant afterwards. He began to correspond with women in the community in Helena based on his delusional beliefs. He filed lots of complaints with law enforcement officials about supposed harassment. He also developed an extensive delusional system regarding the "Ruby Satellite" which he claimed to have invented. He slept under aluminum foil to protect himself from radio waves. In July 1998, Mr. Weston's delusional ideations spread to include beliefs of "Blackheva" (a disease which causes people to rot) and cannibalism. He abruptly left the Midwest and traveled to Washington, DC where the alleged even occurred on 7-24-98. He was charged with homicide and assorted other charges. The clinical notes indicate that the proposed justification for medication was that paranoid psychosis rendered him dangerous as well as not competent to stand trial. It was noted that no other intervention had been effective. The patient's psychiatric condition was felt to be responsive to antipsychotic medication. This was report was signed by Brian Herbel, MD.

Seclusion twenty-four hour watch records indicate the patient has been observed every fifteen minutes from May 1999 through at least July 2000.

Delusions were frequently indicated to be present in the daily nursing notes in a checklist format. Flat affect was periodically noted. Frequent episodes of declining verbal response and eye contact were noted. An example of a notation is "no response, staring straight ahead", sitting in bed…staring at me. He did not respond verbally. The officer states he was talking earlier in the day. He was not infrequently mute but at other times discussed such topics as NATO and "Bozo Figures", the "Blackheva", "Zombie". He discussed the notion that staff were escaped federal prisoners. He discussed needing to be tried by the senate, because he was a General, that he was doing his job so nothing will happen to him.

Review of the clinical documentation suggests a trend toward being less communicative and interested in matters outside himself.

On an occasion when he was asked if he wanted any reading material, he did not respond verbally or non-verbally, he was noted to be in no apparent distress, but later said, “You are all prisoners. My father is a Commander, and if you force that injection on me, you will be charged by NATO. In a very assertive voice, cross-handed, then refused the Heparin injection.

July, 2000, lab reports at Butner FCI indicated tests of hematology, HIV, syphilis, blood chemistry, and erythocyte sedimentation rate to be unremarkable. Urinalysis remarkable for trace ketones and trace protein.

The patient was transferred to the CCA, CTF in Washington, DC in relation to further court proceedings. An admission evaluation of July 21, 2000 used the diagnosis of paranoid schizophrenia. Review of the clinical record through October 24, 2000 indicated that the patient was generally considered alert and oriented. At times he was described as “alert and verbally responsive” and noted to say “hello”, “thankyou” or smile as he spoke. On one occasion he was noted to have stated “how are you?” He was noted to have asked for a bar of soap. At other times it was noted that the patient declined verbal communication. There are no descriptions of more extensive conversations by the patient. On one occasion the patient was noted to “be awake all night”. On September 12, 2000 his blood pressure was noted to be 110/68, pulse rate approximately 70 bpm, respiratory rate 20/minute.

I conducted three meetings with the patient in his room at CTF. The meetings totaled approximately three hours.

September 24, 2000:

In the first meeting I was introduced to the patient by his defense attorney, AJ Kramer. Elisabeth Prochnik, LCSW participated in segments of the interview. The patient was alone in the room upon entry. An anteroom led into the room. There was a hospital bed intersecting a wall at a right angle. On one side of the bed was food. On the other side were blue slippers and a walker. The room had a camera in one corner aimed in the general direction of the bed. A vertical frosted window was on the wall parallel to the bed. The walls of the room were a bland cream color. At the entrance end of the room was a room containing a steel toilet and sink and a shower. The door to the room was locked, contained a glass slit, and led to the anteroom. The anteroom door was labeled from the outside :”Isolation”

The patient appeared alert initially and animated. He quickly indicated verbally that upon the advice of his attorney he would not respond to questions. Subsequently, he did not engage me or make eye contact or attempt to verbally respond to anything said. It was explained to him my purpose in evaluating him and he was offered the court order to read. He did not respond to the request. He declined to speak again including declining discussion of any manner. Attempts to engage the patient ranged among numerous

subjects including, for example, his general status, psychiatric status, orientation, physical and medical status, food, current events, and other matters considered to be neutral. He sat in bed at an angle of approximately 120 degrees. His arms were crossed. He closed his eyes throughout the interview, at times appearing to squeeze his eyelids tightly. His eyelids fluttered actively through much of the meeting. He did not look about the room as if with responding to auditory or visual hallucinations. His hands were not tightly closed or like fists. He covered his body with a sheet and blue blanket up to approximately his pectoral muscles. His general appearance was unkempt especially his hair. He had an unkempt appearing beard. No body odor was evident. After his response to m entering the room he displayed a constricted affect with no indication of elevation of mood or depressed mood or other evidence of sadness. He displayed no verbally or physically threatening behavior.

A brace was in place on his right hand. A mild resting tremor was noted of his head. After approximately 40 minutes he relaxed the posture of his arms. During questions about whether he had any regrets about past behaviors he put his head in his hand and appeared thoughtful. He shifted his posture when asked whether he had thoughts of harming himself.

October 5, 2000:

I met with the patient alone. During my time in the cell the patient sat up with his head in his hand and arms crossed. I began the meeting by reading the court order explaining my role and offering to allow him to read it. He declined to read it. The patient appeared to have an alert sensorium and to hear my speech. However, he declined to respond to me with any communicative gesture including speech throughout interview. He made no eye contact, appearing to actively avoid eye contact. He appeared to attempt to focus his attention off the interviewer and at times appeared to squeeze his eyelids shut. He appeared to be concentrating on and preoccupied with internal mental activity and to be attempting to shut out my questions.He did not engage me in any manner. He appeared to react to some statements by changing position or moving a limb. The posture looked tense and uncomfortable. He refused to discuss any matter including current events, the food he receives, his physical condition, or any aspect of his mental life. He appeared unkempt. The interaction was qualitatively similar to the first interaction. Immediately upon my exiting the room he quickly resumed a lying down posture in his bed.

The third meeting with the patient was conducted on October 24, 2000.

Prior to the interview the patient was observed on the nursing station video monitor to be alert, apparently comfortable, lying in bed with his eyes open. He appeared to focus his attention on “picking” at the skin on his head, arms, and chest. The patient resumed this behavior after the interview. Nursing staff indicated that this was how they felt the patient spent most of his time.

Elisabeth Prochnik, LCSW participated in the third interview. The patient sat up as we entered the room and assumed a posture similar to that of the previous two interviews.

Upright, leaning forward, head in his left hand. His eyes appeared to be squeezed tightly shut. His eyelids could be seen fluttering through most of the interview. Upon entering the room I read the court order describing my purpose in being there and offered it to the patient to read. He did not respond to this offer. He did not verbally communicate with me during the meeting. His posture appeared tense. He appeared intently alert and gave the impression of actively processing but attempting not to react to my questions. I asked him about neutral, medical, and psychiatric topics. I explained my purpose and requested his input into my evaluation. He appeared exceedingly guarded and tense throughout the meeting. As I exited the room he glanced in my direction, made very brief eye contact with me, then turned his head away and closed his eyes.

His appearance was poorly kempt. There was no body odor detected. On his right arm, there appeared to be scattered small 5mm or so mildly erythematous circular areas.

The impression created by the three meetings was consistent with past experience with guarded, regressed, autistic, negativistic behavior among the more severely ill paranoid schizophrenic patients.

Ms. Celeste Brown, Assistant Director of Nursing at CCA, CTF, Washington, DC was interviewed on October 24, 2000: She emphasized the patient's low output of verbal communication and little eye contact.

Ms. Martha Brown, licensed practical nurse at CCA, CTF, Washington, DC was interviewed on October 24, 2000: She noted that she had known the patient during his previous stay there. She noted that the patient generally smiles and nods when he sees her, directs her where to place things in his room and is generally alert. She says it is difficult to compare his mental status now to his previous stay because there is much less opportunity for interaction now. During the previous stay she says he was provided "total care" in contrast to a much lesser degree of active involvement by staff currently. She notes however, that he read his Bible and discussed it before. She has not observed this during the current stay.

Ms. Margaret Green, licensed practical nurse at CCA, CTF, Washington, DC was interviewed on October 24, 2000: She noted that she had known the patient during his previous stay there. She noted that the patient was polite, thanked her, made eye contact, and directs her where to put things. He says little more. He does not appear to talk as much as during his previous stay. She also indicated that this might be related to the different level of care provided currently. He eats his meals.

Dr. Nwosu at CCA, CTF, Washington, DC was interviewed on October 24, 2000: He indicated that his current level of involvement with the case was sparse.

Interview with Sally C. Johnson, MD by telephone on October 3, 2000:

Dr. Johnson expressed the belief that the patient remained extremely dangerous. She noted that the delusional system that had led him to commit violence in the past had apparently not changed. She noted that he had apparently widened that delusional system and brought more people into it. She noted that he might regard those around him as adversaries in relation to the mission he perceives for himself within his delusional system. She noted that he had taken on a threatening demeanor on occasions when staff were apparently incorporated into some of his delusional beliefs. She noted that his concept of death in relationship to time might weaken the notion of permanency of death, and therefore its consequences. She felt that it was plausible that he would strike out against people if it fit certain rules in his delusional system.

Regarding the patient's clinical course since incarceration, she felt that the patient had been initially verbal and interactive, and had the significant ability to relate to other people, which had gradually been lost almost entirely over the course of his incarceration, although there had been some fluctuation. Despite the psychosis, he had been able to interact broadly around issues and needs separate from the delusional system. The delusional system and become broader with more people pulled in, his affect had become flatter, he had become socially withdrawn, apathetic, less attentive to physical needs. Initially he seemed to be able to consider his legal situation-he no longer displayed the capacity to consider it. It was appearing that he became disinterested in self-care; kept his head covered and would not get out of bed, and resisted routine care of himself; there has been some improvement in that. His interest in interface with his family has declined.

Regarding the effect of seclusion, she felt that his symptom picture might have worsened as a result of isolation of seclusion. Even though there was a person by the door at times, he never chose much to speak to the prison officials extensively. The isolation was likely to reinforce certain negative ideas that had decreased the amount of challenging of his symptom picture, and had contributed to a regressed phenomenon. He has refused opportunities to have books and use the phone. He has deteriorated to the point where he does not play games or request things, and does not use the phone when available.

Regarding medication response, she noted that there was limited information in the record and that she had also spoken to the patient's family. She felt that he did begin to respond, but did not receive an adequate trial of antipsychotic medication. . Dr. Johnson expressed that she firmly believed that he could be treated.

Ellen P. Lappin, MA, Psychologist was interviewed by telephone on October 25, 2000: In regard to her recollection of the patient's response to pharmacotherapy during his hospitalization at Montana State Hospital from October 11, 1996 though December 2, 1996 she stated: "I do remember he improved immensely on medication". She noted that when Rusty was admitted he was very psychotic and that he was aggressive on one occasion, didn't take his medications voluntarily, eventually got them and noted "improvement very quickly". That he "steadily improved to the point where although the delusions were still present, he didn't feel compelled to talk about them all the time." After he was aggressive she said she did not recall future incidents of aggression which she said she "would personally attribute to medicine". When asked if she felt the benefits outweighed the side effects she stated" I do personally" "I did see a big change". She noted however that she was not a physician.

DISCUSSION

REVIEW OF ORDER APPOINTING MEDICAL EXPERT:

Pursuant to this court's August 3, 2000, Order regarding the appointment of a psychiatric expert in this case pursuant to Fed. R. Evid. 706 and 18 U.S.C. S4241, et seq, the Court hereby appoints Dr. David G. Daniel for the purpose of providing the Court with an expert opinion as to whether it is in the defendant's medical interests to administer anti-psychotic medication without his consent.

VALIDITY OF THE EVALUATION:

This evaluation is based on the following: three meetings with the patient at the Correctional Treatment Facility (CTF) of Corrections Corporation of America (CCA) on September 24, 2000, October 5, 2000, and October 24, 2000; interviews of Celeste Brown (Assistant Director of Nursing), Ms. Martha Brown, LPN, and Margaret Green, LPN, at the Correctional Treatment Facility (CTF) of Corrections Corporation of America (CCA) on October 24, 2000; telephone interview of the patient's parents on September 21, 2000; telephone interview of Dr. Sally Johnson on October 3, 2000; viewing of videotaped interviews of the patient in 1996 at the Central Intelligence Agency; viewing of a videotape of the patient on December 25, 1997 at his parents' home; viewing of a videotape of interviews of the patient conducted by Dr. Phillip Resnick on January 31, 1999, and March 27, 1999, at the Correctional Treatment Facility in Washington, DC; and undated notes written by the patient. A complete list of material reviewed can be found in Appendix II.

The three interviews provided an opportunity to directly observe the patient's recent behavior for a total of approximately three hours. On October 24, 2000, I also directly observed the patient's behavior before and after the interview on the nursing station monitor.

Direct of observation of the patient's behavior for approximately three hours on three separate days provided useful clinical material despite the patient's decision not to converse with the interviewer. The patient stated at the start of the first interview that upon advice of attorney he would not converse with me and maintained this position throughout our meeting. (At that time, AJ Kramer explicitly stated to the patient that that was not his position). The patient's behavior in the presence of the interviewer was consistent with active social withdrawal as is seen in severely paranoid patients who avoid social contact out of fear and suspiciousness. The interview observations also provided clinical material consistent with past experience in the presence of suspicious, guarded, regressed, negativistic behavior and preoccupation with internal mental activity as is characteristic among the more severely and actively ill patients with schizophrenia, paranoid type. Despite the patient's refusal to answer questions during the three interviews, the body of material available to consider in making clinical conclusions

regarding the question of whether it is in the medical interests of the defendant to be administered anti-psychotic medication without his consent, while not optimal, appears adequate upon which to base an opinion. For purposes of context, it is noteworthy that the available clinical material provides significantly more historical background than a clinician might usually have at hand and might consider in the context of making a diagnostic and treatment decision for an individual patient who is uncooperative in providing information about himself.

ETHICAL CONSIDERATIONS:

"Pursuant to this court's August 3, 2000, order regarding the appointment of a psychiatric expert in this case pursuant to Fed. R. Evid. 706 and 18 U.S.C. S4241, et seq, the Court hereby appoints Dr. David G. Daniel for the purpose of providing the Court with an expert opinion as to whether it is in the defendant's medical interests to administer anti-psychotic medication without his consent."

The task requested by the court does not appear to create a conflict with the ethical principals promulgated in the documents displayed in Government Exhibits 11, 12, or 13 in the July 24-27, 2000, compendium. Nor am I aware of an ethical conflict with any other professional norms of conduct promulgated by any applicable professional or governmental organization with jurisdiction in the United States of America.

I. CONSIDERATIONS IN DETERMINATION OF WHETHER INVOLUNTARY ANTIPSYCHOTIC TREATMENT IS IN THE MEDICAL INTEREST THE DEFENDANT:

The determination of whether a treatment is in the medical interest of a patient involves fundamental questions:

1. Does the patient have a diagnosable illness causing the patient to experience significant distress or disability?
2. Does a treatment exist that is available and appropriate for treatment of that condition?
3. Is the treatment reasonably safe and is the treatment likely to be reasonably well tolerated?
4. Is there a less invasive treatment that may provide adequate benefit?
5. Does an individual clinical risk-benefit analysis for the patient indicate that the treatment is in the patient's medical interest?

1. DOES THE PATIENT HAVE A DIAGNOSABLE ILLNESS THAT CAUSES THE PATIENT TO EXPERIENCE SIGNIFICANT DISTRESS OR DISABILITY?

DIAGNOSTIC FORMULATION:

Multiaxial Evaluation:

I. Schizophrenia, Paranoid Type, Continuous, Severe (295.30)
II. None (V71.09)
III. Status/post multiple gunshot wounds July 24, 1998; fracture and external fixation of the right humerus; partial radial nerve palsy of the right upper extremity; right wrist drop; fracture with internal fixation of the left femur; status/post pneumothorax with currently normal breatihing; sacral decubitis
IV. Severe Legal Issues, Incarceration, Severe Social Isolation
V. GAF=15 (current)

Discussion of DSM-IV Criteria Schizophrenia, Paranoid Type, Continuous, Severe (295.30)

The following discussion and conclusion that the patient suffers from Schizophrenia, Paranoid Subtype is based on Diagnostic Criteria for Schizophrenia
From the Diagnostic and Statistical Manual of Mental Disorders Edition IV.

A: Characteristic Symptoms: The patient's history is replete with descriptions of his bizarre delusions and disorganized speech dating at least from 1996.

B: Social/occupational Function: The patient did not meet the expected level of interpersonal or academic performance. Prior to his graduation from high school, the patient was noted to be impaired in his interpersonal relations. This impairment appears to have progressed markedly over time. After completing high school, he had continual difficulty with sustained employment. His self-care (personal hygiene) was noted to be impaired when the patient lived in Montana after high school.

C. Duration: Continuous signs of the disturbance have persisted for more than 6 months. The prodromal symptoms may be considered to have begun prior to graduation from high school, with discomfort and awkwardness in social interactions, idiosyncratic thinking, and odd beliefs. His close social relationships have been consistently limited beyond his nuclear family and grandparents. Avolition was evident in the lack of consistent

occupationally goal directed behavior after high school. Delusional thinking and disorganized thinking is documented in the videotape of the patient at the CIA headquarters in 1996 and alluded to in clinical reports that year and subsequently. The patient's father recollects the patient expressing an element of grandiose thinking 2-3 years after high school graduation regarding the patient's perception of his ability to have been valedictorian of his high school.

D. Schizoaffective and Mood Disorder Exclusion: Earlier in the patient's course, clinical records indicate that he was diagnosed as having a primary mood disorder. Considering the longitudinal course of the patient's illness from the current perspective, a diagnosis of Mood Disorder with Psychotic Features is excluded because that disorder is characterized by psychotic symptoms occurring exclusively during periods of mood disturbance, rather than the continuous, unimitigated psychotic symptoms experienced by the patient since at least 1996. The patient also received the diagnosis of schizoaffective disorder, bipolar type (295.70) in the past. This diagnosis requires an uninterrupted period of illness in which, at some time, there is either a Major Depressive Episode, a Manic Episode, or a Mixed Episode concurrent with symptoms that meet criteria A for schizophrenia. The patient has been described as having bizarre delusions and disorganized thinking during periods in which he apparently met criteria for manic episode. During the same period of illness, there were delusions for at least two weeks in the absence of prominent mood symptoms. However, for the preponderance of the patient's active and residual period of illness, available evidence does not support the presence of symptoms that meet criteria for a mood episode. Therefore, the relative prominence of mood disturbance compared to schizophrenic symptoms does not appear sufficient to justify a current diagnosis of schizoaffective disorder.

E. Substance/general medical condition exclusion: Substance abuse was never established as a factor in the clinical presentation of the patient's psychotic illness. There are contradictory statements in the record regarding his alcohol use. The preponderance of views, including the patient's view and that of his parents, is that there had been no clinically significant use of alcohol or clinically significant recreational use of legal or illicit drugs for more than five years prior to the patient's alleged activity at the U.S. Capitol in 1998.

There is no evidence that a prescribed medication has contributed to his illness. There is insufficient evidence that a general medical condition has caused or significantly impacted his psychiatric presentation. However, the patient is reported to have experienced multiple traumas to his head, beginning with an accident in childhood. It is noted that clinicians opined about the possibility of traumatic brain injury, alcohol induced brain injury, and toxin induced (i.e., metal) brain injury on occasion in their clinical assessments. This material is collected among the social security disability determination documentation. However, there is no documentation of persistent, clinically significant changes in behavior, cognition, reality testing, or organization of thinking being temporally or causally linked to these conjectured etiologies. Moreover, there is no evidence from structural or physiological assessment of brain structure or function, urine tests for metal or other toxins, endocrine tests, vitamin levels, or tests for

syphilis or HIV infection to support the notion that physical trauma, toxins, or a medical illness account for the patient's psychotic illness. The psychological test results do not appear to be specifically incompatible with schizophrenia.

F. Relationship to a Pervasive Developmental Disorder: There is no history of Autistic Disorder or another pervasive developmental disorder. Moreover, delusions are a prominent aspect of the patient's illness.

Potentially Useful Additional Diagnostic Evaluations:

Among additional tests that might be considered to be helpful in the differential diagnosis of the patient's psychotic condition are in-depth neuropsychological testing, magnetic resonance imaging of the brain (MRI), repeat (follow-up) electroencephalography (EEG), lyme antibody titers (if not previously obtained), recent antinuclear antibody (ANA), recent erythrocyte sedimentation rate (ESR). However, given the patient's course of illness, the likelihood of the primary diagnosis being other than schizophrenia is relatively low.

THE PATIENT'S PSYCHIATRIC CONDITION PLACES HIM AT SUBSTANTIAL RISK OF COMITTING FUTURE VIOLENCE::

In assessing the question of whether the patient is dangerous to himself or other people, several considerations are prominent:

I. Past violent behavior is considered a strong risk factor for future violent behavior. Past violent behavior attributed to the patient includes:

a) On October 15, 1996, at Montana State Hospital (per Progress Notes): "Pt began punching, kicking, hitting, and attempting to bite and punch staff. Pt taken to the floor by staff after he punched female staff in face and assaulted staff. We required assistance of additional staff and SDA's to subdue pt. He punched another male staff member in the face, attempted to bite staff." "The patient wanted to call the FBI to inform them that the Lewis and Clark Sheriff Dept. was selling drugs and that the FBI needed to come in and do a full scale investigation."
b) On July 24, 2000, the patient allegedly entered the east front entrance of the U.S. Capitol building, took out a handgun and fired it at an officer, hitting him in the head, then ran down the hall and shot another officer in the chest. The patient was subsequently overwhelmed by other guards. In relation to this alleged incident, the patient described a central role for himself in an elaborate paranoid and grandiose systematized delusional system involving these officers and a safe in the Capitol Building.

Subsequent to the July 24, 1998, incident and while incarcerated and housed in seclusion under close observation, the patient has not committed an act of violence.

Examples of incidents that have possible relevance in evaluating the status of the patient's delusional system and his potential for violent behavior while incarcerated are:

a) On 12-23-99, in the Progress Notes, the patient was quoted to say to Ms. Etheridge, art therapist, "I'm the winner of the Congressional Medal of Honor, and you are not to come within ten feet of me." and "You are an escaped federal prisoner, and you have to turn yourself in.";

b) On 4-6-00, P. Rogall, the physical therapist noted that the patient "appears somewhat hostile";

c) On 4-13-00, in the Progress Notes, Rhett Landis III, PhD, documented that the patient said to him, "You are the terror of Oklahoma. You murdered your wife and your daughter. I am a federal law enforcement officer and you are under arrest. The military base Ajuna (illegible) near here, I am the commanding officer. You are to turn yourself into the federal law enforcement officers." It was noted that with effort the patient was verbally redirected;

d) On 4-14-00, Rhett Landis III, PhD, wrote in the Progress Notes that the patient said: "Why do you have to commit all those crimes? You used a 10" butcher knife on your wife, you sodomized your children."

Thus, the patient has a past history of committing serious violent acts, allegedly including assault in 1996 and homicide in 1998. The alleged incidents are separated by over 18 months. There have been no physical assaults documented since incarceration; however the patient has been in a seclusion cell with a high degree of observation since he was incarcerated.

II. The underlying condition, paranoid schizophrenia, believed to be the etiology of the paranoid delusional beliefs that appear to underlie his alleged past acts of violence, is untreated. Moreover, the delusional material the patient has expressed indicates that he believes that death for himself and others is not permanent. Thus, the consequences of suicide or homicide are substantially reduced in his belief system and the attendant risk of violence heightened.

The examples of delusional material quoted in the Progress Notes on 12-23-99, 4-6-00, 4-13-00, and 4-14-00 indicate that the paranoid delusional system has persisted, consistent with the anticipated course of untreated chronic paranoid schizophrenia. The patient's behavior described in subsequent Progress Notes and during my three meetings with the patient at the Correctional Treatment Facility (CTF) of Corrections Corporation of America (CCA) on September 24, 2000, October 5, 2000, and October 24, 2000, is consistent with extreme suspiciousness, guardedness, and preoccupation with delusions and internal experience to the exclusion of almost any apparent interest in or substantive interaction with the world outside of his own mind. There is no evidence of remission of the patient's paranoid schizophrenia or specific evidence that the delusional substrate that has apparently been the foundation of the patient's past violent behavior is diminished. Thus, the patient appears to remain at significant risk of repeating delusionally based violent behavior.

III. Lack of expression of regret for past violent behavior may be considered a risk factor for repeating similar acts. The patient is not**)** documented to have expressed regret or contrition for alleged past violent behavior. Along the same lines, lack of insight into the delusional basis of past violent behavior would be considered a risk factor for repeating similar acts. The patient is not documented to have expressed insight into the delusional basis of alleged past homicidal behavior.

IV. The patient's seclusion status and the high degree of observation impose a situation in which it would be very difficult for the patient to commit a physically aggressive act. In this restricted environment, the patient does not apparently, on a day-to-day basis, present a substantial immediate, acute threat of violence. Given the patient's psychiatric illness and past history of violent behavior, however, the patient's lack of aggressive behavior in seclusion cannot be inferred to indicate that he is not acutely dangerous, only that he is prevented from carrying out dangerous activity. It cannot be inferred that the patient would not be harmful to himself or others in the general prison population where the environmental safeguards provided by seclusion and nearly constant observation would be absent. Unmedicated and in the general prison population, the patient would be at an extremely high risk of inflicting violence on other inmates, staff members, or visitors who might become incorporated into his delusional system. The timing of such potential violence could be very hard to predict. Without seclusion and close observation, additional objects potentially useful as weapons might be available and should he choose to inflict violence, he would possess the element of surprise. In summary, the clinical course of this patient's paranoid schizophrenic illness if untreated is at very high risk of repeated violence toward other individuals. The patient's current mental state is likely to have a high propensity for commission of behavior dangerous to or violent to other people. The time course of actual commission of dangerous behavior is unpredictable; however, there is no rationale for inferring that the patient's violent impulses are lessened, only that environmental restrictions currently inhibit their expression.

2. DOES A TREATMENT EXIST THAT IS AVAILABLE AND APPROPRIATE FOR THAT CONDITION:

GENERAL CONSIDERATIONS IN THE EFFECTIVENESS OF ANTIPSYCHOTIC TREATMENT:

A consideration of current knowledge of antipsychotic medication and evaluation of the patient's past treatment response suggests that the patient is likely (but not certain) to benefit from an adequate trial of antipsychotic medication. The following is excerpted from the Seventh Edition of Kaplan and Sadock's Comprehensive Textbook of Psychiatry: (Chapter 12.8 Schizophrenia: Somatic Treatment; authored by Stephen R. Marder, MD)::

A large body of evidence supports the effectiveness of antipsychotics for schizophrenia. Many of these studies were carried out in the 1960's when there was skepticism that these agents were truly antipsychotic rather than more effective tranquilizers. An evaluation of these studies by the 1995 Schizophrenic Patient Outcomes Research Team (PORT) found that about 70% of patients treated with an antipsychotic achieved remission. In contrast, only about 25% of patients treated with placebo remitted.

Under the heading "TREATMENT OF ACUTE EPISODES" Indications for Somatic Treatment", Dr. Marder writes:

> Nearly all patients with acute psychotic symptoms benefit from an antipsychotic medication. Aside from relieving symptoms, evidence indicates that lengthy delays in initiating drug treatment may alter the long-term course of schizophrenia. This evidence is summarized in a scholarly review by Richard J. Wyatt, who found that treatment delays-usually six months or more- were associated with a greater need for hospital treatment and a worse social and vocational outcome. Many of these studies reviewed by Wyatt have important limitations such as lack of randomization, and comparing individuals treated during different decades. However, for ethical reasons a definitive study will never be carried out to determine if withholding treatment worsens the long-term course of schizophrenia so it is probably prudent for clinicians to consider the possibility that untreated psychosis can result in a type of permanent damage. (see Appendix III for additional discussion).

Under the heading "Strategies for Poor Responders" Dr. Marder writes:

> When patients with acute schizophrenia receive an antipsychotic medication approximately 60% improve to the extent that they will achieve a complete remission or experience only mild symptoms; the remaining 40% of patients improve, but still demonstrate variable levels of positive symptoms that are resistant to the medications. Rather than categorizing patients into responders and non-responders, it is more accurate to consider the degree to which the illness is improved by the medication. Some resistant patients are so severely ill that they require chronic institutionalization; others respond to an antipsychotic drug with substantial suppression of their psychotic symptoms but demonstrate persistent hallucinations or delusions.
>
> Before considering a patient a poor responder to a particular drug one must be certain that they received an adequate trial of the medication. A 6-week trial on an adequate dosage of an antipsychotic agent is considered reasonable for most patients. If patients exhibit even mild improvement during this period it may be reasonable to wait because data indicate that patients may improve at a steady rate for 3 to 6 months.
>
> Substantial evidence suggests that clozapine is effective for patients who respond poorly to dopamine receptor antagonists.

> There is also evidence suggesting that risperidone and olanzapine may be helpful when a dopamine receptor antagonist is only partially effective. A Swiss study found that clozapine and risperidone were equally effective in a treatment resistant population, but risperidone's side effects were more easily tolerated. Another study found that risperidone was somewhat more effective than haloperidol in a similar population and that risperidone was better tolerated. A multicenter comparison of olanzapine and haloperidol in a largely treatment-resistant group of patients found that olanzapine was more effective for both positive and negative symptoms. Taken together these studies support the practice of trying patients on risperidone or olanzapine when they have responded poorly to a dopamine agonist.

Under the heading "Negative and Cognitive Symptoms" Dr. Marder writes:

> Some evidence suggests that the SDAs are more effective in treating negative symptoms than conventional agents. However, it is unclear if these effects are related to a reduction in secondary negative symptoms**.** Until this issue is decided by adequate controlled studies, it is reasonable for clinicians to consider prescribing an SDA to patients who have substantial negative symptoms.

(note: SDA is an acronym for serotonin antagonist antipsychotic. Examples include clozapine, risperidone, quetiapine and olanzapine)

> Patients with schizophrenia frequently suffer from impairments in attention and information processing. These cognitive impairments can also interfere with their social and vocational rehabilitation, even when the psychotic symptoms have been well controlled. As with negative symptoms, cognitive impairments can be due to other causes such as substance abuse or drug effects of medications. The anticholinergic effects of either an antipsychotic or an antiparkinsonism medication such as biperiden (Akineton) or benztropine (Cogentin) may cause cognitive impairments that are difficult to distinguish from symptoms that are part of schizophrenia. Decreasing the use of anticholinergic medication by changing to drugs that do not require antiparkinsonian medications-particularly SDAs-may be helpful. Evidence also suggests that clozapine, risperidone, olanzapine, and other SDAs may be more effective at treating cognitive impairment than dopamine antagonists. For example, a recent study found risperidone effective in improving verbal working memory. Others have reported that clozapine is effective in improving verbal fluency. Olanzapine has resulted in improvement in a number of cognitive measures. If confirmed, these findings will support the practice of treating cognitively impaired patients with schizophrenia with an SDA.

3. IS THE TREATMENT REASONABLY SAFE AND LIKELY TO BE REASONABLY WELL TOLERATED? :

While there are serious potential side effects resulting from antipsychotic medications, the side effects can most often be managed or an alternative course of treatment provided to the benefit of the patient. General experience with antipsychotics, particularly the newer medications, indicates that given their benefits they are reasonably safe and well-tolerated. As a class, with the exception of clozapine, the SDA's have tolerability advantages over the more traditional antipsychitic agents.

Among the principal potential risks of harm to the patient from antipsychotic medication are: 1) motor side effects; 2) cardiovascular side effects; 3) sedation; 4) weight gain; 5) neuroleptic malignant syndrome; 6) hematologic disorders; 7) endocrine disorders; and 8) seizures. Photocopies of prescribing information for haloperidol, loxitane, risperidone, and olanzapine can be found in the Physicians Desk Reference (2000). This material photocopied from the year 2000 Physician's Desk Reference describes the relative frequency of the most common adverse events of these medications. Motor side effects associated with conventional neuroleptic treatment (including temporary, reversible phenomena such as acute dystonic phenomena, akathisia and parkinsonism; and potentially irreversible tardive dyskinesia) appear to occur less frequently with olanzapine and lower doses of risperidone. Dose reduction and antiparkinsonian medication may reduce the risks of short-term motor side effects of conventional neuroleptic treatment. Dose adjustment and timing of administration (i.e., bedtime) may reduce daytime sedative effects. Endocrine dysfunction is generally reversible and is relatively infrequent with olanzapine. Neuroleptic malignant syndrome occurs infrequently, particularly with atypical antipsychotics. Hematologic dysfunction is unusual and generally reversible with these compounds. . In general, monitoring of the aptient and early detection of side effects facilitates effective intervention.

4. IS THERE A LESS INVASIVE TREATMENT THAT MAY PROVIDE ADEQUATE BENEFIT?

Antipsychotic medication is essential to the treatment of psychotic disorders such as schizophrenia. Psychotherapy without antipsychotic medication is not considered to be an effective treatment for schizophrenia. Seclusion has the potential to interact with and worsen core "negative" symptoms of schizophrenia, including autistic tendencies, social isolation, egocentricity, passive social withdrawal and general social impairment. Moreover, seclusion represents the "opposite" of psychosocial treatment of schizophrenia, which is considered to "augment the benefits of pharmacotherapy and enhance functioning in psychotic disorders" (Huxley et al, 2000, for review). The clinical effects of two years or more of seclusion on a patient with schizophrenia are not readily addressable by case example in the literature. However, in general, the field places severe limitations on the use of seclusion in clinical psychiatry because eit is considered to be inherently aversive when used for prolonged periods of time. It is, therefore, generally reserved for short term emergencies in which the patient poses an immediate direct threat to himself or others and cannot be managed in a less restrictive fashion.

Examples of material which bear on the field's view of prolonged use of seclusion are noted in Appendix V. This material is included to provide perspective on the notion of the patient's medical interest in respect to use of long-term seclusion as an alternative to involuntary medication. In general, involuntary medication may be viewed as a less toxic and in the longer term far more effective treatment of psychotic illness and associated dangerous behaviors than prolonged periods of seclusion. Moreover, seclusion is not generally regarded as a treatment per se. It provides environmental limitations on the patient's ability to cause or participate in dangerous or disruptive behaviors. It may also provide temporary benefit to an overstimulated patient in an acute emergency by reducing environmental stimulation. However, with prolonged use, the deprivation of social and other environmental stimulation brings risk of detrimental effects to the psychological well-being of the patient and could be considered a risk factor for deterioration in the clinical course of a patient with schizophrenia. This may be particularly true of socially withdrawn behavior, autistic and other self absorbed behavior, and general preoccupation with egocentric and internally based themes.

5. DOES THE INDIVIDUALIZED CLINICAL RISK-BENEFIT ANALYSIS FOR THE PATIENT INDICATE THAT THE TREATMENT IS IN THE PATIENT'S MEDICAL INTEREST?

In considering involuntary treatment of this patient's psychotic illness, potential benefits to the patient may include, chiefly:

1) Amelioration of symptoms that distress the patient;
2) Amelioration of symptoms that impair the patient's cognition, social and occupational function, and general quality of life;
3) Obviation of effects of the disease that increase the risk of the patient harming himself or others;
4) Prevention of compromise to the patient's future degree of recovery or general well-being by an extended, very prolonged period of untreated behavioral regression, florid positive symptoms, or unchecked activity of any underlying destructive cerebral process (i.e., the ramifications to patients of untreated tertiary syphillis or extensive use of toxic recreational drugs).
5) The patient gaining insight into the nature of his illness and its treatments.

This patient's illness has been characterized by severe preoccupation with and distress from a plethora of systematized bizarre, paranoid and grandiose delusions. These delusions have secondarily pervaded and disturbed virtually all other aspects of the patient's existence. For example, this delusional system has disrupted all the patient's interpersonal relationships and led the patient to take actions that have caused himself and others great distress and harm. It appears that the effects of the patient's illness have progressed to the point where the patient appears preoccupied and dominated by his delusional system to the exclusion of almost all aspects of existence beyond vegetative functions. He invokes delusions to explain actions that have led to a chain of events placing him in a seclusion cell in incarceration. He demonstrates virtually no interest in any external phenomena, including matters he was previously interested in, such as his family.

The patient's past experience with antipsychotic medication involved consecutive hospital courses of brief treatment with risperidone 2 mg po bid from October 11-17; haloperidol 10 mg po bid; perphenazine 8 mg po q AM and 16 mg po q PM from October 28-November 11; and loxitane 10 mg po bid from Novemeber 12 –December 3 (hospital discharge). No data to independently verify the patient's compliance with loxitane treatment after hospital discharge is available. Depakote, used as a mood stabilizer in psychiatry was administered concurrently with these antipsychotic treatments at a total daily dosage of 1000mg. Haloperidol was administered in th earlier segment of the hospitalization.

In terms of tolerability, loxitane produced no life threatening or prohibitive side effects. He experienced classic neuroleptic side effects to a high dose of haloperidol. It cannot be determined with certainty whether the transient edema in his hands he experienced on

perphenazine was related to the treatment. He may have subjectively experienced palpitations while taking risperidone.

The duration of treatment with perphenazine was insufficient in duration to constitute an adequate therapeutic trial. The dosage of loxitane was on the low side. The 1998 Physicians' Desk Reference notes: "Initial dosage of 10 mg twice daily is recommended, although in severely disturbed patients initial dosage up to a total of 50 mg daily may be desirable. Dosage should then be increased fairly rapidly over the first seven to ten days until there is effective control of psychotic symptoms. The usual therapeutic and maintenance dosage is 60 to 100 mg daily. However, as with other antipsychotic drugs, some patients respond to lower dosage and others require higher dosage for optimal benefit. Daily dosage higher than 250 mg is not recommended." The clinical record from Montana State Hospital suggested the patient was calmer, less agitated, less threatening, exhibited some insight that he was ill, less emotionally invested in his delusional material and better able to attend to other matters after treatment. A quantitative indicator of the patient's improvement in function was the change in his Global Assessment of Function (GAF) (Axis V on the DSM-IV Multiaxial Assessment). The patient's GAF noted early in his admission assessment at Montana State Hospital was 20 fell to 15 around the time he was assaultive and improved to 50 at discharge. DSM-IV notes that "Axis V is for reporting the clinician's judgment of the individual's overall level of functioning. This information is useful in planning treatment and measuring its impact, and in predicting outcome." It goes on to say: "The GAF scale may be particularly useful in tracking the patient's progress in global terms, using a single measure. The GAF is to be rated with respect only to psychological, social, and occupational functioning."

Thus, based upon review of the patient's record of antipsychotic treatment in 1996, he appears to have responded in a clinically meaningful and beneficial fashion to antipsychotic treatment, despite relatively modest dosage of and relatively short duration of documented compliance with the last agent, loxitane. Marder (2000) suggests that partial response early in treatment is a good prognostic sign for additional improvement over time. There are many dimensions of psychopathology in schizophrenia which may improve at different rates to treatment. Although, the patient's delusions persisted after treatment in 1996, the delusional conviction, their influence on his behavior, affect, aggressiveness, and interpersonal relations became noticeably less marked. The centrality of the role of the delusions in his life diminished. He was less distressed by his symptoms. His ability to function in other areas improved. He was considered safe to be able to leave the hospital.

Clinicians generally regard past treatment response as a valuable predictor of future treatment response. In 1996 this patient apparently experienced a robust clinical response to what would generally be considered a suboptimal dosage and duration of treatment of an antipsychotic medication. In the future, the patient may respond to an adequate dose and duration of treatment better than he did to the limited dose and duration in 1996. As noted, Marder (2000) points out that many schizophrenic patients who experience a partial response to a sufficient dose regimen given for 6 weeks will go on to experience further improvement over time. Furthermore, the clinical efficacy of a serotonin-

dopamine antagonist antipsychotic such as clozapine, risperidone, or olanzapine may be superior in response to that of a more conventional antipsychotic such as haloperidol, perphenazine or loxitane and be better tolerated.

The patient's clinical response pattern is consistent to Marder's (2000) allusion to different patterns of improvement not precluded by the persistence of delusions.

There is a substantial body of literature that suggests that non-treatment of severe mental illness, and schizophrenia in particular, increases the risk of violence and that treatment reduces this risk (see Appendix). The patient was hospitalized at Montana State Hospital in 1996 because of threatening behavior and an assault occurred early in the hospitalization. This behavior was apparently driven by the patient's delusional convictions. Over the course of the patient's treatment during that hospitalization, the patient is described as having become calmer, more cooperative, was considered less invested in his delusions and less dangerous. Subsequently, when untreated, the patient committed extreme acts of violence apparently as a result of delusional convictions. The likelihood of violence recurring may be reduced by treating the delusions. Even if the delusional beliefs do not disappear, the degree of emotional investment in them and the extent to which they pervade the patient's view of and interactions with the world are likely to diminish, as they apparently did after treatment in 1996. The patient has expressed belief that the police he allegedly shot were part of a dangerous conspiracy. He also has expressed the notion that they may be brought back to life. These beliefs could be applied to other people in the patient's environment in the future unless he is treated.

Approximately 10% of patients with schizophrenia complete suicide. This patient's risk may be increased by his expressed belief that death for him is not permanent. Treatment of this delusion may give the patient a more realistic idea of the consequences of harm to others and the permanency of death.

In the Comprehensive Textbook of Psychiatry, 7th Edition, Dr. Marder writes: "…. It is probably prudent for clinicians to consider the possibility that untreated psychosis can result in a type of permanent brain damage." Dr. Marder, however, does not question the appropriateness of antipsychotic treatment for patients who have experienced long delays between onset of symptoms and treatment or gaps in treatment. Nor am I aware of any literature in a peer reviewed psychiatric journal that argues that it is inappropriate or not in the medical interest of a severely ill schizophrenic patient with an extended delay from onset of psychotic illness to treatment to have an adequate trial of antipsychotic medication. As described in the Appendix, there is substantial literature suggestive that delay to treatment is a relatively adverse factor in prognosis. However, although such patients, as a class, may be disadvantaged in their ultimate outcome compared to patients who received prompt treatment, the literature does not indicate that these patients lack clinically meaningful responses to antipsychotic treatment or argue against treating them. In fact, for purposes of example, one paper referenced in the Appendix appears to document clinical response to antipsychotic medication in a sample of just such patients.

To the extent that untreated psychosis can impair future treatment response or even result in brain damage, it would appear to compel rapid involuntary treatment of this patient. Dr. Sally Johnson, the patient's parents, and a review of the Progress Notes since the patient's incarceration indicate that the patient has deteriorated in his course since he was incarcerated in 1998. Noteworthy are diminished social interaction, muteness, less interest in events outside of himself, and a lower ratio of non-delusional to delusional conversation. In the opinion of Dr. Sally Johnson, over the course of his incarceration (which has been without antipsychotic treatment), the patient's delusional system appears to have become more all-encompassing and he has less interest in his family or any type of interpersonal interaction. A review of the nursing and physician notes, videotapes, and other materials suggests a global deterioration in the patient's function. He appears to have become increasingly preoccupied with his delusions and internal experience to the exclusion of almost any apparent interest in or interaction with the world outside himself.

Less invasive, alternative treatments to involuntary antipsychotic treatment do not appear beneficial or realistic. Psychotherapy without antipsychotic medication is not considered to be an effective treatment for schizophrenia or other psychotic disorders. In the absence of involuntary antipsychotic treatment, seclusion has been utilized for the preponderance of the patient's incarceration apparently to protect from the patient harming others or himself in response to delusional beliefs. This has resulted in severe social isolation of the patient. It is reasonably likely that the patient's deterioration may be in part related to existing in an untreated delusional paranoid state with marked social isolation and the lack of stimulation in the solitary arrangement his greater than 2 year incarceration. Seclusion has the potential to interact with and worsen core "negative" symptoms of schizophrenia, including autistic tendencies, social isolation, egocentricity, passive social withdrawal and general social impairment. Involuntary medication appears to be a more medically appropriate intervention and more in the patient's medical interest than living for years in seclusion. This judgment is based on the prediction that antipsychotic treatment will diminish the delusional conviction that has apparently played a role in the patient's alleged violent activity in the past.

When the patient entered the hospital in 1996, he apparently had no insight that he had a serious psychiatric illness that is normally treated with medication. By the latter part of his hospitalization in 1996, he acknowledged having an illness and apparently the need for medication despite having only had a very superficial and distorted view of his illness. The patient currently appears to be extremely ill with no apparent insight that he is severely psychiatrically ill or that medication is available to address the symptoms of that illness. By the very nature of psychotic illness, a severely ill psychotic patient cannot distinguish psychotic symptoms from reality. The delusional aspects of this patient's illness lead him to incorporate treatment into his persecutory belief system. He cannot objectively evaluate the value of treatment until the conviction of his delusional system is reduced. There is a substantial likelihood that, after an adequate course of antipsychotic treatment, the patient's delusional conviction will be reduced and he may display insight into the presence of a serious psychiatric disorder and the role of antipsychotic treatment. Given the pervasiveness of the patient's paranoid delusional system and its overarching

effect on the patient's judgment, the only way to initiate this process is with involuntary treatment.

CONCLUSIONS

Utilizing the criteria from the Diagnostic and Statistical Manual of Mental Disorders (DSM) and based on the patient's history and current condition, his diagnosis is that of schizophrenia, paranoid subtype. This condition has impaired his social and occupational functions and has led to acts of violence based on his delusional system. His history of violence and untreated status are strong predictors of the potential for future violence to others. Thus, while it is impossible to determine with absolute certainty whether he will indeed commit violence in the future, or when, there is a strong likelihood that if untreated he will. .

There are numerous marketed antipsychotic treatments that have received regulatory approval for the psychotic manifestations of schizophrenia. While some patients do suffer side effects from the medication, generally the side effects themselves can be treated, the dose adjusted or a different antipsychotic agent administered. The more recently introduced SDA class of antipsychotics have significantly lower side effect liability in several important areas than do the classical dopamine antagonist antipsychotics. Further, and quite significantly, the patient demonstrated a positive response to antipsychotic medication in the past. While there has been a relatively long period in which the patient has been untreated for his illness, the improvement documented by his clinical team in relation to his pharmacotherapy in 1996 is a good prognosticator of future improvement in symptoms, if treated. .

While the patient's current seclusion does, indeed, limit his ability to harm himself and others, it cannot be considered an acceptable "treatment" as generally agreed upon by most professionals in this field or by the National Alliance for the Mentally Ill, the Health Care Financing Administration, or the American Psychiatric Association. Thus, although seclusion of the patient may prevent the patient from exercising violent impulses it does not fall within the rubric of acceptable long-term treatment for his illness. Nor, does it address or ameliorate any of the multitude of symptoms of schizophrenia.

The patient's lack of insight, which is a characteristic symptom of untreated schizophrenia, precludes the patient from the opportunity to exercise a reality based decision about whether he wishes to be treated or not.

Based on this reasoning and that expressed elsewhere in the Discussion, it is my opinion that it is currently medically appropriate and in the defendant's medical interest to treat him with antipsychotic medication without his consent.

APPENDIX : MATERIALS REVIEWED

APPENDIX: EFFECTS OF PROLONGED TREATMENT DELAY ON THE LIKELYHOOD OF FUTURE TREATMENT RESPONSE

A relatively long period of untreated or minimally treated psychiatric illness, including, for example, social and vocational dysfunction, delusional thinking, and difficulty with goal directed thinking may be associated with some diminished response to treatment compared to schizophrenic patients treated early in their course of illness (Wyatt and Henter, 1998; Tandon, Haas et al, 1998; Waddington and Scully, 1998; Malla et al, 1999; Wyatt et al, 1999; de Haan et al, 2000).

There is substantial sentiment in the field literature, examples of which are cited above, that prolonged delays to first antipsychotic treatment may have a detrimental effect on the course of certain schizophrenic symptoms. 15 psychiatric experts were polled on a number of questions bearing on the effects of early and sustained intervention on the long- term morbidity of schizophrenia (Tandon, 1998). When asked if "Delay in antipsychotic treatment contributes to the development of treatment refractoriness", responses included: "Completely disagree" (2); "Neutral" (1), "Somewhat agree" (7), and "Completely agree" (6).

When asked if "***Data*** suggest that antipsychotic treatment clearly has beneficial effects on the long-term course of schizophrenic illness", responses included: "Completely disagree (1); somewhat disagree" (0); neutral (3); "Somewhat agree" (8); "Completely agree" (4). When asked if "***Evidence*** suggests that early effective antipsychotic treatment attenuates the progression of neurobiological abnormalities in schizophrenia, responses included: "Completely disagree (1); somewhat disagree" (0); neutral (10) "Somewhat agree" (4); "Completely agree" (1).

Examples of literature bearing on the question include studies indicating associations between delay to treatment and "negative symptoms" and cognition; (Waddington et al, 1995); and lower frequency of remission and longer time to remission (Loebel et al, 1992). Crow et al (1986) found an association between the length of first treatment delay for psychotic symptoms and risk of relapse over the first two years of antipsychotic treatment. De Haan (2000) found a non-statistically significant trend of association between duration of untreated psychosis and "negative symptoms" but not positive symptoms, "10 year outcome", or various functional measures.

The relationship among delay to treatment, the severity of positive symptoms and the effects of treatment on positive symptoms (ie-delusions and hallucinations) may be ephemeral. De Haas et al (1998) found an association between delay of a year or more from onset of psychotic symptoms and the severity of "negative" but not positive symptoms at admission. However, De Haas reported that there was no effect of delay to first medication on the effects of treatment, that is, change in symptom severity over time for positive symptoms, negative symptoms, or general psychopathology. In other words, the effectiveness of treatment for symptoms such as hallucinations and delusions

was not significantly impaired by delay to first hospitalization. Moreover, in the “long-delay” group, treatment reduced “scale scores” for hallucinations from slightly above 3 to slightly below 1.5. and “scale scores” for delusions from approximately 4 to below 3. Under the rubric of “Disorganization Syndrome,” “Bizarre” “scale scores” fell from approximately 1.8 to approximately .8 in the delay to treatment group.

Thus, examples are available in the literature consistent with the notion that severity and treatment response of “positive symptoms” may not be differentially affected by delay to treatment; and at least one example is available in the literature indicating treatment response in schizophrenic patients who have experienced prolonged delay to treatment.

It is my opinion that although it is desirable to begin treatment as early as possible in the course of diagnosed schizophrenia, neither the literature nor current clinical practice or beliefs argues against a trial of antipsychotic medication in a schizophrenic patient with severe psychotic symptoms who has experienced a long unmedicated period.

APPENDIX: DISCUSSION OF EFFECTS OF NON-TREATMENT ON INCREASED RISK OF VIOLENCE:

Substantial evidence exists that treatment of mentally ill patients may reduce the likelihood of violence. Mentally ill individuals with no treatment contact in the past six months may have substantially higher odds of violence (Swanson J, Estroff S, Swartz M et al, 1997). A study of inpatients with schizophrenia reported an inverse correlation between their propensity to violence and their blood level of antipsychotic medication (Yeasvage, JA, 1982). A study of severely mentally ill patients in a forensic hospital found a highly significant correlation between failure to take medication and a history of violent acts in the community (Smith, LD, 1989). There appears to be an association between severity of violence and delusional motivation (Taylor, P, 1985). Inadequately treated delusions and hallucinations and medication non-compliance are associated with hostility and violent behavior (Bartels, Drake, Wallach, 1991). Patients who refuse medication are more likely to be engage in assaults and require seclusion and restraint (Kasper, Hoge, Feucht-Haviar et al, 1997).

Several studies suggest that being severely mentally ill, having delusions, and not taking medication is a powerful predictor of violence:

Yesavage JA, 1982.

Smith LD, 1989

Taylor P, 1985.

Bartels J, Drake RE, Wallach MA, et al, 1991.

Martell DA, Dietz PE, 1992

Kasper JA, Hoge SK, Feucht-Haviar T et al: 1997

Steadman HJ, Mulvey EP, Monahan J et al, 1998

Swartz MS, Swanson JW, Hiday VA et al, 1998.

APPENDIX: COMMENTARY ON THE USE OF SECLUSION IN PSYCHIATRY

Excerpts from a National Alliance For the Mentally Ill (NAMI) paper downloaded from the internet 9/4/00 addressing NAMI's position on Seclusion and Restraint) (summarized from the NAMI Policy Platform):

1. The use of involuntary mechanical or human restraints or involuntary seclusion is only justified as an emergency safety measure in response to imminent danger to one's self or others. These extreme measures can be justified only so long as, and to the extent that, the individual cannot commit to the safety of themselves and others.
2. Restraint and Seclusion have no therapeutic value and should only be used for emergency safety by order of a physician with competency in psychiatry or a licensed independent mental health professional (LIP).
3. Alternatives to the use of restraint should be used. De-escalation techniques and debriefings after each restraint and seclusion incident should be used.
4. In October 1998, the Hartford Courant published an investigative five-part series that revealed an alarming number of deaths resulting from the inappropriate use of physical restraints in psychiatric treatment facilities across the United States. A 50-state survey conducted by the newspaper documented at least 142 deaths in the past decade connected to the use of physical restraints or the practice of seclusion. The news report also suggested that the actual number of deaths is many times higher because many incidents go unreported.

Excerpts from "Testimony of Michael Hash, Deputy Director of the Health Care Financing Administration before the Senate Finance Committee on Patient Treatment in Mental Hospitals October 26, 1999:

> We are profoundly disturbed by the reports of deaths and injuries resulting from the inappropriate use of seclusion and restraints in mental health facilities. We strongly agree with patients advocates that use of seclusion and restraints must be recorded, reported, and always a last resort. We are taking steps to ensure that use of seclusion and restraints to manage behavior is an emergency measure reserved for unanticipated, severely aggressive or destructive behavior that places the patient or others in imminent danger.

Health Care Financing Administration Interpretive Guidelines for Hospital Conditions of Participation for Patients Rights (COP) downloaded from the internet 9/4/00. Excerpts from "(f) Standard: Seclusion and restraint for behavior management":

1. The patient has the right to be free from seclusion and restraints of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff.

2. Seclusion is the involuntary confinement of a person in a room or area where the person is physically prevented from leaving.
3. Seclusion or restraint can only be used in emergency situations if needed to ensure the patient's physical safety and less restrictive interventions have been determined to be ineffective.
4. (3) The use of a restraint or seclusion must be (i) Selected only when less restrictive measure have been found to be ineffective to protect the patient or others from harm.
5. (A) Orders for the use of seclusion or a restraint must never be written as a standing order or on an as needed basis (that is, PRN).
6. (D) Each written order for a physical restraint or seclusion is limited to 4 hours for adults.
7. The original order may only be renewed in accordance with these limits for up to a total of 24 hours.
8. After the original order expires, a physician or licensed independent practitioner (if allowed under state law) must see and assess the patient before issuing a new order.

Health Care Financing Administration Interpretive Guidelines for Hospital Conditions of Participation for Patients Rights (COP) downloaded from the internet 9/4/00. Excerpts from "(f) Standard: Seclusion and restraint for behavior management": Interpretative Guidelines: 482.13 (f):

1. Emergency is defined as a situation where the patient's behavior is violent or aggressive and where the behavior presents an immediate and serious danger to the safety of the patient, other patients, staff, or others.
2. Documentation in the patient's record should indicate a clear progression in how techniques are implemented with less intrusive restrictive interventions attempted (or considered prior to the introduction of more restrictive measures).
3. Does the clinical record reflect changes in behavior and staff concerns regarding potential danger on the unit/ward prompting use of seclusion or restraints? Did the patient's behavior place others/self at risk of harm? Were other behavior interventions tried and documented?
4. Ongoing authorization of restrictive techniques is not permitted. The absence of evidence to justify such usage constitutes a "PRN order" to control inappropriate behavior, and is prohibited.
5. The use of physical restraint or seclusion must be limited to the duration of the emergency safety situation regardless of the length of the order.… Staff should be assessing, monitoring, and re-evaluating the patient so that he or she is released from the restraint or seclusion at the earliest possible time.

Excerpts from Statement of The American Psychiatric Association to the Senate Finance Committee Hearing on Seclusion and Restraint of Psychiatric Patients October 26, 1999:

Attachment #1, Letter from Steven Mirin, MD, Medical Director, APA to Nancy Ann Min DeParle, Administrator, Health Care Financing Administration:

1. APA shares HCFA's concern that special care be taken when patients are placed in seclusion or restraint, particularly for psychiatric purposes. We agree that death should never be a direct result of placing a patient in seclusion or restraint. We concur that such interventions should be taken with the utmost care and concern for patient safety as well as the safety of staff and others, should be viewed as two of numerous alternative interventions, and should be undertaken in circumstances in which a physician determines that the patient's clinical condition warrants the intervention. Likewise, we agree that seclusion and restraint should be terminated at the earliest opportunity when the specific threat to the safety of patient, staff, and others has passed and other alternatives are clinically appropriate.

Excerpts from Resource Guide on Seclusion and Restraint by the American Psychiatric Association, May, 1999:

1."Seclusion" is defined for this statement as "locked door seclusion".

2. Seclusion and Restraint may be indicated:

To prevent harm to the patient or other persons, including other patients, family members and staff, when other interventions are not effective or appropriate.

a) To ensure a safe treatment environment when other interventions are not effective or appropriate.

2. Use of seclusion and restraint is a matter of clinical judgment that should include a thorough understanding of the clinical needs of the individual patient and the context in which the use of seclusion and restraint are being considered.

3. The use of seclusion and restraint should be minimized to the extent that is consistent with safe and effective psychiatric care and the specific clinical needs of individual patients.

4. The decision to continue seclusion or restraint should not be viewed as "routine". Patients should be removed from seclusion or restraint when, in the physicians' judgment, the patient no longer poses a threat to himself/herself, or other patients, or staff.

5. The use of seclusion and restraint may be traumatic for some patients. The treatment team should consider post-intervention counseling whenever clinically indicated.

6. The provision of optimal psychiatric treatment, including appropriate use of psychosocial and pharmaco-therapeutic interventions, is an important component of a strategy to reduce the use of seclusion and restraint.