1 STATE OF MINNESOTA DISTRICT COURT

2 COUNTY OF WINONA THIRD JUDICIAL DISTRICT

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4 In the Matter of the Civil Commitment of: Court File No: 85-PR-24-46

5 David Austin Russell, **ECT HEARING**

6 Respondent.

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8 **TRANSCRIPT OF PROCEEDINGS**

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9 The above-entitled matter came on for hearing before

10 the Honorable Carmaine Sturino, Judge of District Court, on

11 Monday, May 6, 2024, at 10:32 a.m. via Zoom for Government.

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13 **A P P E A R A N C E S**

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15 Paul R. Ellison, Assistant Winona County Attorney,

16 Winona, Minnesota, appeared via Zoom on behalf of the County of

17 Winona.

18

19 David J. Jones, Esq., Rochester, Minnesota, appeared

20 via Zoom on behalf of the Respondent, who also appeared via Zoom

21

22 ALSO PRESENT: Amy Engel, Winona County Health and

23 Human Services.

24

25

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1 (Whereupon, the following proceedings were held:)
2 - - -
3 THE COURT: We are here in the matter of the civil
4 commitment of David Austin Russell, 85-PR-24-46. Mr. Russell, are
5 you with us?
6 THE RESPONDENT: I am.
7 THE COURT: All right.
8 THE RESPONDENT: I had two friends that were going
9 to testify on my behalf, Lucille Buteau and John Mayo, and I don't
10 see them. In addition, I was aware that a bunch of other people
11 planned to show their support joining this hearing as observers.
12 THE COURT: All right. One moment. I would note
13 that Mr. Jones is here with his client, David Russell, the
14 respondent. Mr. Ellison is here from the county attorney's
15 office. We do have Dr. Shack here from Mayo Clinic and
16 Dr. Tomford here who filed an examiner's statement.
17 Mr. Jones, have you been able to review the
18 petition before the Court at this time with your client?
19 MR. JONES: Thank you, Your Honor. I did speak
20 with my client last Friday. My client had initially been placed
21 in Joseph 7. He's been relocated to Generose 2E. I did speak
22 with my client. He apposes the Price-Sheppard petition.
23 THE RESPONDENT: We spoke very briefly --
24 THE COURT: Very good.
25 THE RESPONDENT: -- number he was disconnected.

1 We didn't discuss anything. I have not seen the petition. I have
2 been given no evidence or witnesses, and I was not able to speak
3 for more than two minutes with the court-appointed attorney until
4 he was disconnected.
5 THE COURT: All right. Thank you.
6 Mr. Ellison, with that, do you believe you are
7 ready to proceed when we're ready for your witnesses?
8 MR. ELLISON: I believe so, Your Honor.
9 THE COURT: All right. Mr. Russell, I have heard
10 you. I know that Mr. Jones has been conducting these hearings for
11 a long time, and I have confirmed with him on the record here
12 today that he had the ability to meet with you and go over
13 documents relevant.
14 I also want to put on the record that now I have
15 been made aware by you, Mr. Russell, and -- that prior to this
16 hearing I've been made aware of behaviors associated with an
17 advocacy group that you've just referenced who are opposed to all
18 forms of mental health care. The specific behaviors include
19 attempts to contact medical staff and counsel for Mr. Russell via
20 various methods repeatedly. The Court is presently aware of
21 numerous unidentified persons present wishing to attend and
22 potentially testify during today's hearing. Respondent's counsel
23 has not made specific requests of the identities of the specific
24 persons known.
25 This Court has conducted several hearings with

1 this respondent historically and now in conjunction with the 60-90
2 day report and petition that brings us here today. The Court is
3 relying on Minnesota Statute 253B.08 and has instructed court
4 staff to lock the Zoom attendance and chat features.
5 At this point I will go forward with the State
6 proceeding with any witnesses it wishes to call and then,
7 Mr. Jones, any witnesses you wish to call. And we are ready when
8 you are, Mr. Ellison. Who would you like to call first?
9 MR. ELLISON: Thank you, Your Honor.
10 I would call Dr. Shack.
11 THE COURT: All right. Dr. Schak, I'm going to
12 have you raise your right hand and be sworn in.
13 COURT CLERK: You do swear that the testimony you
14 give here will be the truth and nothing but the truth, so help you
15 God? If so, please say "I do."
16 THE WITNESS: I do.
17 THE COURT: All right. Go ahead, Ellison.
18 MR. ELLISON: Thank you, Your Honor.
19 MR. JONES: Your Honor, before the County begins,
20 are there some housekeeping matters that we should perhaps address
21 to expedite this matter?
22 THE COURT: Very good. Thank you, Mr. Jones.
23 Are there any exhibits that the State intends --
24 or the County intends to offer?
25 MR. ELLISON: Yes, Your Honor. Your Honor, I

1 would after Dr. Tomford's court examiner report, the 60-90 day
2 reports, as well as the court reports and an accompanying Court
3 order issued on the provisional discharge revocation.
4 THE RESPONDENT: I object because I have not seen
5 any of these documents.
6 THE COURT: All right. Mr. Jones, have you had an
7 opportunity to review those documents.
8 MR. JONES: Your Honor, all of those documents
9 have been received by my office. I believe the County would also
10 be intending to offer the ECT petition itself. So no objection to
11 the Court receiving those items into evidence.
12 As an additional housekeeping matter, Dr. Schak is
13 very familiar to me. Dr. Tomford as well is very familiar to me.
14 I am willing to make a stipulation that each is an expert witness
15 for all purposes of today's hearing.
16 THE COURT: Thank you. All right, then, Dr. --
17 I'm sorry. ECT petition will be Exhibit No. 1, and that was on
18 April 24th. The 60-90 day report will be Exhibit 2. That's from
19 April 30th. Dr. Tomford's report will be Exhibit 3. That is from
20 May 1st. Court order on revocation is something the Court is
21 aware of and relying on for the purpose of this hearing. And I
22 will note stipulations to foundation on both witnesses here today
23 the County intends to call as expert witnesses.
24 (Exhibit Nos. 1-4 Received into evidence.)
25 THE COURT: Mr. Ellison, anything that you want to

1 be heard on, then?
2 MR. ELLISON: I don't believe so, Your Honor.
3 THE COURT: All right. Mr. Jones, anything else
4 that you want to be heard on?
5 MR. JONES: Nothing else except I do wish to note
6 to the Court that the Court has made the correct citation to the
7 applicable law of 250B.08, Subd. 3. That does apply here. The
8 Court has made the appropriate reference and appropriate findings.
9 Thank you, Your Honor.
10 THE COURT: All right. Mr. Jones, your client had
11 his hand up. I will rely on you to tell me when you would like me
12 to take a break so that you can meet with him in private if you
13 wish to conduct your case in that manner. Okay?
14 MR. JONES: Thank you, Your Honor.
15 THE RESPONDENT: May I speak to the Judge? Just I
16 am not being represented by him. I've already said I've not even
17 seen the evidence that is being presented. I have not seen it
18 personally. How am I supposed to communicate with -- about a
19 court-appointed -- sorry. I'm frustrated. I have not been able
20 to see any of the evidence against me.
21 THE COURT: All right. Mr. Russell, when it is
22 your turn to present your case, your attorney will do that as he
23 chooses to do so. I would also note that File 85-PR-19-1081 is a
24 matter in which the Court has appointed a guardian and conservator
25 for Mr. Russell. In doing so, the Court did make a decision that

1 Mr. Russell lacks sufficient understanding to act on his own
2 behalf in both the guardian and conservator proceeding. I would
3 note they are both here. Michael Hanratty is the guardian who is
4 here, Brittany Dannehy is here as the conservator, and then the
5 social worker, of course, is also here.
6 All right. Mr. Ellison.
7 MR. ELLISON: Thank you, Your Honor. Petitioner
8 calls Dr. Schak.
9 THE COURT: Dr. Schak, if you could raise your
10 right hand and be sworn in, please.
11 COURT CLERK: You do swear that the testimony you
12 give here will be the truth and nothing but the truth, so help you
13 God? If so, please say "I do."
14 THE WITNESS: I do.
15 THE COURT: Go ahead.
16 MR. ELLISON: Thank you, Your Honor.
17 - - -
18 KATE M. SCHAK, M.D.,
19 called on behalf of the Petitioner, being first duly
20 sworn, was examined and testified as follows:
21 **DIRECT EXAMINATION**
22 BY MR. ELLISON:
23 Q. Dr. Schak, where are you employed?
24 A. Mayo Clinic.
25 Q. What is your position at Mayo Clinic?

1 A. Inpatient psychiatry hospitalist.
2 Q. Do you know David Russell?
3 A. I do. I have had -- I've worked with Mr. Russell since
4 September 2020 and then during inpatient stay at Generose, and now
5 more recently I have assumed his care as recent as today. I have
6 not been caring for him this hospital stay until today, but I'm
7 well aware of his care from previous work and have reviewed his
8 hospital course up until today.
9 Q. Do you know approximately when Mr. Russell was most
10 recently admitted to your facility?
11 A. Yeah. I'm going to double check the medical record to
12 be specific, but he presented to the Saint Marys emergency
13 department on -- I have April 16th of 2024.
14 Q. Does Mr. Russell have a diagnosed mental illness?
15 A. Yes. Schizoaffective disorder, among other diagnoses,
16 but that would be the primary one for which we are treating here
17 during the current hospitalization.
18 Q. And what types of symptoms or behaviors have been
19 exhibited in line with that diagnosis?
20 A. Delusional thoughts would be the primary predominant
21 symptom for which is impairing his function.
22 Q. Is Mr. Russell prescribed any neuroleptic medications?
23 A. He is, and he has been taking the neuroleptics that are
24 being prescribed. That is -- olanzapine is a generic name or
25 Zyprexa is a brand name. This is a previous antipsychotic that

1 Mr. Russell has been prescribed in the past.
2 Q. So to make sure I understand correctly, he has been
3 taking the medications while at Mayo Clinic?
4 A. He has, yes.
5 Q. Are you aware of Mr. Russell taking the medication when
6 in a community setting?
7 A. My understanding is that he had not been taking
8 antipsychotic medication, which, from what I understand, is
9 complicated by the fact that he was at another facility during
10 which time they discontinued antipsychotic medication and then was
11 discharged on no antipsychotic medication.
12 Q. Have the medications as olanzapine been sufficient
13 independently to treat Mr. Russell's mental illness?
14 A. In review of his past care with Zyprexa or olanzapine,
15 it looks like he has been stabilized at times in the more distant
16 past. This hospital stay at the recommended full dosing of
17 olanzapine, 30 milligrams a day, we are continuing to see
18 continued delusional thoughts as well as significant irritability
19 and anger. But I want to underscore it's the delusional thoughts
20 that are most concerning.
21 Q. Does Mr. Russell believe he needs any types of mental
22 health treatment?
23 A. Mr. Russell does not have any insight into the
24 schizoaffective disorder for which he's been diagnosed previously
25 and generally disagrees with being on antipsychotic medication.

1 Sorry. I -- and generally disagrees with being on antipsychotic
2 medication.
3 Q. Okay. Has Mayo Clinic considered other forms of
4 treatment for Mr. Russell?
5 A. We have. Recommendation and request of the Court today
6 is for electroconvulsive therapy. That is a treatment that we do
7 not take lightly and for which we only consider after multiple
8 antipsychotic trials have failed.
9 THE COURT: All right. I'm just going to make a
10 record that Mr. Russell has left the Zoom screen. I am not aware
11 if he left the room -- oh, there he is. So he was walking around.
12 Okay. Go ahead, Dr. Schak and Mr. Ellison.
13 THE RESPONDENT: I'm just frustrated based on her
14 testimony and so walking around to stay calm.
15 THE COURT: Very good. Thank you.
16 BY MR. ELLISON:
17 Q. And, Dr. Schak, what is -- can you describe how ECT
18 works?
19 A. Yeah. So electrodes -- a person is given anesthesia and
20 electrodes are placed on the scalp and a brief seizure is induced.
21 It's carefully monitored in a well-documented treatment for
22 primary psychotic disorders.
23 Q. Is ECT the next medically indicated step after
24 medications?
25 A. Yes.

1 Q. And you mentioned that multiple medications have failed.
2 Do you know the other medications at all?
3 A. Yeah. I'm going to look at the medical record just so
4 I'm not going on my memory alone.
5 So as I mentioned earlier, he's currently on the
6 olanzapine for which he's previously been treated. He has also
7 been on -- olanzapine is a second-generation antipsychotic that we
8 usually use first in the medical community for people that do not
9 always respond to the -- the second-generation antipsychotics. We
10 use first-generation antipsychotics, and Mr. Russell has been
11 trialed on that as well. And that would be fluphenazine as the
12 primary antipsychotic. He's also been on aripiprazole, maximal
13 dosing, which is also a second-generation antipsychotic.
14 Q. Thank you. Has Mayo staff attempted to have discussions
15 with Mr. Russell about the risks and benefits of ECT?
16 A. Yes. This is very challenging. And I understand --
17 we're well aware of how much Mr. Russell disagrees with the
18 recommendation or ECT. So it's been very difficult to have a
19 meaningful conversation that we're able to give him the full
20 comprehensive overview of why we would recommend this treatment.
21 It was also discussed during a previous psychotic hospitalization,
22 so I am aware of this recommendation having been made before in
23 2020, around that time, as well. So we have tried, but I don't
24 think we've been able to fully engage for our overview of the
25 recommendation.

1 Q. To your knowledge, does Mr. Russell understand the risks
2 and benefits of ECT?
3 A. Not to my knowledge.
4 Q. In your medical opinion, is Mr. Russell able to give
5 informed consent to ECT?
6 A. No. Particularly due to his lack of insight or
7 agreement that he has a mental illness of schizoaffective
8 disorder.
9 Q. Does -- has Mr. Russell indicated whether he believes he
10 has any form of a mental illness?
11 A. From past work he has previously agreed upon a diagnosis
12 of post-traumatic stress disorder. I will admit today to the
13 Court that I don't know what Mr. Russell agrees with in terms of
14 his psychiatric diagnoses to date, but I know he does not agree
15 with the primary schizoaffective disorder.
16 Q. Has Mayo Clinic determined if ECT is medically
17 necessary?
18 A. Yes, we have. And that is due to the lack of response
19 to antipsychotic medication. At current, top recommended dosing
20 of olanzapine as well as previous trials of maximal dosing of
21 antipsychotics, including the aripiprazole as well as the
22 fluphenazine.
23 Q. What is the objective of treatment with ECT?
24 A. To target the delusional thoughts, ideally resolution or
25 at least significant reduction of delusional thoughts.

1 Q. Is ECT experimental?
2 A. It is not. It is a well-documented treatment for mental
3 illness, including primary psychotic disorders such as
4 schizoaffective disorder.
5 Q. I think I know from your previous answer, but is ECT
6 generally accepted in the medical community for the treatment of
7 Mr. Russell's mental illness?
8 A. It is.
9 Q. And besides the reduction and elimination of the
10 delusional symptoms, are there any other therapeutic effects that
11 you would hope to see with this treatment?
12 A. Possibly improved mood, but I would -- I would speculate
13 that just the reduction in psychotic symptoms will improve mood,
14 so we really are targeting the psychotic symptoms. But there is a
15 potential benefit that mood will improve with treatment with just
16 ECT alone. But the reduction of psychotic symptoms should improve
17 mood and, therefore, just overall function of being able to manage
18 relationships, conversations, and general interactions with
19 people.
20 Q. Is there a time frame for how long the ECT treatments
21 have the benefits to a patient?
22 A. Yeah. So that's really unclear until one starts a
23 course of ECT. We generally recommend up to three treatments a
24 week for an acute course. An acute course could be as short as
25 6 treatments to as high as 12 to 18, is what the literature would

1 say. In my clinical experience, I would estimate around 6 to 12
2 treatments. We always aim -- we always hope for as few as
3 treatments as possible and then the question after an acute course
4 of whether a maintenance course may be recommended, which would be
5 contingent on the clinical benefits of the treatment. For
6 example, if one saw resolution of psychotic symptoms with this
7 treatment, then I think a careful review of consideration for
8 maintenance treatments, which could be done as infrequent as once
9 a month long-term, would be considered.
10 At the same time, though, I want to just mention because
11 I know -- I'm well aware of how much Mr. Russell does not want
12 this treatment and so we don't take this lightly. My hope -- I
13 think it's reasonable to give an acute course, review, and see if
14 we can maybe stabilize that with medication and not look to a
15 maintenance course. But as I present the treatment of ECT, I want
16 to give the overview, but my hope would be is that an acute course
17 for this episode with a possible transition into an antipsychotic
18 medication to manage from there I think is still a reasonable
19 goal.
20 Q. And realizing that you don't intend to give the full
21 amount if you can avoid it, but the petition requests
22 authorization for up to 30 treatments over the next six months.
23 Is that accurate?
24 A. Yes.
25 Q. Are you able to estimate at all how likely ECT is to

1 provide benefits for Mr. Russell?
2 A. I'm not able to give percentages. ECT is generally more
3 effective than medication. We know that from -- historically ECT
4 was used much more frequently and earlier on for treatment of a
5 primary psychotic disorder. Now it's become relatively less
6 common because we have so many antipsychotic medications. So I
7 just don't have an ideal reference to give percentages. But the
8 effectiveness is usually quite beneficial to patients with primary
9 psychotic disorders more so than medication. I'm comfortable
10 saying that today.
11 Q. Is there anything that you have not testified to that
12 would impact how many treatments are determined to be given to
13 Mr. Russell?
14 A. No. I think -- I just want to -- I know Mr. Russell --
15 so that he could review too, we would be thinking up to three
16 treatments a week for probably two to three weeks. That would be
17 around eight to nine treatments. Ideally there would just be
18 benefits sooner and we would be able to either decrease frequency
19 within a week or just stop the ECT course and transition to
20 medication, meaning improvement with ECT course and pause and then
21 talk about long-term medication options.
22 Q. Are there any potential side effects associated with ECT
23 treatment?
24 A. Yeah. Most common are going to be body aches, possible
25 memory loss around the time of treatment -- so that's within the

1 days to a week of treatment but generally not long-term memories
2 from childhood or events prior to hospitalization -- are going to
3 be the most common from the ECT. And then the general risks of
4 having anesthesia.
5 Q. Will Mr. Russell be monitored and treated for any such
6 side effects?
7 A. Very carefully both during the course of the ECT
8 treatment as well as around the -- within 24 -- like, he's in the
9 hospital so we would be monitoring very carefully 24/7 following a
10 treatment.
11 Q. Are there steps taken to especially ensure the safety of
12 a patient when undergoing ECT?
13 A. Yes. So our monitoring is very careful. We would also
14 -- as we think about potential side effects of Mr. Russell having
15 headaches, body aches, problems like that that might be
16 uncomfortable or painful, quite frankly, we can use Tylenol,
17 acetaminophen, and ways to treat that proactively. We do careful
18 assessments after ECT to find out what a patient is experiencing
19 and try to plan ahead for the treatment very carefully.
20 If someone is having too much confusion, we will space
21 out the ECT treatments to make sure that they're not having too
22 much confusion as well.
23 Q. In your medical opinion, do the benefits of treatment
24 with ECT outweigh the possible risks to Mr. Russell?
25 A. Yes. And I'll add back in 2020 when our team had been

1 considering this, various physicians on our team, I was very
2 hesitant about ECT then. I really try to meet the patient where
3 they're at and try to be patient-centered. But I appreciate that
4 despite the medication trials that occurred then, since then, and
5 his inability to function successfully outside of a hospital
6 really warrant the ECT recommendation at this time.
7 Q. Given the medical trials -- or the medication trials --
8 are there any realistic alternatives to the use of ECT at this
9 time?
10 A. No.
11 Q. What is Mr. Russell's prognosis if he does not receive
12 ECT treatment?
13 A. Prognosis is poor. Prognosis would be what has been --
14 it would just be unchanged or continued symptoms of what he's
15 exhibiting now.
16 Q. I don't believe I have any further questions at this
17 time. Thank you.
18 THE COURT: Mr. Jones.
19 **CROSS-EXAMINATION**
20 BY MR. JONES:
21 Q. Dr. Schak, this is David Jones. I'm representing the
22 respondent in connection with this proceeding.
23 It appears that my client has a diagnosis now of
24 schizoaffective disorder. Has the diagnosis of schizoaffective
25 disorder or schizophrenia been a consistent diagnosis for my

1 client over the years?
2 A. My understanding is yes, at least since the time I've
3 known him. As I look back in the record, it might have been more
4 ill-defined earlier on. But as far as I can see in our electronic
5 medical record, the diagnosis has been present with speculation as
6 far back as 2013, at least in the Mayo Clinic electronic medical
7 records. But they were speculating between schizophrenia versus
8 schizoaffective disorder in 2013.
9 Q. In your testimony you referred to delusional and
10 psychotic demonstrations by my client. Can you give the Court
11 examples of delusional or psychotic presentations which would be
12 caused by untreated mental illness?
13 A. Yeah. So when I say (Zoom cuts out) psychosis, within
14 that would be the delusional thoughts. When he initially came
15 into the emergency department, he was describing that he had been
16 in, quote, telepathic fully in conversation with the military and
17 talking about unwilling conspiracy of torture, rape with mental
18 healthcare institutions, reporting -- he had reported that he has
19 been used for much of his life being involved with trafficking,
20 torture, and nonconsensual pornos all centered around the mental
21 healthcare system. And then continued talk of conspiracy theories
22 has been going on during the hospital stay despite the current
23 antipsychotic treatment.
24 Q. Even though my client has been taking his prescribed
25 drugs, has he at any point in his time in his current

1 hospitalization at Saint Marys required emergency medication?
2 A. I'm reviewing the medical record now to verify. It is
3 not clear to me that he has required, like, the emergency
4 administration with restraint during the current hospital stay.
5 Q. And with respect to the current hospitalization, while
6 it would appear my client understands that he's in a hospital,
7 what can you tell the Court regarding his awareness for the
8 reasons for his hospitalization?
9 A. Yeah. My understanding -- so it was in the brief
10 conversation this morning so I don't want to portray it otherwise
11 for being -- Mr. Russell. He wanted to focus on advocating
12 against the recommendation of the ECT, so we weren't able to have
13 a prolonged conversation.
14 But as I reviewed the record prior to coming to court
15 this morning, he has been focused on conspiracy theories going on
16 outside of the hospital -- has been a prominent topic that he's
17 been discussing throughout his hospitalization. Unfortunately,
18 he's become quite focused on advocating against ECT more recently,
19 and that has been the focus of a lot of the conversation. But
20 prior to that, the list of conspiracy theories has been quite
21 significant, both in his presentation in the emergency department
22 as well as initially when he came in.
23 Mr. Jones, I'm not sure if I answered your question
24 clearly, so if you would restate your question so I can be more
25 specific if I missed it.

1 Q. You did answer the question.
2 A. Okay. Thank you.
3 Q. And, Doctor, in your medical opinion, is ECT therapy
4 medically necessary at this time?
5 A. Yes, due to the lack of response from the maximal
6 treatment of antipsychotic medications both currently at the
7 Zyprexa 30 as well as previous antipsychotic trials at maximal
8 dosing.
9 Q. And you're requesting a maximum of 30 treatments over
10 the next six months; is that correct?
11 A. Yes.
12 Q. Is that within an acceptable range of treatments that
13 have been shown to be affective for my client's condition?
14 A. It is. We're including three treatments a week up to 18
15 treatments for an acute course, which I do not suspect will take
16 that many for Mr. Russell, but we do request that because it's
17 possible that someone could require that much for the acute
18 course. And then as you decrease into two treatments a week or
19 then to one treatment a week and ideally get down to as many --
20 like as small a number as possible, we do ask for the 30 in the
21 six months. But we always go for the minimal amount of
22 treatments.
23 Q. In your medical opinion, do the benefits outweigh the
24 risks?
25 A. Yes. I'm very hopeful that -- and I think there's good

1 reason to be -- that this could really treat his psychotic
2 symptoms in a way that he could have significant improvement and
3 function outside of a psychiatric hospital, even -- just more
4 meaningful independent living potentially. I think there's a real
5 chance that things can improve dramatically for Mr. Russell.
6 Q. Is this procedure reasonable?
7 A. It is reasonable and medically indicated.
8 Q. Is the goal of this procedure to restore his ability to
9 function within society?
10 A. It is. And that's really -- I think Mr. Russell's been
11 sick for so long and has struggled so much with the understanding
12 of his diagnosis and compliance to medications, I think that this
13 treatment could dramatically improve his quality of life.
14 Q. Has the respondent provided some specific reason why he
15 apposes ECT treatment?
16 A. To my knowledge, I'm unclear about his exact concern
17 about ECT, though I note historically, whether it's been
18 medications or just psychiatric care in general, he generally is
19 feeling that he doesn't require it in the way that we recommend
20 it. I know he's been open -- he's asked for therapy in the
21 hospital, like individual psychotherapy, but when it comes to
22 medications for treatment of psychosis he has been strongly
23 opposed when I've discussed this with him in the past.
24 Q. Do the records show that at this time my client has an
25 understanding of the risks and benefits and alternatives of ECT

1 treatment?

2 A. I have not been able to personally review that with him,

3 but from the record, I don't think we've been able to have a

4 conversation, any of our providers, due to arguments. So we are

5 not able to assess that he is able to know all that information.

6 Q. And at this time does my client have competency to make

7 decisions regarding the administration of ECT treatment?

8 A. No. He disagrees that he has a primary psychotic

9 disorder as a diagnosis.

10 Q. Thank you, Doctor.

11 MR. JONES: No further questions, Your Honor.

12 THE COURT: Mr. Ellison --

13 THE RESPONDENT: May I ask a simple question? If

14 the electroconvulsive therapy does not elicit the changes you

15 want, specifically in thinking that I'm delusional -- where I'm

16 from the jail got shut down. Senior staff at the --

17 THE COURT: Hold on. Hold on. Hold on.

18 Mr. Russell, Mr. Russell, I'm going to ask --

19 THE RESPONDENT: At any --

20 THE COURT: Hold on. Hold on.

21 Dr. Schak, if the first time -- if you were Court

22 ordered to conduct the ECT and if you did not see a positive

23 result after the first treatment, what is the course?

24 THE WITNESS: We often don't see benefit after the

25 first treatment. And honestly, it's often up to five treatments

1 until we see benefit for someone that has been struggling with
2 psychotic thoughts for so long. So it is multiple treatments.
3 And so during the early stages it's usually headaches and body
4 aches that are the most bothersome, and we would treat that. But
5 we would not expect there to be immediate response after one
6 treatment, unfortunately. If it happened --
7 THE RESPONDENT: After how many treatments where
8 you see no change in my delusional thinking -- at what point do
9 you say the very real effects of cognitive impairment, permanent
10 brain damage, memory loss, both short-term --
11 THE COURT: Hold on. Mr. Russell, hold on. Hold
12 on.
13 THE RESPONDENT: -- when do you say the side
14 effects aren't worth it because we aren't getting the elicit
15 response of me thinking I'm crazy? And I don't --
16 THE COURT: Hold on. Mr. Russell, Mr. Russell,
17 I'm going to let her answer your question, if she can. Okay.
18 Go ahead, Dr. Schak.
19 THE WITNESS: Yeah. So for the memory loss we are
20 watching -- we are monitoring that very carefully. So we're doing
21 cognitive assessments after each treatment and before the next
22 treatment. So if there is confusion or even disorientation based
23 on "I can't remember what day of the week it is" or "where I am,"
24 we would pause and not do another treatment until there's clarity
25 of thinking in that regard.

1 The memory loss is around the time of treatment.
2 So one might forget like what happened the day before or the
3 details of what transpired over the days before the treatment, but
4 we would not be expecting there to be brain damage in a way that
5 one would not remember past events.
6 THE COURT: All right. Dr. Schak, is there --
7 THE RESPONDENT: She didn't answer the question.
8 I would like to know --
9 THE COURT: Hold on.
10 THE RESPONDENT: -- after how many treatments
11 where you don't get the elicit response --
12 THE COURT: Right. Mr. Russell, Mr. Russell, I
13 understand the question.
14 THE RESPONDENT: Clearly there are very damaging
15 effects when you can't remember --
16 THE COURT: Mr. Russell.
17 Dr. Schak, in the event you pass that 6 treatment
18 or 10 treatment sessions, is there a medical route where you
19 decide that further treatments are not going to be beneficial?
20 THE WITNESS: Yeah, around 10 to 12 treatments.
21 Ideally sooner. I will admit that today. But I think that we
22 would be maxing around 10 to 12 treatments, would be the decision
23 point.
24 THE COURT: And what would happen next?
25 THE WITNESS: We'd have to talk about more --

1 sorry -- medication changes as primary. Like alternatives if we
2 were not able to see benefit from the ECT.
3 THE COURT: Is it accurate that those medications
4 may actually cause more trouble for Mr. Russell than --
5 THE RESPONDENT: Yes.
6 THE COURT: -- the ECT?
7 THE WITNESS: Yes. And that's why we wouldn't
8 recommend them before the ECT. They would be alternatives if the
9 ECT was not beneficial.
10 THE COURT: Thank you.
11 Mr. Jones, any follow-up?
12 **RECROSS-EXAMINATION**
13 BY MR. JONES:
14 Q. Just to follow up on the Court's last question,
15 Dr. Schak, from my experience representing other mentally ill
16 individuals, clozapine or Clozaril is sometimes prescribed for
17 some of the most significant cases prior to ECT.
18 Could you comment on that and its applicability to the
19 respondent?
20 A. I haven't discussed that with Mr. Russell. If he's
21 interested, I would be happy to discuss that further. It wouldn't
22 change my recommendation for ECT today. My concerns in explaining
23 to Mr. Russell and the Court why we're not pursuing that now is
24 Mr. Russell's concerns -- concerns about medication side effects
25 in general. The clozapine can be quite complicated. It is a

1 daily medication that one can only take by mouth. It requires
2 careful monitoring of blood work. Clozapine can reduce one's
3 white count -- white blood cell count and have other medical
4 sequelae.
5 And having worked with Mr. Russell in the past and
6 knowing his concerns for his medical health, I do think ECT is
7 preferred over clozapine in the recommendation today. But if he
8 were interested, I think we could talk further about a course of
9 clozapine as well, but I still think ECT is recommended.
10 THE RESPONDENT: Can I ask again. Specifically,
11 at what point do you acknowledge and say all of the treatments you
12 are using on me are causing me irreversible damage --
13 THE COURT: Mr. Russell, I am not going to require
14 her to answer that. I'm going to consider it argumentive. I've
15 given you leeway to interact, and at this point we're moving on.
16 Mr. Ellison, any follow-up questions for your
17 witness?
18 MR. ELLISON: I don't have anything further, Your
19 Honor.
20 THE COURT: Mr. Jones?
21 MR. JONES: No follow-up. Thank you, Your Honor.
22 THE COURT: All right. Dr. Schak --
23 THE RESPONDENT: I asked you if I've ever been a
24 threat to myself or --
25 THE COURT: Hold on, Mr. Russell. It's my turn.

1 Dr. Schak, thank you for your testimony. It's
2 been very clear and concise, and I was able to understand you
3 well. You are always welcome to stay with us. However, I also
4 know you have a full calendar, and if you need to leave and
5 disconnect you're welcome to do that. Okay?
6 THE WITNESS: Thank you.
7 THE COURT: All right. Mr. Ellison, your next
8 witness.
9 MR. ELLISON: Your Honor, the petitioner calls
10 Dr. Travis Tomford.
11 THE COURT: All right. Dr. Tomford, I'm going to
12 have you raise your right hand and be sworn in.
13 COURT CLERK: You do swear that the testimony you
14 give here will be the truth and nothing but the truth, so help you
15 God? If so, please say "I do."
16 THE WITNESS: I do.
17 THE COURT: Go ahead, Mr. Ellison, whenever you're
18 ready.
19 MR. ELLISON: Thank you, Your Honor.
20 - - -
21 TRAVIS TOMFORD, Psy.D, L.P.,
22 called on behalf of the Petitioner, being first duly
23 sworn, was examined and testified as follows:
24
25

1 **DIRECT EXAMINATION**

2 BY MR. ELLISON:

3 Q. Dr. Tomford, did you conduct an evaluation of David

4 Russell for purposes of this hearing?

5 A. I did.

6 Q. Have you conducted previous evaluations with

7 Mr. Russell?

8 A. Yes. I was the examiner for the initial commitment

9 proceedings back in January.

10 Q. Were you able to speak with Mr. Russell for today's

11 hearing?

12 A. I was.

13 Q. Did you review any collateral records regarding

14 Mr. Russell?

15 A. Well, I refamiliarized myself with the record from the

16 initial commitment proceedings and then I did obtain updated

17 records from his current placement.

18 Q. Have you rendered or in your review of the records is

19 there a particular diagnosis for Mr. Russell?

20 A. Yes. He carries an assigned diagnosis for

21 schizophrenia.

22 Q. Can you explain if there's any difference between a

23 schizophrenia doctor -- excuse me -- a schizophrenia diagnosis and

24 a schizoaffective diagnosis?

25 A. Schizoaffective would have a mood component. They both

1 fall under the umbrella of schizophrenia spectrum and other
2 psychotic disorders. It would not be surprising if he does -- has
3 been assigned a diagnosis for schizoaffective disorder as well
4 just given his history of a very unstable mood dysregulation.
5 Q. Are there particular symptoms that you took note of in
6 your interactions and/or review of the records regarding
7 Mr. Russell?
8 A. Yes. Symptoms consistent of schizophrenia would include
9 his durational thoughts; often underlying themes of paranoia and
10 grandiosity; extreme mood lability and agitation, which is a
11 common symptom of schizophrenia; at times disorganized in his
12 thinking, his speech, and behaviors. So that would be the
13 symptoms that I have observed and read. Also, perceptual
14 distortions, so hallucinations.
15 Q. As best as you can determine, does Mr. Russell believe
16 he has a mental illness?
17 A. He acknowledged that he has some struggles with his
18 mental health. He is quite dismissive of being labeled mentally
19 ill. Certainly disagrees with his assigned diagnosis for a
20 psychotic disorder.
21 Q. What is Mr. Russell's insight into his mental health at
22 this time?
23 A. Very poor. Does not fully appreciate the chronic nature
24 and severity of his symptoms. Does not appreciate his need for
25 treatment that would be standard, typical preferred first-line

1 treatment to manage his illness. Very opposed to traditional
2 treatments for his illness.
3 Q. And when you say first-line treatment, is that the
4 initial treatment that would be offered for someone with this
5 condition?
6 A. Yes. Typically it would be medication management, but
7 there are certainly alternatives, evidence-based treatments.
8 Q. When you spoke with Mr. Russell, did he give any
9 indication that he believes that he needs any types of mental
10 health treatment?
11 A. He indicated he is opposed to a treatment that would be
12 clinically indicated and that he does not need any treatment
13 that's being offered.
14 Q. Are you familiar in dealing with ECT?
15 A. I'm not. Typically they're administered by a medical
16 provider like a psychiatrist, but certainly I'm familiar with its
17 use.
18 Q. And generally speaking, is ECT a treatment method that
19 is used for a condition such as Mr. Russell's?
20 A. Yes, particularly for like refractory conditions, so
21 conditions that aren't responsive to, like, we'll say,
22 medications. It's more so a treatment-resistant psychosis,
23 treatment-resistant depression, etc.
24 Q. When you spoke with Mr. Russell, did he indicate whether
25 he would voluntary engage with ECT in any way?

1 A. He will not engage in voluntary treatment with ECT or
2 medication management.
3 Q. Historically, have there been concerns about
4 Mr. Russell's follow through when outside of a hospital or
5 treatment setting?
6 A. Yes.
7 Q. Generally speaking, what have those concerns been?
8 A. That he will not take his medications as prescribed,
9 regardless under his placement of a Jarvis order; that he will
10 subsequently experience rather abrupt psychiatric decompensation
11 and engage in erratic behaviors that pose a danger to himself or
12 others.
13 Q. In your opinion, does Mr. Russell currently have
14 capacity to make decisions regarding ECT?
15 A. No.
16 Q. Please explain why that's your opinion.
17 A. I was just looking at the statute and some of the
18 language. Certainly he understands he's in the hospital, but he
19 does not understand or have any awareness of his chronic mental
20 illness, the nature of his condition, or his need for further
21 inpatient stabilization to ensure his safety.
22 He will voice a number of concerns regarding the
23 potential risks of these procedures. However, he is completely
24 dismissive of the potential position or potential benefits from
25 medications or ECT.

1 I don't believe his communication or his opposition
2 towards treatment is reason-based but is grounded in a number of
3 paranoid delusional beliefs regarding the healthcare system. It
4 is also directly related to his extremely poor insight into his
5 mental illness.
6 Q. Dose Mr. Russell believe there's any validity to
7 concerns about his safety or the safety of others given his
8 underlying mental illness?
9 A. No. He's actually tried to contact supports outside the
10 hospital to more so seek validation and reenforce his belief that
11 he poses no danger to himself or others.
12 Q. Is it your understanding that ECT would be provided
13 under the direction of medical providers at the Mayo Clinic?
14 A. Yes. It's performed under general anesthesia.
15 Certainly providers would need to be present to monitor his
16 response, yes.
17 Q. In your opinion, does Mr. Russell require any further
18 mental health treatment?
19 A. Yes.
20 Q. What would his prognosis be if he does not receive ECT
21 or other appropriate treatment?
22 A. His prognosis, in my clinical opinion, would remain
23 poor. It would be likely that he would not be deemed appropriate
24 for discharge given ongoing safety concerns. And in the event he
25 was discharged and remained undertreated, I would expect that he

1 would be hospitalized in a very short duration.
2 Q. In your clinical opinion, does Mr. Russell meet the
3 criteria for an ECT order?
4 A. Yes.
5 Q. Is there anything that you have not mentioned that would
6 support your opinion on that fact?
7 A. No. No, thank you.
8 Q. I don't believe I have any further questions right now.
9 Thank you.
10 THE COURT: Mr. Jones.
11 **CROSS-EXAMINATION**
12 BY MR. JONES:
13 Q. Doctor, you examined my client with respect to the
14 commitment and Jarvis petitions earlier. Can you comment to the
15 Court as to my client's condition now compared to his condition at
16 that time?
17 A. Well, certainly there's some similarities between his
18 mental state. He was undertreated at the time. There was
19 concerns he was not taking his medications in January as well. He
20 was presenting as irritable and hostile and agitated at the time,
21 and we're continuing to see that.
22 It is noted, as is noted in my most recent report, he
23 did agree to speak with me. He was not overtly disrespectful or
24 oppositional. So at least there was some, I guess you could say,
25 ability to have reciprocated conversation. The concern remains,

1 though, that he continues to lack very poor insight, he's paranoid
2 about the healthcare system, and this is going to pose a barrier
3 to him receiving treatment.
4 Q. From your interaction with my client, as well as a
5 review of the records, does it appear that my client has an
6 understanding of the consequences of his refusal to pursue ECT
7 treatment?
8 A. No. Again, he is dismissive of his need for treatment.
9 He does not agree with any assertions that he has engaged in
10 unsafe behaviors towards himself or others; and, therefore, I do
11 believe his judgment is certainly flawed with regards to the
12 proposed treatment.
13 Q. The Price-Sheppard decision indicates that one of the
14 factors to be considered is the patient's ability to competently
15 determine for himself whether the treatment is desirable.
16 At this time is my client competently able to determine
17 for himself whether the treatment is desirable?
18 A. Not in his current state, no.
19 Q. Thank you, Doctor.
20 MR. JONES: No further questions, Your Honor.
21 THE COURT: Mr. Ellison.
22 MR. ELLISON: I have nothing further for
23 Dr. Tomford, Your Honor.
24 THE COURT: All right.
25 THE RESPONDENT: Can I ask exactly what behaviors?

1 I've never been violent to anybody, I've never engaged in --
2 THE COURT: Hold on. Hold on. Hold on. We're
3 going to try. So your question is what behaviors lead to his
4 conclusion today. Is that correct, Mr. Russell?
5 THE RESPONDENT: That I am a threat to myself or
6 others, correct.
7 THE COURT: Dr. Tomford, if you're able to answer
8 that, go ahead. If you're not able to, just say so.
9 THE WITNESS: Sure, Your Honor.
10 There was -- so he's been civilly committed on
11 numerous occasions. This current commitment -- while he was
12 hospitalized as St. John's, there was -- Prairie St. John's --
13 there was documented instances of him threatening to kill everyone
14 on the unit. He presented as extremely agitated, yelling various
15 persecutory beliefs. He has presented as intimidating and
16 posturing towards other residents at a group home placement prior
17 to that admission. And that's what proceeded this current
18 commitment period, Your Honor.
19 THE COURT: Thank you.
20 THE RESPONDENT: I disagree with that assessment.
21 I was --
22 THE COURT: All right. Hold on. He answered your
23 question. This is where the questions are.
24 THE RESPONDENT: Okay.
25 THE COURT: Okay. Thank you.

1 THE RESPONDENT: But yet I'm not allowed to see
2 the evidence. I'm not allowed -- I --
3 THE COURT: Hold on, Mr. Russell.
4 Mr. Ellison --
5 THE RESPONDENT: I will testify --
6 THE COURT: -- any follow-up now?
7 THE RESPONDENT: -- that I'm vehemently against
8 electroconvulsive therapy and that I'm not --
9 THE COURT: Mr. Russell, Mr. Russell.
10 Okay. Mr. Ellison, any follow-up with that
11 additional answer?
12 MR. ELLISON: No, Your Honor.
13 THE COURT: Mr. Jones?
14 MR. JONES: No follow-up, Your Honor.
15 THE WITNESS: Your Honor, I do have another
16 hearing that I'm quite late for.
17 THE COURT: Yeah.
18 THE WITNESS: If the Court is okay, may I please
19 be excused?
20 THE COURT: Absolutely. Thank you.
21 THE WITNESS: Thank you.
22 THE COURT: All right. Mr. Ellison, do you have
23 any other witnesses?
24 MR. ELLISON: No further witnesses, Your Honor.
25 Petitioner rests.

1 THE COURT: All right. And noting that the Court
2 previously received Exhibits 1, 2, and 3, Mr. Jones, how would you
3 like to proceed?
4 MR. JONES: And Exhibit No. 4, Your Honor. I
5 believe that was the provisional discharge revocation order.
6 THE COURT: Yes. Thank you.
7 MR. JONES: And there would be a report related to
8 that. Each of those was filed around April 17th.
9 Your Honor, before I inquire of my client, I would
10 inquire of the social worker, Amy Engel.
11 THE COURT: All right. Ms. Engel, I'm going to
12 have you turn your camera on, raise your right hand, and be sworn
13 in, please.
14 COURT CLERK: You do swear that the testimony you
15 give here will be the truth and nothing but the truth, so help you
16 God? If so, please say "I do."
17 THE WITNESS: I do.
18 THE COURT: Go ahead, Mr. Jones.
19 - - -
20 AMY ENGEL,
21 called on behalf of the Respondent, being first duly
22 sworn, was examined and testified as follows:
23 **DIRECT EXAMINATION**
24 BY MR. JONES:
25 Q. Ms. Engel, are you the case manager for the respondent?

1 A. Yes, I am.
2 Q. And are you familiar with him through interactions with
3 him as well as the review of the records?
4 A. Yes.
5 Q. My client is currently in Saint Marys, but the
6 hospitalization before that was at Prairie St. John's; is that
7 correct?
8 A. Yes.
9 Q. Was there a provisional discharge agreement reached with
10 Prairie St. John's allowing his release into the community?
11 A. Yes.
12 Q. Did that require medication compliance?
13 A. Yes.
14 Q. Do you know what the details were of that?
15 A. Just regarding the medications?
16 Q. Yes, please.
17 A. That he needed to take medications as prescribed every
18 day.
19 Q. And did the respondent appear to comply with that
20 provision of the provisional discharge agreement?
21 A. I can't be positive, but it did not appear that he was
22 stable. Although, they did discharge him without the
23 antipsychotic as well.
24 Q. In one of the prior commitments, my client was
25 discharged from a hospital to a group home in Mankato; is that

1 correct?
2 A. Yes.
3 Q. And in this particular commitment he was discharged from
4 Prairie St. John's but just simply sent back to Winona; is that
5 correct?
6 A. That is correct.
7 Q. Were you part of the decision-making process to simply
8 return him to Winona?
9 A. No.
10 Q. Would you have supported that decision?
11 A. No.
12 Q. And why is that?
13 A. I believed he needed, well, further -- he was on a
14 wait-list for a state facility, one of the CVHHs or Anoka. So we
15 were waiting for that. And then we believe he needed a more
16 structured setting instead of just being returned to his mother's
17 house. And his mother did not actually, in fact, want him there,
18 but the hospital pretty much made her take him back for a few
19 days.
20 Q. I don't want to put words in your mouth, but it was kind
21 of a -- was it a surprise to you to find out that he had been
22 discharged back to the community?
23 A. I knew that they were going to discharge him a few days
24 ahead of time. I did everything I could, as well as the guardian,
25 speaking to the State to see what we could do to stop it, and

1 there was nothing we could do.
2 Q. Thank you, Ms. Engel.
3 MR. JONES: No further questions, Your Honor.
4 THE RESPONDENT: Can I ask some questions?
5 THE COURT: Tell me one of your questions first.
6 THE RESPONDENT: The first question is that
7 hospital agreed with me that --
8 THE COURT: Hold on. Hold on. Mr. Russell, I
9 need to hear a question mark soon. Take your time.
10 THE RESPONDENT: Did the medical staff at that
11 hospital deem that the treatment would not get rid of my alleged
12 delusions and that I'm not able to be locked up for nothing more
13 than making scenes? I do have a copy of your --
14 THE COURT: Hold on. I think you had a question
15 right there so stop.
16 Ms. Engel, are you able to answer that question?
17 THE WITNESS: The first part of the question they
18 did --
19 THE RESPONDENT: Did --
20 THE WITNESS: -- I believe he asked about --
21 THE RESPONDENT: -- doctors at Prairie St. John's
22 disagree and state that no amount of treatment is going to help
23 and the damaging effects of chemical lobotomies or ECT far -- the
24 damaging effects far outweigh any potential benefit --
25 THE COURT: Hold on one second.

1 Ms. Engel, do you feel you can testify as to the
2 beliefs of the medical staff at saint -- Prairie St. John's?
3 THE WITNESS: Their discharge summary said that
4 they did not believe that they could get rid of your delusions.
5 THE RESPONDENT: And I was released on an
6 antidepressant or SSRI mood stabilizer, which I was taking,
7 correct? Further, I had outpatient things. I --
8 THE COURT: Hold on. Mr. Russell, you have to
9 stop at the question mark.
10 THE RESPONDENT: Sorry. I do better with --
11 THE WITNESS: You did discharge on Zoloft, I
12 believe.
13 THE RESPONDENT: Of which I was taking willing?
14 THE WITNESS: I can't guarantee that you were.
15 THE RESPONDENT: Okay. But one of the reasons I
16 blew up was because I had a guardian/conservator who refused to
17 give me money to buy groceries, so my mother actually had to pay
18 for my groceries and --
19 THE COURT: Hold on. Mr. Russell, at this point I
20 don't hear anymore questions. And if there's going to be
21 testimony from you, I'm going to leave it to your attorney to
22 elicit it. Okay?
23 Mr. Ellison, do you have anymore questions for
24 this witness?
25 MR. ELLISON: Just a couple very brief, Your

1 Honor.

2 **CROSS-EXAMINATION**

3 BY MR. ELLISON:

4 Q. Ms. Engel, the circumstances you understood around the

5 time of the provisional discharge revocation would be included in

6 your court report. Is that accurate?

7 A. Yes.

8 Q. And any information you thought was relevant you would

9 have included in that report?

10 A. Correct.

11 Q. Thank you. I have nothing further.

12 THE COURT: Mr. Jones?

13 MR. JONES: No follow-up, Your Honor.

14 THE COURT: Thank you, Ms. Engel.

15 THE WITNESS: Yep.

16 THE COURT: All right. Mr. Jones.

17 MR. JONES: Thank you, Your Honor. I would call

18 my client for testimony.

19 THE COURT: All right. Mr. Russell, you can

20 unmute and raise your right hand and be sworn in, please.

21 COURT CLERK: You do swear that the testimony you

22 give here will be the truth and nothing but the truth, so help you

23 God? If so, please say "I do."

24 THE WITNESS: I do.

25 THE COURT: Go ahead, Mr. Jones.

1 DAVID RUSSELL,

2 called on behalf of the Respondent, being first duly

3 sworn, was examined and testified as follows:

4 **DIRECT EXAMINATION**

5 BY MR. JONES:

6 Q. After the testimony of Dr. Tomford and Dr. Schak, do you

7 agree that you have the substantial psychiatric disorder of

8 schizophrenia or schizoaffective disorder?

9 A. Give me a reasonable amount of time to answer this

10 question. I believe that I meet the DSM statistical criteria for

11 one of those or a lot more; however, I'm well aware that a label

12 does not tell you what somebody is going through or how to help

13 them. If I were to, say, have a label of autism as opposed to

14 schizophrenia, it tells you very little about what's actually

15 going on.

16 I have readily acknowledged I have extreme mental health

17 problems often caused by the mental health system. Amy Engel

18 wants to send me to Anoka again. I have committed no crimes. I'm

19 not a threat to myself or others. Even if I am delusional, that's

20 not a reason to forcibly drug or electrocute me.

21 Q. Do you understand that you're in the hospital now due to

22 a revocation of your provisional discharge?

23 A. I do.

24 Q. And what did you do to cause the revocation of your

25 provisional discharge?

1 A. I blew up at Winona Volunteer Services who was donating
2 a bike to me but kept telling me to go pick up a bike in an
3 alleyway. Knowing that's shady as hell, I got upset and said that
4 is absolutely absurd. It's being treated like this that makes me
5 want to blow my brains out.
6 In addition, I had a case manager that refused to give
7 me money to buy groceries for my family, so I was suicidal about
8 that. Amy Engel stopped by with law enforcement at my mother's
9 house and basically just said we're going to -- we're going to
10 lock you up again.
11 Q. Mr. Russell, do you agree that you need to be in the
12 hospital at this time?
13 A. No, I do not agree that I need to be in the hospital at
14 this time. I believe that the treatments that are being forced
15 are damaging, will not correct -- even if I am delusional about
16 something, the medication and electroconvulsive therapy -- I'm
17 already sleeping 12-plus hours a day. I can't think. I'm
18 miserable. To say I'm a threat to myself or others is denying the
19 actual complex reality, and this hospital doesn't provide any
20 therapy, talk therapy, of which I have been utilizing and has been
21 affective. But while I'm in a hospital, I can't talk to a
22 therapist. And it seems like the only thing that's wanted is for
23 me to calm down about things like being given a
24 guardian/conservator despite being a software engineer.
25 Q. What benefits are you currently receiving from your

1 neuroleptic medication?
2 A. None.
3 Q. If you were to discontinue your neuroleptic medication,
4 what would happen?
5 A. Depends on if they were weaned off or instantly. If
6 it's instantly discontinue them, I'd probably have some mania and
7 stuff like that. If it's weaned off, absolutely nothing. I would
8 start to sleep a normal amount, would be able to think, would not
9 be as miserable. This has happened time and time again. However,
10 the reality is the group home that I was kicked out of had three
11 deaths within the last five years, two residents. And that's why
12 I started getting upset at staff because two residents were abused
13 there.
14 Q. Mr. Russell, what are the potential benefits of ECT
15 treatment?
16 A. According to them, that I'll magically not be
17 delusional. I'm -- potential benefits? I don't see how sending
18 electricity through your brain could be anything more than
19 damaging. It's guaranteed to cause damage. And based on a long
20 history and watching other people being given that, I'm terrified,
21 literally terrified. When they acknowledge the guaranteed things
22 after being pressured is you won't remember the treatment, you
23 won't remember the week, and that kind of thing -- it causes
24 permanent brain damage -- I do not want that. I will not benefit
25 from that.

1 Q. Has any medical provider, a psychologist or
2 psychiatrist, told you that ECT is not appropriate for you at this
3 time?
4 A. Numerous. The staff at Prairie St. John's said that
5 this is not beneficial and we don't support that. In addition, we
6 don't think that the antipsychotics are doing anything other than
7 making your life more miserable than it is.
8 In addition, the staff at Horizon Homes, until I blew
9 up, agreed with the assessment that the antipsychotics were part
10 of the problem. And for over six months was not on any
11 antipsychotics and doing just fine, despite being only given $25 a
12 week for personal needs.
13 Q. And you acknowledge that you have never had ECT
14 treatment in the past; is that correct?
15 A. That is correct.
16 MR. JONES: Thank you, Your Honor. Nothing
17 further.
18 THE COURT: Mr. Ellison.
19 MR. ELLISON: I don't have any questions, Your
20 Honor.
21 THE COURT: All right. Thank you, Mr. Russell.
22 Mr. Jones, any other witnesses?
23 MR. JONES: No, Your Honor.
24 THE RESPONDENT: I have two friends that said they
25 would attend. I'm not sure if it's based on everybody else.

1 Lucille Buteau, who would testify I'm not a threat to myself or
2 others, I get verbally upset and angry but never am I violent, and
3 further, that he is adamantly against electroconvulsive therapy;
4 as well as another friend, John Mayo, both of whom I've known for
5 over 20 years that are vehemently opposed to being forced
6 electroconvulsive therapy. I don't know where they are. I could
7 call one of them because I have their number. The other one would
8 require a computer to get in touch with.
9 THE COURT: All right. Thank you, Mr. Russell.
10 I do recognize your position against
11 electroconvulsive therapy and your gathering of opinions by those
12 you know who share your mistrust and disbelief in the process.
13 That has been duly noted.
14 Mr. Ellison, I'll hear from you.
15 MR. ELLISON: Thank you, Your Honor. Both doctors
16 here testified to the appropriateness of ECT. I err on the side
17 -- not err -- I think the Court should take their testimony as was
18 presented. The report of Dr. Tomford and the other documents are
19 in line with what was presented by Dr. Schak and Dr. Tomford. I
20 believe that supports the requests by Mayo Clinic here today.
21 Thank you.
22 THE COURT: Mr. Jones?
23 MR. JONES: Your Honor, the applicable law in a
24 case like this comes from *Price v. Sheppard* from the Minnesota
25 Supreme Court, 239 N.W.2d, 905. It's a supreme court case from

1 back in 1976. Price-Sheppard decision, unlike the Jarvis statute
2 of 253B.092, Subd. 5, which references capacity -- the
3 Price-Sheppard decision refers to competency. I actually deem
4 those terms to be synonymous. I don't see any difference between
5 those terms. And, in fact, my inquiries usually track along with
6 the Jarvis statute to see if it's necessary.
7 From the testimony of my client, he does not
8 believe that ECT is necessary. He sees only harm that will come
9 from it. He sees no potential benefit. He's also seeing no
10 benefit from the neuroleptics, only harm from the neuroleptics.
11 He would ask for denial of the Price-Sheppard petition.
12 THE COURT: Thank you.
13 THE RESPONDENT: I would also add that I've known
14 a dozen people that are shells of themselves because of ECT. They
15 say they were forced it. It didn't help. In addition, I'm aware
16 of one person that was given electroconvulsive therapy until they
17 couldn't talk. I would beg of the Court please do not allow them
18 to forcibly electrocute my brain.
19 THE COURT: Thank you.
20 As all parties present who work in this area
21 routinely day in and day out, no Court ever takes these lightly.
22 And it is obvious the extent of Mr. Russell's distrust and fear
23 over the procedure. With that, as gently as I can, I'm going to
24 order the requested relief.
25 It is clear to me that Mr. Russell and any support

1 that he has gathered believes this to be an experimental
2 treatment, and that is certainly not the case nor the finding of
3 this Court or many other courts. This treatment is accepted by
4 the medical community and has been supported not only by today's
5 testimony but in a long history of civil commitments that pass
6 through Jarvis and arrive here at what's been referred to as the
7 Price-Sheppard process.
8 I've heard testimony from Dr. Schak, Dr. Tomford,
9 social worker Amy Engel, and Mr. Russell himself. I have
10 Exhibits 1 through 4. This Court is aware, based on the record
11 today and statements of Mr. Russell and accumulation of my
12 observations of his history of civil commitments, his history of
13 not being medically compliant once discharged to the community,
14 and a long history of distrust with medical providers and
15 associated conspiracies -- and in this case, even when taking his
16 prescribed medications, he's not able to have a particular insight
17 to his mental health diagnosis. In general, he has no awareness
18 of the chronic mental illness that he, in fact, suffers from. And
19 he is at this time, given the prolonged extent of his illness,
20 having delusional thoughts that are at a nature that prohibit his
21 ability to be released to the community successfully. Without the
22 ECT treatments, he is not looking at a discharge from the
23 hospital.
24 In the event that the ECT treatments are not
25 successful, as is Mr. Russell's concern, the Court is also aware

1 that the next steps for him are medications with a much greater
2 likelihood of adverse side effects. So while the Court has heard
3 Mr. Russell, the Court is also aware that what he is asking for
4 is, in fact, more dangerous to himself than the ECT being
5 petitioned by the County and the hospital.
6 THE RESPONDENT: What I'm asking for is the
7 ability to refuse damaging treatments that don't help. While I've
8 been here, I have not been a threat to myself or others. Staff
9 says I'm not willing to communicate, but that's strictly because I
10 do not want these treatments. When you go, we're going to
11 continue treatment after treatment, you don't give a fuck about my
12 well-being. You don't give a fuck about --
13 THE COURT: Mr. Russell, I've been generous and
14 I've allowed you to speak outside of the direction of your
15 attorney. You are not going to conduct yourself in that manner in
16 my courtroom.
17 I am going to order the relief questioned. Again,
18 I do find that a reasonable person would authorize the treatment.
19 That is what's going to happen here today.
20 Mr. Ellison, is there anything else you think that
21 you need on the record?
22 MR. ELLISON: I don't believe so, Your Honor. I
23 think that covers everything.
24 THE COURT: Mr. Jones?
25 MR. JONES: Some additional considerations for the

1 record. Is the Court making the finding that ECT is medically
2 necessary at this time?
3 THE COURT: I am. I'm finding that he lacks the
4 capacity to make decisions regarding the administration of the ECT
5 because he does not demonstrate the awareness of his situation,
6 including the reasons for hospitalization and the possible
7 consequences of refusing this treatment. Again, he doesn't
8 understand the risks, benefits, or alternatives. He's not
9 communicated a choice that is reasonable based on reason versus
10 his delusions. Again, its not experimental, and there is nothing
11 -- no alternative available to the Court at this time.
12 The benefits certainly outweigh the risks of these
13 treatments. I've looked at the extent and duration of changes and
14 behavior patterns and mental activity. We've had a lot of
15 testimony to the risk of adverse side effects based at the
16 prompting of Mr. Russell's questions. We've heard from both the
17 physicians.
18 The extent of intrusion of the patient's body and
19 pain connected with the treatment, again, is different as
20 presented by the medical community and the testifying medical
21 providers contrary to that which Mr. Russell would put on the
22 record. And I don't think he can competently determine for
23 himself if treatment is appropriate.
24 I am finding it's reasonable and necessary that he
25 be treated with ECT at this time. And, again, I have listened to

1 him and his history and his -- I would call it his social value of
2 being opposed to this type of treatment or really any kind of
3 medical treatment.
4 Mr. Jones, anything else?
5 THE RESPONDENT: I have received great response
6 from actual talk therapy, but that's not provided here. I find it
7 absolutely disgusting and horrifying that you are willing to,
8 despite absolute obvious indications that it will not help. Only
9 instead saying if ECT doesn't help, we're going to try even more
10 damaging drugs over and over again when I'm not a threat to myself
11 or others.
12 THE COURT: Mr. Ellison, when you draft the order
13 can you include the respondent's request for talk therapy to be
14 included whenever possible and as soon as possible for his care?
15 MR. ELLISON: Yes, Your Honor.
16 THE COURT: Thank you. Anything else you want on
17 the record, Mr. Ellison?
18 MR. ELLISON: I don't believe so, Your Honor.
19 Thank you.
20 THE COURT: Court clerk?
21 COURT CLERK: No, Your Honor.
22 THE COURT: All right, then. This matter has been
23 decided. I will sign an order as soon as it's ready.
24 Mr. Jones, anything else?
25 MR. JONES: Nothing further, Your Honor.

1 THE COURT: All right. Thank you everyone. That
2 will be all for today.
3 - - -
4 (Whereupon, the proceedings were adjourned at 11:48 a.m.)
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3 **CERTIFICATE**
4
5 **STATE OF MINNESOTA)**
)
6 **COUNTY OF WINONA)**
7
8 I, Deborah A. Grebin, RPR, Official Court Reporter in and for the
9 State of Minnesota, Third Judicial District, hereby certify that
10 the foregoing 54 pages are a true and complete record of the
11 proceedings held herein, as transcribed from the audio recordings.
12
13
14 */s/Deborah A. Grebin* Dated: September 8, 2024
15 Deborah A. Grebin, RPR
District Court Reporter
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