REPORT

MULTIFACETED GRASSROOTS EFFORTS TO BRING ABOUT MEANINGFUL CHANGE TO ALASKA'S MENTAL HEALTH PROGRAM

In 2015, the results of these efforts disintegrated, which I have written about in Lessons from Soteria-Alaska? on MadInAmercia.Com.

by

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II. INTRODUCTION

As someone who managed to escape becoming permanently mentally ill by successfully resisting the mental illness system's[1] insistence that everyone coming within its purview must take psychiatric drugs indefinitely, and through my work with mental health "consumers" and my service on the Alaska Mental Health Board, I had a general idea about the way in which psychiatric drugs are, in the main, ineffective, harmful, and counterproductive. However, I didn't think I had any particular insight into actions I might take to try to rectify the situation. Then, Robert Whitaker's *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill* was published in 2002. *Mad in America* laid out an absolutely unassailable scientific presentation that overall, contrary to pharmaceutical company hype and thus popular belief, the neuroleptics are not beneficial, but rather extremely harmful. In fact, they dramatically reduce recovery rates for people diagnosed with schizophrenia. In addition to being a terrific, compelling book, to me, *Mad in America* represented a litigation roadmap for challenging forced psychiatric drugging based on the lack of scientific evidence to support it.

It was for that reason, in late 2002, the public interest law firm Law Project for Psychiatric Rights (PsychRights®) was formed to pursue strategic litigation against forced psychiatric drugging and electroshock. However, attacking current practice without offering solutions is not enough. So two non-profits, CHOICES, Inc., and Soteria-Alaska, were formed in early 2003 to provide alternatives to the "everybody must take drugs forever" paradigm of treatment. A fourth non-profit, Peer Properties, had been formed a couple of years earlier to provide peer-run housing that would not insist on people taking psychiatric drugs as a condition for receiving housing assistance. These four non-profits are designed to serve complementary roles in the effort to create alternatives in Alaska to our mental illness system's virtually exclusive focus on the administration of psychiatric drugs for "treatment" of people diagnosed with serious mental illness.

There is a huge debate over whether or not the drugs are as ineffective, harmful, and counterproductive as asserted, and it is not my purpose to engage in that debate here[2]; rather, the efforts described here are to transform the system so that it allows choice. I know people who find the drugs helpful and some who feel they saved their lives. I think people who want the drugs should have access to them.[3] By the same token, those who do not want the drugs should be given the choice to decline them and they should have support for this choice. Each of the four non-profits plays a role in this, although it was always anticipated one of them, Soteria-Alaska, could be rolled into CHOICES, Inc., depending on timing and funding, and some movement in that regard has taken place.

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[1] Because of the way what we call the "mental health system" channels people into chronic mental illness, I think it is more fairly described as a mental illness system, rather than a mental health system.
[2] However, there are references and links which demonstrate these are the facts.
[3] I do think the truth about them should be disclosed, though.

The purpose of this Report, then, is to describe the strategy, history, progress to date, and current prospects for this effort in Alaska[4] to improve the outcomes of people diagnosed with serious mental illness by making available alternatives to the coercive, substantially illegal, and essentially exclusive over-medication regime now in effect.

It cannot be over-emphasized this effort is about people's right to make choices regarding whether or not to assume the risks associated with these drugs in the hope of achieving their perceived benefits, or to try something else.

The Report includes extensive footnotes for those who wish to explore the topics in greater depth, and a glossary is included defining terms and acronyms.

III. BACKGROUND

The underlying premise is that the mental illness system's over-reliance on medication is at least doubling the number of people who are diagnosed as seriously and persistently mentally ill and is causing great harm to a great number of people,[5] including death.[6] By offering various alternatives to medication, many of which have been proven to work,[7] we are convinced that

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[4] I live in Alaska and as will be described below, it has some unique attributes, which make it a particularly good place to attempt to accomplish the type of meaningful change described here. The general ideas, however, can be used by people around the country (and to a certain extent, the world).

[5] It would unacceptably increase the length of this Report to support this statement here, and readers are directed to the terrific book, *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America*, released in April, 2010, which scientifically documents the horrendous societal toll this paradigm of treatment has inflicted and continues to inflict. See also the Scientific Research by Topic section of the PsychRights website, http://psychrights.org/Research/Digest/Researchbytopic.htm, as well as its Suggested Reading webpage, http://psychrights.org/Market/storefront.htm, for such support. If only one book is to be read on this topic, *Anatomy of an Epidemic: Magic Bullets, Psychiatric Dugs, and the Astonishing Rise of Mental Illness in America*, by Robert Whitaker, is recommended. The Affidavit of Robert Whitaker filed in a forced drugging case in Anchorage in September of 2007 is a succinct distillation of the scientific evidence contained in *Mad in America* with hyperlinks to the sources, and can be found at http://psychrights.org/litigation/WhitakerAffidavit.pdf.

[6] See, e.g., "Prospective analysis of premature mortality in schizophrenia in relation to health service engagement: a 7.5-year study within an epidemiologically complete, homogeneous population in rural Ireland," *Psychiatry Research*, 117 (2003) 127–135, which can be found at http://psychrights.org/Research/Digest/NLPs/MM-PsychRes2003.pdf. This study concluded: "On long-term prospective evaluation, risk for death in schizophrenia was doubled on a background of enduring engagement in psychiatric care with increasing provision of community-based services and introduction of second-generation antipsychotics." In other words, the death rate doubled over the already elevated rate with the introduction of the so-called "atypical" neuroleptics, such as Zyprexa and Risperdal. More recently, Morbidity and Mortality in People with Serious Mental Illness, by the National Association of State Mental Health Program, October 2006, found that people diagnosed with serious mental illness are now dying twenty-five years earlier than the general population.

[7] See, e.g., the material at Effective Non-Drug Treatments, http://psychrights.org/Research/Digest/Effective/effective.htm.

substantially better outcomes will result.[8] That the over-reliance on psychiatric drugs is not only worsening outcomes, but creating great harm, makes involuntary medication (Forced Drugging) particularly abhorrent. Legal proceedings in the United States for involuntary commitment and medication are essentially a sham,[9] and the lack of efficacy and the serious harm caused by the medications (and other treatments, such as electroshock) eliminate the justification for the prevailing paternalistic attitude that "We can't let people's pesky rights get in the way of what we know is in their best interests."

If people's rights were actually honored, court orders for Forced Drugging would not occur.[10] However, it is recognized (a) that society will not tolerate people who come to the attention of authorities in a way that invokes the involuntary "treatment" mechanisms, and (b) such people often really can benefit from (and want) a safe, nurturing, and helpful environment in which to work through their acute problems. Thus, even with respect to legal rights to be free from illegally imposed forced "treatment," it is absolutely essential that alternatives to the current, essentially medication-only treatment regime be made available.

The four non-profits are designed to offer the choice to pursue a non-medication approach in four distinct functional areas: Acute Care, Community-Based Services, Housing, and Honoring the Legal Right to Choose. As mentioned earlier, acute and community-based services can be performed by one agency. There are a number of benefits to this, the most important perhaps being that people do not lose the community-based support system they have when they want acute services and vice versa. In other words, they can continue working with the people whom they have hopefully grown to trust.

IV. ALASKA ATTRIBUTES

Alaska possesses several attributes that are fairly important in making it a particularly favorable environment to accomplish the goals presented here.

A. Small Population

Alaska has a very small population, which makes it easier for one person or a relatively small group of people to impact policy. Policy makers are generally much more accessible than in most places. I have been involved in mental health policy development for a long time, know

[8] The current system essentially channels people into becoming permanently disabled and thus a permanent financial burden on government. One of the side benefits of the change envisioned here is that a substantial number of people can get off or never get on the disability rolls, thus not only having much better lives, but decreasing the cost to government.

[9] See Section VI. D(3) below. See also J. Gottstein, "Involuntary Commitment and Forced Psychiatric Drugging in the Trial Courts: Rights Violations as a Matter of Course," 25 *Alaska L. Rev.* 51 (2008), which can be found at http://psychrights.org/Research/Legal/25AkLRev51Gottstein2008.pdf.

[10] This is based on the premise that people may not constitutionally be psychiatrically drugged against their will unless it can be scientifically proven it is in their best interests and there is no less intrusive alternative that could be made available.

many of the key players, and like to think I have a certain amount of credibility and respect. As will become apparent in the course of this Report, the goals are still not easy to accomplish.

B. Alaska Mental Health Trust Authority

A totally unique attribute of Alaska is the Alaska Mental Health Trust Authority, which was created as a result of the 1994 settlement of litigation (Trust Settlement) over the State of Alaska stealing 1 million acres of land granted in trust for Alaska's mental health program (Trust).[11] The Trust now has over $350 million in cash corpus, makes some money off its land corpus, and currently spends about $23 million a year on what it considers innovative programs and facilitating major initiatives, such as constructing a new state hospital. In addition to people diagnosed with mental illness, the Trust's beneficiaries include people diagnosed with developmental disabilities, chronic alcoholism, and Alzheimer's disease and related dementias. The influence and ability of the Trust Authority to impact Alaska's mental health program far exceed the relatively small amount of money it has to spend on it, a fact that should not be underestimated. A key to the Trust Authority's beneficial impact is that it has viewed success being measured by asking the question, "Is what we are doing improving the lives of our beneficiaries?" in contrast to the more standard bureaucratic question, "How many services are we providing?"

C. Alaska Mental Health Board

Under the Trust Settlement, four State boards, each representing one of the four groups of Trust beneficiaries, provide recommendations to the Trust Authority regarding mental health program funding. The Alaska Mental Health Board provides recommendations with respect to people diagnosed with mental illness. The quality and influence of the Mental Health Board has waxed and waned over the years, depending on its personnel and the political climate. At least one-half of the members of the Alaska Mental Health Board must be people with a mental disorder or members of their family, which potentially gives excellent representation for Consumers' interests in policy development.[12] Appointments to the board are by the governor, though, and are thus political to a greater or lesser extent.[13] The activities of the Alaska Mental Health Board were largely combined with the Advisory Board on Alcoholism and Drug Abuse a few years ago. In the last few years it is hard to discern much leadership or influence by the Mental Health Board.

D. Alaska Peer Support Consortium

In 2002, all of the Consumer-run programs in the state got together and formed the "Consumers Consortium" to provide a united voice to policy makers. See

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[11] See http://www.touchngo.com/lglcntr/spclint/mht.htm. I was one of the four plaintiffs' attorneys in that case. The Trust Settlement was valued at $1.1 billion by the trial court and consisted of $200 million in cash and a little under 1 million acres of land, approximately half of which was mineral estate only, such as the oil and gas rights.

[12] See AS 47.30.662(b), which can be accessed at http://www.touchngo.com/lglcntr/akstats/Statutes/Title47/Chapter30/Section662.htm.

[13] I was on the Mental Health Board from 1998 to 2004.

http://akmhcweb.org/Announcements/2002rfr/consortiumproposals.htm for its initial set of proposals. It is worth quoting its organizational statement:

> Consumers Consortium came together when disparate and exhausted consumer run organizations discovered their common problems and began looking for common solutions. The consortium has the assumption of commonness rather than the assumption of separation. We believe that it will be much easier for the MH system to respond effectively to us as a group, working together. In that spirit, we have come together to build a consensus around the mental health system in response to the Board's call for input into the budget building process.

From 2002 until 2005, the Consortium's members were able to reach a consensus on how available funds for Consumer-run programs should be allocated. However, for the State fiscal year starting in July 2005, funding was cut so much[14] that this was no longer possible and policy makers became increasingly concerned about the consumer groups themselves deciding how the money should be allocated. This resulted in the typical free-for-all competition process with winners and losers. The Consortium has since evolved into the Alaska Peer Support Consortium[15] with 501(c)(3) status and continues to be a great help to its member organizations; it has significant influence on policy related to issues of concern to it, including funding for peer support initiatives. Its current Vision on its website reads:

> The Alaska Peer Support Consortium is a statewide network of peer operated, peer support organizations. Each member organization addresses peer support in a very unique way, following their own communities' strengths, needs, and values. We are a group of groups which provides organization to organization support, recovery education, collective advocacy and being each other's advocates. We find that by gathering together, and finding our shared common experience, we can take care of ourselves better and provide a model for society of wellness. We cultivate new leadership in the peer movement and encourage consumers to gather, mentoring start up groups and encouraging support groups to form all over the state. We are a sustainable community of peer leaders dedicated to leading the charge toward making Alaska's human services one of the most effective and peer driven systems in the world.

E. Ionia

In 1987, a group of what I think of as refugees from the mental illness system in Massachusetts founded the community and non-profit, Ionia, in Kasilof, Alaska. They pooled their resources and created a lifestyle that works for them.[16] They now have over forty-five people living there, including many children. They built their own log houses, eat a strict macrobiotic diet, growing and gathering much of their own food, and meet every morning for as long as it takes to work through issues. A number of years ago, they needed some grant funding to expand their agricultural operation and build a community building they call the "Longhouse."

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[14] The Trust Authority doubled the amount of money it had previously allocated for what was called Consumer-run programs, but expanded eligibility to include all four of its beneficiary groups in what it called the "Trust Beneficiary Group Initiative," or "TBGI," which is now called "Beneficiary Projects Initiative," or "BPI."

[15] See http://www.akpeersupport.org.

[16] See http://akmhcweb.org/recovery/ioniaadn.html and http://ionia.org/.

The grant application brought what they were doing to the attention of policy makers, and Ionia became an example of a program that works. It is a group of people who, after being pronounced hopelessly and permanently mentally ill, created their own environment, and proved it is possible to recover from a diagnosis of serious mental illness and thrive.[17] They have been a driving force behind the Alaska Peer Support Consortium.

V. GENESIS OF EFFORT

While I have been involved in mental health policy in Alaska for quite a long time in various capacities[18] and had a pretty good sense of the failure of the mental illness system to truly help most people diagnosed with serious mental illness, the effort to create non-drug choices arose out of my reading *Mad in America* in late 2002. It is an excellent, very readable and enjoyable, yet extremely alarming book in that it reveals the vast numbers of people being greatly harmed by the current "treatment" paradigm.[19] Of course, there have been many books documenting the same thing, including *Rethinking Psychiatric Drugs*, by Dr. Grace Jackson, and the *Myth of the Chemical Cure*, by Dr. Joanna Moncrieff.

I was on the Alaska Mental Health Board at the time and sent every member of it, as well as every member of the Trust Authority, a copy of *Mad in America*, urging them to take action to improve the outcomes for people diagnosed with serious mental illness by providing alternatives to the drugs.[20] PsychRights brought Robert Whitaker, the author of *Mad in America*, to Anchorage in December 2002, to give a presentation to the Alaska Mental Health Board. While he was here, Mr. Whitaker also spoke to the Alaska Psychiatric Institute and to the statewide organization of community mental health centers. The Mental Health Board's reaction was mostly positive, but with state personnel and NAMI-Alaska members on the Board tending to be negative. However, there was general agreement people ought to have the choice to pursue a non-medication approach to care.

In the spring of 2003, as chair of the Mental Health Board's Finance Committee, I convened a Budget Summit, which produced a report that can be found at http://akmhcweb.org/Docs/AMHB/2003BudgetSummitReport.pdf. This report was formally adopted by the whole board in August of 2003. Here are a couple of significant passages from this report:

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[17] See http://ionia.org/.
[18] A brief bio can be found at http://psychrights.org/about/Gottstein.htm.
[19] This is one of the reasons why I often put "treatment" in quotation marks. Another is the idea that if it isn't voluntary, it isn't treatment.
[20] The transmittal to the members of the Alaska Mental Health Board can be found at http://psychrights.org/states/alaska/2002/MadInAmericatxtoMHBltr4Web.pdf. In March of 2003, I also transmitted a copy of *Mad in America* and other materials to the Commissioner of the Alaska Department of Health and Social Services exhorting him to address the situation. This transmittal letter can be found at http://psychrights.org/alaska/DMHDD/3-24-03jgtogilbertson.pdf.

> There were discussions of . . . whether it was clear enough from the data that the current reliance on psychiatric medications substantially increases chronicity. These and similar items are referred to the full Board/Planning Committee for further development and consideration. (p. 1)
>
> The Mental Health System currently relies heavily on psychiatric medications. It is recommended that further research on how the use of these medications impact desired results should be conducted. (p. 10)

I think it is fair to say there has been little, if any, follow-up on this since I left the board.

The four non-profit organization effort is designed to work within existing mechanisms to make non-coercive, non-medication options available in Alaska.

VI. SPECIFIC EFFORTS: STATUS & PROSPECTS

A. Acute Care: Soteria-Alaska

Soteria-Alaska's vision is to allow people with acute and long-term symptoms of mental illness to recover in a non-coercive, home-like environment, with choice about medication, and using the development of personal relationships as the primary intervention. Using this approach, it is believed that the trajectory of chronic disease, disability, and costly hospitalizations can be averted for many people. The program is an evidence-based, cost-effective alternative to permanent disability and poverty that is responsive to individual needs, desires, and cultural values.

Dr. Loren Mosher's Soteria-House project and study in the 1970s proved that people who are in acute psychiatric crisis, who would normally be hospitalized, can be at least as successfully treated short term and have much better long-term outcomes (lives) if they are allowed to get through their initial psychotic episode(s) without the use of neuroleptics or are given them for only a short time in low doses.[21] The Michigan State Psychotherapy study proved the same thing.[22] The Michigan study also shows that in the short term there are significant cost savings and the long-term cost savings are enormous.[23] In 2006 Jaako Seikkula

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[21] See "Soteria and Other Alternatives to Acute Psychiatric Hospitalization, A Personal and Professional Review," by Loren R. Mosher, M.D., *The Journal of Nervous and Mental Disease*, 187:142-149, 1999, which can be found at http://psychrights.org/Research/Digest/Effective/soteria.pdf, and the other studies located at http://psychrights.org/Research/Digest/Effective/effective.htm. In addition, Dr. Mosher's book, *Soteria: Through Madness to Deliverance* (published posthumously) is an incredibly good book about Soteria and gives one the feeling of what Soteria House was like.

[22] See "The Michigan State Psychotherapy Project," by Bertrom P. Karon and Gary R. VandenBos, which can be found at http://psychrights.org/Research/Digest/Effective/MIPsychProj.pdf. See also *Psychotherapy of Schizophrenia: The Treatment of Choice* (Jason Aronson, 1996), by Bertram P. Karon and Gary R. VandenBos, which has the most complete description of the Michigan study.

[23] One of the things that happens is that people who get caught by the system are channeled onto SSI/SSDI/Medicaid as a way to get them basic living funds and medical services. However, as the Budget Summit Report points out, "the Medicaid/SSDI/SSI eligibility and funding mechanism is essentially a one way ticket to permanent disability and poverty." See

reported that utilizing his "Open Dialogue" approach in Finland, five years after initial diagnosis, 82% of his psychotic patients were symptom-free, 86% have returned to their jobs or to school, and only 14% of his patients were on neuroleptic medications.[24]

Soteria-Alaska, Inc., was incorporated in January of 2003 as a vehicle to create a Soteria-like program in Alaska. Shortly thereafter, Jerry Jenkins came to Alaska to be the Executive Director of Anchorage Community Mental Health Services (ACMHS), the largest community mental health center in the state, and expressed support for being given non-medication choices. The decision was made that it would be easier to try and develop a Soteria-like program through ACMHS, and therefore Soteria-Alaska's efforts were put on hold.[25] However, as the 15-month deadline approached for filing for tax-exempt status and with ACMHS's efforts to establish a Soteria-like program faltering, Soteria-Alaska filed its application for tax-exempt status in the spring of 2004 in order to be in a position to move forward, itself.

Starting in the summer of 2004, Soteria-Alaska — first primarily with the extremely valuable help of Dr. Aron Wolf, and then through the addition of Susan Musante as Program Manager in the spring of 2006 — worked with the Alaska Mental Health Trust Authority to plan for and obtain funding to open a Soteria-like program in Anchorage. Because it should be one of the array of options available to people, both Soteria-Alaska and the Trust believe Soteria-Alaska funding should be part of the State's mental health program. The Trust recommended such funding to the governor and legislature for Fiscal Years 2008 and 2009, but the governor's budgets did not include such funding, nor did the legislature appropriate the funds for FY 2008 or 2009. The Trust continued the program with its own funds and Soteria-Alaska opened in June of 2009. In its 2010 session, due to the extraordinary efforts of Ms. Musante, the members of Soteria-Alaska's board, and with the support of other players, such as the Trust Authority, the Alaska State Legislature made an appropriation that partially funded Soteria-Alaska for fiscal year 2011, beginning July 1, 2010. While it is anticipated Soteria-Alaska's continued funding will be a struggle, the financial participation by the State of Alaska is a huge milestone.

In late June, 2011, tragedy struck Soteria-Alaska with a former resident who was back visiting in anticipation of becoming a volunteer was shot and killed by another former resident who was high on street drugs. It is hard to describe the extreme shock this was to everyone and the toll it has taken. However, Soteria-Alaska has survived this and continues to carry on its terrific work.

B. Community-Based Services: CHOICES, Inc.

CHOICES, Inc., was formed at the same time as Soteria-Alaska to provide an alternative

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http://akmhcweb.org/Docs/AMHB/2003BudgetSummitReport.pdf, page 8. This approach is part and parcel of the erroneous view that people don't recover from serious mental illness, especially a diagnosis of schizophrenia. This means droves of people unnecessarily become permanent financial burdens on the government.

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

[25] Probably the biggest concern with ACMHS implementing a Soteria-like program is whether it would remain faithful to Soteria precepts. As a traditional community mental health center, it has historically been very oriented toward requiring its clients to take psychiatric drugs, which is its corporate culture.

to the drug-only treatment modality in the community. It is a Consumer-run program. On its website, CHOICES describes its program as follows:[26]

> The philosophy behind CHOICES is reflected in both its name and the words which create the acronym CHOICES — Consumers Having Ownership In Creating Effective Services — which is people having options of their own creation and choosing.
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> CHOICES, Inc., a tax exempt, 501(c)(3) organization, was formed to provide alternatives in the community to the current medication dominated mental health system. CHOICES is a peer run community mental health provider established to facilitate self-directed empowering opportunities for people experiencing psychiatric symptoms to assist in achieving their individual self-directed recovery life goals.
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> CHOICES specializes in assisting people improve their lives and we help people learn, practice and develop methods and habits which serve their behavioral health needs and healthy lifestyle choices. CHOICES believes that individuals have the right to direct the services they receive in order to promote and enhance their individual recovery. CHOICES exists to assist our clients in achieving their recovery goals. Empowering them for lasting change.
>
> CHOICES is what is known as a Consumer Run program, where "consumer" means someone who has been labeled with a serious mental illness and is a past or present recipient of mental health services.
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> CHOICES has three primary modes of operation.
>
> 1. To provide people the types of services or other resources they **choose** to help them recover.
> 2. To develop and provide, to the extent possible, the types of community mental health services described by Loren Mosher and Lorenzo Burti in Chapter 9 of their excellent book, *Community Mental Health: A Practical Guide*.[27]
> 3. To be a conduit for "pass-through" grants to other Consumer Run programs that do not have tax exempt status or the administrative wherewithal to do so themselves.

CHOICES is a community-based analog to Soteria-Alaska in many ways.[28] CHOICES and Soteria-Alaska were launched as separate non-profits so that both the acute and community-based components could be developed on parallel tracks. In the summer of 2007, Susan Musante became the acting Executive Director of CHOICES in addition to Soteria-Alaska. CHOICES began providing services in the summer of 2007. Both boards of directors now have the same members.[29]

It is fair to say CHOICES is recognized as a tremendous resource for the community, while at the same time there is some push-back from the all-drug, all-the-time providers. CHOICES is now regularly asked to work with people with whom the system has had great

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[26] See http://choices-ak.org/.
[27] See http://choices-ak.org/cs/Portals/0/Ch9.pdf.
[28] It should be pointed out here, however, that the goal and expectation is that many people going through Soteria-Alaska will recover and come to rely on the mental health system much less, if at all.
[29] I left the boards of both CHOICES, Inc., and Soteria-Alaska at the end of October, 2007.

difficulty. This has led to some interesting clashes of culture with CHOICES standing by its principle of no coercion. These have served as tremendous demonstrations of the benefits of no coercion.

C. Housing: Peer Properties

Katsumi Kenaston and I co-founded Peer Properties, Inc., to provide housing for people diagnosed or diagnosable with serious mental illness and homeless and at risk of homelessness or in a bad living situation. Peer Properties does not provide services, but operates on the peer support principle. The peer support principle is relationships based upon shared experiences and values, and characterized by reciprocity, mutuality, and mutual acceptance and respect. The helper's principle, a corollary of the peer principle, is that working for the recovery of others facilitates personal recovery.

In 2004, Peer Properties received a capital grant of approximately $190,000 from the Trust, which, combined with a $25,000 grant from the Rasmuson Foundation, enabled the purchase of a four-bedroom house. It was anticipated Ms. Kenaston would devote a substantial amount of time to Peer Properties, but she departed fairly early on, which left it up to the volunteer board of directors and my tremendous assistants, Michele Turner and then Lisa Smith, to manage the project. There were the expected challenges with such a program, especially when new people moved in, but overall it worked very well, providing much needed safe, comfortable, and affordable housing to four women at a time when they would otherwise have been homeless or living in bad situations. At the same time, it was just too much of an uncompensated human resource burden and in May of 2010, through electing consumers associated with ACMHS to replace existing board members, control was essentially transferred to ACMHS' Consumer-Directed Services division.

It has long been recognized that being homeless or in a bad living situation contributes to psychiatric symptoms and prevents recovery.[30] It has more recently been recognized that linking housing to services can be counterproductive. There is a rather pervasive policy of community mental health centers requiring "compliance" with medication and/or utilizing certain services as a condition to receiving and/or being allowed to remain in housing. Thus, Peer Properties' philosophy, as originally constituted, neither encouraged nor discouraged the use of psychiatric medications; instead, it supported its tenants' choices in the matter. It is hoped this philosophy will continue under its new management.

Whether it does or not, Peer Properties has demonstrated the worth and viability of its approach, with the caveat that such a program's human resources needs must be provided.

D. Legal: Law Project for Psychiatric Rights

The Law Project for Psychiatric Rights (PsychRights®) is a non-profit, tax-exempt 501(c)(3), public interest law firm whose mission is to mount a strategic litigation campaign

[30] In the *Myers* case described below, Dr. Mosher testified (by affidavit), that "Without adequate housing, mental health 'treatment' is mostly a waste of time and money." See http://psychrights.org/States/Alaska/CaseOne/30-Day/ExhibitRLRMosherAff.htm, emphasis in original.

against forced psychiatric drugging and electroshock around the country, akin to what Thurgood Marshall and the NAACP mounted in the 40s and 50s on behalf of African American civil rights.[31] When one has a situation such as exists now in the mental illness system where entrenched and well-financed interests support an illegal system, litigation may very well be an essential element of reform.[32] Currently, due to massive growth in psychiatric drugging of children and youth and the current targeting of them for even more psychiatric drugging, PsychRights has made attacking this problem a priority. Children are virtually always forced to take these drugs because it is the adults in their lives who are making the decision. This is an unfolding national tragedy of immense proportions.

In addition to myself, Don Roberts and Chris Cyphers serve on its board of directors.[33] I currently donate all my services *pro bono publico*, although my financial situation has so dramatically deteriorated, I am hopeful PsychRights will be able to raise enough money to hire me.

(1) *Development*

While I had a general sense of what was happening with Forced Drugging, prior to reading *Mad in America*, I didn't think I had anything in particular to contribute toward ending this practice. *Mad in America* provided a litigation roadmap for marshalling the scientific evidence against Forced Drugging. It turned out the NARPA conference that November, 2002, included as keynote speakers: (1) Robert Whitaker, the author of *Mad in America*, (2) Loren Mosher, M.D., of Soteria House fame, and (3) Professor Michael Perlin, author of "The" treatise on mental health disability law and over 150 legal articles on the subject.

I wrote the articles "Unwarranted Court Ordered Medication: A Call to Action,"[34] and "Psychiatry: Force of Law."[35] When I attended the November 2002 NARPA conference, I also arranged for an off-agenda presentation.[36] There I met Mr. Whitaker, Dr. Mosher, and Professor Perlin. Then I arranged for Mr. Whitaker to come to Alaska for a presentation in December 2002. I also asked him to send me all of the articles cited in *Mad in America*. These articles were scanned and posted on the PsychRights' website to make them more accessible, and particularly so other attorneys could download and attach them as exhibits when fighting Forced Drugging cases.[37] Since then, these articles have been augmented with more recent research and expanded to include other topics.[38]

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[31] Since this Report is about Alaska efforts, PsychRights' efforts in other states is not covered.
[32] The article "How the Legal System Can Help Create a Recovery Culture in Mental Health Systems," which can be found at http://psychrights.org/Education/Alternatives05/RoleofLitigation.pdf, describes in some detail how strategic litigation, combined with influencing public opinion and the creation of alternatives to medication, is a key component in system change.
[33] Bios of the board of directors and other key personnel can be found at http://psychrights.org/about.htm.
[34] http://psychrights.org/calltoaction.htm
[35] http://psychrights.org/force_of_law.htm
[36] PsychRights provided a number of free copies of *Mad in America* to people who could not afford to purchase it, which helped with attendance.
[37] http://psychrights.org/Research/Digest/Chronicity/NeurolepticResearch.htm
[38] See Scientific Research by Topic at http://psychrights.org/Research/Digest/Researchbytopic.htm.

(2) *Finances*

PsychRights has a general policy against taking government funding because it is thought that one can not seriously challenge what the government is doing with its money. This has certainly proven to be true with respect to other government-funded attorneys in the arena. However, because of the unique nature of the Trust Authority, $5,000 in funding was accepted from the trust to help present a seminar on Mental Health Disability Law in September of 2003 by Professor Perlin and Robert Whitaker.[39] Also, a $10,000 Small Project grant was accepted for representation expenses, such as filing fees, deposition costs, expert witness fees, etc. PsychRights has also received attorney fee awards in a few cases. Otherwise, PsychRights is entirely sustained by private donations. While it is not the reason for undertaking the case, it is possible PsychRights will receive substantial funding through one or more of its federal False Claims Act cases, such as *United States ex rel Law Project for Psychiatric Rights v. Matsutani, et al.* PsychRights' finances are completely transparent, with comprehensive information posted at http://psychrights.org/about.htm.

(3) *The Role of Litigation for System Change*

Litigation as a means for changing systems is a proven strategy. The civil rights litigation by Thurgood Marshall and the NAACP in the 1940s and 50s overturning segregation is a classic example. In Alaska, in addition to the Mental Health Trust Lands litigation, we have had the *Molly Hootch* case for rural education and the *Cleary* case for prison administration. In situations such as currently exist with our mental illness system, where governmental policies are supported by large economic interests, litigation is often a necessary element in eliminating the abuses.

The Introduction mentions that Forced "Treatment" proceedings are essentially a sham. This is well known to those involved. Psychiatrists, with the full understanding and tacit permission of the trial judges, regularly lie in court[40] to obtain involuntary commitment and forced medication orders:

> [C]ourts accept . . . testimonial dishonesty, . . . specifically where witnesses, especially expert witnesses, show a "high propensity to purposely distort their testimony in order to achieve desired ends. . . ."
>
> Experts frequently . . . and openly subvert statutory and case law criteria that impose rigorous behavioral standards as predicates for commitment. . . .
>
> This combination . . . helps define a system in which (1) dishonest testimony is often regularly (and unthinkingly) accepted; (2) statutory and case law standards are frequently subverted; and (3) insurmountable barriers are raised to insure that the allegedly "therapeutically correct" social end is met. . . . In short, the mental disability law system often deprives individuals of liberty disingenuously and upon bases that have no relationship to case law or to statutes.[41]

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[39] See http://psychrights.org/Education/ak03CLE/Brochure.htm.
[40] This is perjury, a crime.
[41] "The ADA and Persons with Mental Disabilities: Can Sanist Attitudes Be Undone?" by Michael L. Perlin, *Journal of Law and Health*, 1993/1994, 8 JLHEALTH 15, 33-34.

The psychiatric profession explicitly acknowledges psychiatrists regularly lie to the courts in order to obtain forced "treatment" orders. E. Fuller Torrey, M.D., one of the most outspoken proponents of forced psychiatric "treatment" says:

> It would probably be difficult to find any American Psychiatrist working with the mentally ill who has not, at a minimum, exaggerated the dangerousness of a mentally ill person's behavior to obtain a judicial order for commitment.[42]

Dr. Torrey goes on to say this lying to the courts is a good thing. Dr. Torrey also quotes psychiatrist Paul Applebaum as saying when "confronted with psychotic persons who might well benefit from treatment, and who would certainly suffer without it, mental health professionals and judges alike were reluctant to comply with the law," noting that in "'the dominance of the commonsense model,' the laws are sometimes simply disregarded."[43]

It is also well known that:

> Traditionally, lawyers assigned to represent state hospital patients have failed miserably in their mission.[44]

The sham nature of Forced Treatment proceedings, [45] supported by the meretricious testimony of hospital psychiatrists and the overwhelming financial juggernaut of the pharmaceutical industry, has resulted in Forced Drugging being by far the "path of least resistance." In the *Myers* case described below, Dr. Loren Mosher testified by affidavit that as a therapeutic principle, "Involuntary treatment should be difficult to implement and used only in the direst of circumstances."[46] Thus, one of PsychRights' goals is to accomplish this therapeutic goal by making forced treatment more trouble than the more helpful alternatives that are currently eschewed. In that way, PsychRights hopes to create an environment in which these more helpful, more humane alternatives can flourish.

Of course, to the extent the system recognizes people have the right to decline or refuse medication and provides the choices to which they are entitled before they can legally be forced

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[42] Torrey, E. Fuller. 1997. *Out of the Shadows: Confronting America's Mental Illness Crisis*. New York: John Wiley and Sons, 152.

[43] In other words, "We can't let people's rights get in the way of us doing to them what we know is good for them."

[44] "Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization," Michael L. Perlin, *Houston Law Review*, 28 Hous. L. Rev. 63 (1991).

[45] See "Involuntary Commitment and Forced Psychiatric Drugging in the Trial Courts: Rights Violations as a Matter of Course," by James B. (Jim) Gottstein, 25 Alaska *L. Rev.* 51 (2008), which can be found at http://psychrights.org/Research/Legal/25AkLRev51Gottstein2008.pdf. While court-ordered involuntary psychiatric drugging is the most dramatic, coercion to take these harmful drugs is pervasive. As mentioned above, people are told they will not get or will lose their housing if they don't "comply." Other services will be denied. People will be "violated" on parole (i.e., sent back to prison to complete their sentences) if they do not comply. Children are taken away from their parents if they are not given drugs. Children are taken away from parents if the parent(s) don't take the drugs.

[46] See http://psychrights.org/States/Alaska/CaseOne/30-Day/ExR-LMosherAffidavit.pdf.

to take these drugs, litigation would/will not be necessary. In the absence of this, however, there has been some litigation already undertaken and other contemplated or in the works.

(4) *Undertaken Litigation*

(a) Myers — Forced Drugging

PsychRights' first case, *Myers v. Alaska Psychiatric Institute*,[47] directly challenging Alaska's Forced Drugging procedures, was decided by the Alaska Supreme Court on June 30, 2006.[48] In *Myers*, the trial court, after receiving expert testimony from Dr. Loren Mosher and Grace Jackson, as well as the State's psychiatrists, found as a factual matter:

> [T]here is a real and viable debate among qualified experts in the psychiatric community regarding whether the standard of care for treating schizophrenic patients should be the administration of anti-psychotic medication

and

> [T]here is a viable debate in the psychiatric community regarding whether administration of this type of medication might actually cause damage to her or ultimately worsen her condition

yet ordered involuntary drugging because the relevant statute only requires a finding of incompetence to decline the medication.[49] We argued the Alaska and US constitutions require that there must be at least a finding the medication is in the person's best interest. More importantly for changing the system, we also argued involuntary medication can only be constitutionally administered if no less intrusive alternative could be offered.

The Alaska Supreme Court agreed, holding:

> We conclude that the Alaska Constitution's guarantees of liberty and privacy require an independent judicial determination of an incompetent mental patient's best interests before the superior court may authorize a facility like API to treat the patient with psychotropic drugs. . . . [W]e hold that in future non-emergency cases a court may not permit a treatment facility to administer psychotropic drugs unless the court . . . expressly finds by clear and convincing evidence that the proposed treatment is in the patient's best interests and that no less intrusive alternative is available.[50]

However, *Myers'* use of the word "available" was ambiguous. Did it mean that the State could just decide not to fund a less intrusive alternative, making it not "available"? From our perspective, we didn't believe this could possibly be true, which was decided in the 2009 case of *Bigley v. Alaska Psychiatric Institute*, discussed below.

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[47] See http://psychrights.org/States/Alaska/CaseOne.htm for more information on this case, including the briefs and transcripts of some of the hearings.
[48] 138 P.3d 238. A copy of the Decision is available at http://psychrights.org/States/Alaska/CaseOne/MyersOpinion.pdf.
[49] See http://psychrights.org/States/Alaska/CaseOne/30-Day/Order.pdf, pages 8 and 13.
[50] 138 P.3d at 254.

The *Myers* decision, of course, is very good. It respects people's rights and has created the legal foundation for the creation of alternatives by not allowing people to be locked up and forcibly drugged as easily as they are now.

However, this is not enough. As discussed above, people's rights in these types of proceedings are dishonored as a matter of course. In the version of this Report I wrote right after the *Myers* decision came out, I said:

> Unless legal rights are honored, the only impact of the Myers decision is likely to be the addition of two sentences to the forced drugging petition forms and court orders reciting it is in the person's best interests and there is no less restrictive alternative available. In order for *Myers* to be meaningful people need at least a reasonable level of legal representation.

With respect to just adding the two sentences, my prediction proved wrong. As the Alaska Supreme Court noted in the *Bigley* decision discussed below, the hospital didn't even change its form to recite these constitutional requirements. This allowed for a huge win in 2009 in the *Bigley* case over this issue.

We have had less success with the issue of legal representation, however, as is discussed next in connection with the *Wetherhorn* case.

(b) *Wetherhorn I* — Gravely Disabled Standard for Commitment

The *Wetherhorn I* appeal, which was decided January 12, 2007,[51] (1) was taken to establish the right to effective representation, (2) challenged when people can be committed for being "gravely disabled," and (3) raised a couple other issues.[52] If people actually had vigorous representation, only a small fraction of those currently subjected to Involuntary Commitment and Forced Drugging would lose their cases. This would create the incentive for the State to provide other, non-coercive, choices. We had hoped to establish some minimum standards for the performance of counsel, and also that people are entitled to have an "expert witness" paid for, because without an "expert witness" to counter the state's "expert witness" (the psychiatrist), it is not a fair process. The Alaska Supreme Court agreed that people are entitled to effective representation, but declined to consider whether or not Roslyn Wetherhorn had received ineffective representation because her attorney had not had a chance to say why she did not do anything on her behalf. The court ruled a separate proceeding must be brought in which the Public Defender Agency was given the chance to explain why it did or did not do certain things on Roslyn's behalf.

The Alaska Supreme Court, however, did strike down that part of the Alaska Statutes allowing people to be involuntarily committed if failing to do so would result in a "substantial deterioration of the person's previous ability to function independently." It held this could only be constitutional if it means "unable to survive safely in freedom." This is a substantially higher hurdle and it very well may be the first state supreme court decision in the country to specifically address the issue.

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[51] 156 P.3d 371. The slip opinion is available at http://psychrights.org/States/Alaska/CaseFour/WetherhornIsp-6091.pdf.

[52] More information on this case can be found at http://psychrights.org/States/Alaska/CaseFour.htm.

The court held that the other issues we raised on appeal weren't raised by Roslyn's trial attorney and the court therefore wouldn't overturn the decisions. This was really a "Catch-22" because the court said Roslyn couldn't raise the fact that her attorney didn't do anything on her behalf in a direct appeal and then ruled against her on these other issues because her attorney hadn't raised them. This is yet another illustration of the importance of having effective representation.

(c) *Wetherhorn II* — Attorney's Fees

In *Wetherhorn II*, we sought to establish the right to attorney's fees in the event the State does not prevail on its petition(s) for involuntary commitment and/or forced drugging because if we could have done so, it would have encouraged members of the private bar to take some of these cases and adequately represent their clients. However, we lost because the court believed involuntary commitment and forced drugging proceedings are "designed to protect the welfare of at-risk people [and awarding attorney's fees against the state] could . . . deter the state from engaging in needed protective litigation."[53]

(d) *Bavilla* — Forced Drugging in Prison

In the *Bavilla* case, which challenged the procedures for Forced Drugging in prison, the Alaska Department of Corrections admitted to facts constituting violations of the United States Constitution.[54] However, the trial court dismissed the case on sovereign immunity grounds, meaning we should have sued the Commissioner of the Department of Corrections rather than the State. It is very unclear the judge was correct about this, but we had successfully prevented Ms. Bavilla's Forced Drugging up to that point, the prison was putting intense pressure on her in its attempt to "break" her, and Ms. Bavilla declined to file an appeal or recommence the case. However, at an opportune time when we have the resources, we have the admissions of the State regarding their illegal procedures and can commence a new case challenging Forced Drugging in prison in Alaska.

(e) *Wayne B.*

In *Wayne B.*, we challenged the practice of the Probate Masters, to whom these cases are referred in Anchorage, to hold the hearings and make *recommendations* to the Superior Court, of totally ignoring Civil Rule 53(d)(1)'s requirement that their recommendations be accompanied by a transcript of the proceedings. This resulted in the Superior Court judges, who have the responsibility for actually deciding these cases, "rubber stamping" the Masters' recommendations. In 2008, the Alaska Supreme Court held the rule cannot just be ignored:

> We take a strict view of the transcript filing requirement because, as we noted in *Wetherhorn v. Alaska Psychiatric Institute*, involuntary commitment for a mental disorder is a "massive curtailment of liberty." Given the nature of the liberty interest at stake, it was critical that the superior court have full knowledge of the evidence that was said to justify committing Wayne B. to a mental institution. . . .

[53] *Wetherhorn v. Alaska Psychiatric Institute*, 167 P.3d 701, 703 (Alaska 2007) (*Wetherhorn II*).
[54] More information on this case can be found at http://psychrights.org/States/Alaska/CaseThree.htm.

> Where no transcript is filed, but a judge actually listens to a recording of the full proceedings conducted by a master, the error in failing to comply with the transcript requirement should be considered cured. The adjudicative responsibilities of a judge can be fulfilled at least as well based on a recording of proceedings as from a transcript. But there is no indication that this occurred in this case. (footnotes omitted)[55]

In a subsequent case in which PsychRights was involved, this procedure was not followed, the judge apparently being unaware of the requirement to listen to the recording if no transcript is provided. It is not known how prevalent it is for the judges to ignore the Alaska Supreme Court's ruling in *Wayne B*.

(f) *Bigley v. Alaska Psychiatric Institute*

Bigley v. Alaska Psychiatric Institute[56] builds on *Myers* in a number of ways. In this forced drugging case against Mr. Bigley,[57] our primary goal was for the court to order the State provide a specific less intrusive alternative that we had proposed. We, of course, also opposed the court finding that the forced drugging was in Mr. Bigley's best interests. I was given notice late in the day on Friday, May 9, 2008, while I was out of town, that the hearing on the forced drugging petition was going to be held at 10:00 a.m. the following Monday, May 12, 2008. The forced drugging petition merely checked a box on a form that said:

> Petitioner has reason to believe the patient is incapable of giving or withholding informed consent. The facility wishes to use psychotropic medication in a noncrisis situation.

This form predated the *Myers* decision and merely recites the statutory requirements. As mentioned above, I had predicted the only change the *Myers* decision would achieve without keeping the pressure on was that the form would be changed to add the *Myers* requirements that (i) the drugging was in the patient's best interest, and (ii) no less intrusive alternative is available to the forced drugging petitions. However, the State didn't even do that. I had raised this point a number of times in post-*Myers* forced drugging proceedings, which the trial courts uniformly ignored. The *Bigley* case was the first time the issue had reached the Alaska Supreme Court.

Among other things, we objected to (1) the short notice, (2) the failure of the petition to provide adequate notice of the grounds that supported the petition, and (3) the failure of the hospital to provide PsychRights with a copy of Mr. Bigley's medical records. We also presented

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[55] Because the rule was being ignored in all of the cases referred to Masters, as a result of the *Wayne B.* decision, the rule was changed for other types of cases to only require the transcript or listening to the recording if a party objects to Master's recommendations. They couldn't change the rule for involuntary commitment cases, however, because the Alaska Supreme Court implicitly ruled it was a constitutional requirement because of the "massive curtailment of liberty" involved.

[56] 208 P.3d 168 (Alaska 2009), the slip opinion of which is available at http://psychrights.org/States/Alaska/CaseXX/S13116/090522BigleyvAPIsp-6374.pdf.

[57] Mr. Bigley is the client for whom the Zyprexa Papers were subpoenaed in December, 2006, and when Lilly failed to object in time and I received them, released to a number of parties, including the *New York Times*. This resulted in a number of front page stories, which, according to the *New York Times*, caused the criminal investigation of Lilly to "gain momentum," which then led to the $1.4 billion settlement earlier this year.

as good a case as we could in the short timeframe against the forced drugging being in Mr. Bigley's best interests and in support of the less intrusive alternative.

As mentioned above, *Myers'* holding that the State cannot drug someone against their will if there is a less intrusive alternative available did not define what "available" means. In *Bigley*, we argued that of course it doesn't mean the State can just choose not to fund the alternative, therefore making it unavailable. We also argued that by invoking its awesome power to lock someone up after they were found to be mentally ill, the State was required to provide such a less intrusive alternative.

In the 2009 *Bigley* Decision, the Alaska Supreme Court agreed the State could not just make a less intrusive alternative unavailable by failing to fund it, holding that if such a less intrusive alternative is "feasible," the State's choices are to either provide it or let the person go. This may end up being more than half a loaf because in order for the State to be allowed to even bring a forced drugging petition against someone, they must first have been found to be so dangerous to themselves or others as to justify their being locked up. To then turn around and discharge someone instead of providing a less intrusive alternative is inconsistent with that, to be charitable.

With respect to what the petition must include, the Alaska Supreme Court held that as a matter of constitutional Due Process,

> [The petition] must provide a plain, concise, and definite written statement of the facts underlying the petition, including the nature of and reasons for the proposed treatment, in order that the respondent may prepare, if he or she desires, to challenge the petition under the *Myers* factors. This should include information about the patient's symptoms and diagnosis; the medication to be used; the method of administration; the likely dosage; possible side effects, risks and expected benefits; and the risks and benefits of alternative treatments and nontreatment.

This is very important. Unfortunately, it is expected the hospital won't comply, and the judges will initially ignore this requirement because the public defenders assigned to these cases will not be aggressively asserting the requirement. However, over time, especially to the extent PsychRights is able to mount challenges, it can have a significant impact. For one thing, it really makes it far easier to cross-examine the hospital psychiatrist because one can show that they are not being truthful about these *Myers* Factors.

The Court also held as a matter of constitutional Due Process that the hospital has to provide the medical records prior to the hearing.

The Court found the short notice did not deny Mr. Bigley Due Process because we were able "to mount a vigorous challenge to the petition." However, the Court went on to say:

> Nevertheless, it is possible that his presentation of his case under the *Myers* best interests factors could have been compromised. Accordingly, we decline to render an opinion here about whether API met its burden of showing by clear and convincing evidence that the proposed treatment was in Bigley's best interests.

All of the documents from this case, including trial transcripts, are available at http://psychrights.org/States/Alaska/CaseSeven.htm#S-13116.

(g) *PsychRights v. Alaska* — Psychiatric Drugging of Children & Youth by State of Alaska

The State takes custody of a large number of children, and has shipped between 400 and 500 at a time to out-of-state facilities.[58] One can assume well over half of children and youth in state custody, virtually all in residential treatment centers, both inside and outside of Alaska, are being psychiatrically drugged. North Star in Anchorage is notorious for heavily drugging children and youth and engaging in polypharmacy. Polypharmacy is rampant with children and youth as well as adults, and most of the drugs have never even been approved for pediatric use. We know these drugs create structural changes in the brain,[59] but no one has any idea what these drugs are doing to the developing brains of our children and youth. Whenever children and youth are given drugs, they are being Force Drugged because they have no choice. It is especially egregious that those responsible for the well-being of children and youth are blaming the children and youth and subjecting them to the horrors of psychiatric drugging.

PsychRights tried to get the State to correct this situation from 2004, until September, 2008,[60] and upon failing that filed *Law Project for Psychiatric Rights v. State of Alaska*, Case No. 3AN 08-10115 CI, seeking declaratory and injunctive relief that Alaskan children and youth have the right not to be administered psychotropic drugs unless and until:

(i) evidence-based psychosocial interventions have been exhausted,
(ii) rationally anticipated benefits of psychotropic drug treatment outweigh the risks,
(iii) the person or entity authorizing administration of the drug(s) is fully informed, and
(iv) close monitoring of, and appropriate means of responding to, treatment emergent effects are in place,

and that all children and youth currently receiving such drugs be evaluated and brought into compliance with the above.

[58] See http://www.mhtrust.org/documents/BringtheKidsHome.pdf. The Trust has instituted a "Bring the Kids Home" initiative, but if that just means locking them up and drugging them in Alaska, rather than somewhere else, it is not a real solution.
[59] In fact most of the neuroimaging used by proponents of the drugs for the proposition that people with mental illness have brain differences, really show the effects of the drugs. See, e.g., "Broken Brains or Flawed Studies? A Critical Review of ADHD Neuroimaging Research," by Jonathon Leo and David Cohen, *The Journal of Mind and Behavior*, Winter 2003, Volume 24, Number 1, pp. 29-56, which can be accessed at http://psychrights.org/Research/Digest/NLPs/criticalreviewofadhd.pdf.
[60] See http://psychrights.org/States/Alaska/PsychRightsvAlaska.htm#Attempts.

On May 27, 2009, the trial court decided PsychRights lacked standing,[61] which means not having the right to bring the suit. We appealed[62] and oral argument was held in mid-March, 2010. We appealed, but the Alaska Supreme Court upheld the dismissal.

(5) *PsychRights' Medicaid Fraud Initiative Against Psychiatric Drugging of Children & Youth.*

The massive psychiatric drugging of America's children, particularly poor, disadvantaged children and youth through Medicaid and in foster care, is an unfolding public health catastrophe of massive proportions. This catastrophe is being caused by the fraudulent promotion of these harmful practices by pharmaceutical companies, sacrificing children and youth's health, futures, and lives on the altar of corporate profits. In 2009, Eli Lilly agreed to pay $1.4 billion in criminal and civil penalties for illegal off-label promotion of Zyprexa; Pfizer agreed to pay $2.3 billion for the illegal off-label promotion of a number of drugs, including Geodon for use on children and youth; and AstraZeneca agreed to pay $520 million for the illegal off-label promotion of Seroquel for use on children and youth. As large as these fines are, however, they are merely a cost of doing business to these pharmaceutical Goliaths and, in fact, cap their liability for these crimes. Most importantly, these settlements have not stopped the practice of child psychiatrists and other prescribers giving these drugs to children and youth, and Medicaid continuing to pay such fraudulent claims.

PsychRights' Medicaid Fraud Initiative Against Psychiatric Drugging of Children & Youth[63] is designed to address this problem by having lawsuits brought against the doctors prescribing these harmful, ineffective drugs, their employers, and the pharmacies filling these prescriptions and submitting them to Medicaid for reimbursement. Congress prohibited Medicaid from reimbursing the costs of off-label prescriptions unless they are "supported" by at least one of three "compendia." It turns out that much, if not most, of psychiatric prescriptions to children and youth submitted to Medicaid do not qualify. PsychRights has developed a chart of "medically accepted indications."[64] If the indication (diagnosis) is not shown in white on the chart, PsychRights' view is the submission for reimbursement to Medicaid is fraudulent.

Once one sues over specific offending prescriptions, all of such prescriptions can be brought in, which means that any psychiatrist on the losing end of such a lawsuit will almost certainly be bankrupted, because each offending prescription carries a penalty of between $5,500 and $11,000. Each prescriber may have a million dollars to lose, but the pharmacies' financial exposure can run into the hundreds of millions of dollars, and it is hoped this will attract attorneys to take these cases. The prospect of prescribers being bankrupted and pharmacies' exposed to massive financial liability is why it is expected that once this financial exposure becomes known, it will put the brakes on the practice.

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[61] http://psychrights.org/States/Alaska/PsychRightsvAlaska/090527Transcript%28StandingDecision%29.pdf

[62] http://psychrights.org/States/Alaska/PsychRightsvAlaska.htm#Supreme

[63] http://psychrights.org/Education/ModelQuiTam/ModelQuiTam.htm

[64] http://psychrights.org/Education/ModelQuiTam/PediatricPsychotropicMedicallyAcceptedIndications.pdf

PsychRights also developed a streamlined model *Qui Tam* Complaint[65] for use around the country. The model *Qui Tam* Complaint is drafted for former foster youth to bring the lawsuits and receive the whistleblower's share of the recovery, but anyone with knowledge of specific offending prescriptions, such as parents and mental health workers, can bring these suits.

However, these cases are filed under seal (in secret) for at least 60 days to allow the government an opportunity to investigate and decide whether to intervene and take over the case or not. The average time under seal is 13 months. This secrecy procedure will delay public knowledge of prescribers' and pharmacies' financial exposure. However, two such cases in Alaska, recently consolidated, have been unsealed.

(6) *United States ex rel Law Project for Psychiatric Rights v. Matsutani, et al., and United States ex rel Griffin v. Martino, et al.*

On January 25, 2010, PsychRights' first False Claims Act case, *United States ex rel Law Project for Psychiatric Rights v. Matsutani, et al.*,[66] against the following defendants was unsealed

Osamu H. Matsutani, M.D.	Claudia Phillips, M.D.	Irvin Rothrock, M.D.
William Hogan, Commissioner of the Alaska Department of Health and Social Services	Southcentral Foundation	Lucy Curtis, M.D.
Tammy Sandoval, Director of the Alaska Office of Children's Services	Sheila Clark, M.D.	Alternatives Community Mental Health Services D/B/A Denali Family Services
Steve McComb, Director of the Alaska Division of Juvenile Justice	Hugh Starks, M.D.	Anchorage Community Mental Health Services
William Streur, Director of the Alaska Division of Health Care Services	Lina Judith Bautista, M.D.	Fairbanks Psychiatric and Neurologic Clinic, PC
Juneau Youth Services, Inc.	Heidi F. Lopez-Coonjohn, M.D.	Peninsula Community Health Services of Alaska, Inc.
Providence Health & Services	Jan Kiele, M.D.	Bartlett Regional Hospital
Elizabeth Baisi, M.D.	Robert D. Schults, M.D.	Thomson Reuters (Healthcare), Inc.
Ruth Dukoff, M.D	Mark H. Stauffer, M.D.	Wal-Mart Stores, Inc.

[65] http://psychrights.org/Education/ModelQuiTam/PsychRightsModelQuiTamComplaint.pdf
[66] http://psychrights.org/States/Alaska/Matsutani/Matsutani.htm

North Star Hospital | Ronald A. Martino, M.D. | Safeway, Inc.

Kerry Ozer, M.D. | Fred Meyer Stores, Inc.

United States ex rel Law Project for Psychiatric Rights v. Matsutani, et al., United States District Court, District of Alaska, Case No. 3:09-cv-0080-TMB. On May 18, 2010, PsychRights' second case was unsealed, *United States ex rel Griffin v. Martino, Family Centered Services & Safeway*.[67] These two cases were consolidated on July 12, 2010.

On September 24, 2010, this case was dismissed under what is known as the "Public Disclosure Bar" on the grounds government officials already know about the industry-wide fraud and are allowing it to continue.

> [T]he Government already "has pursued False Claims Act cases and achieved extremely large recoveries against drug companies for causing the presentment of claims to Medicaid for prescriptions of psychotropic drugs that are not for medically accepted indications, including Geodon and Seroquel for use in children and youth." Thus, . . . the Government already knows about the conduct . . . .

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PsychRights believes the judge misinterpreted the law and appealed. One of the reasons Congress passed the False Claims Act allowing private parties to sue on behalf of the government to recover for fraud was to address the problem of federal officials refusing to stop fraud against the government. However, on October, 25, 2011, the 9th Circuit affirmed the dismissal in an unpublished decision that is not supposed to be cited as precedent. PsychRights filed a Petitition for Panel Rehearing and Rehearing *En Banc*, which was denied on December 2, 2011. The 9th Circuit decision was basically, "If the government doesn't care about the fraud, why should we?"

Since the 9th Circuit decision is explicitly not precedent, PsychRights may very well pursue another such case.

(7) *Prospective Litigation*

(a) Elder Drugging Abuses

It has become increasingly common around the country for the elderly to be so medicated they can't get out of bed. It is likely that this occurs in Alaska also and an appropriate case may present itself when resources are available. The rules regarding what prescriptions for what indications constitute Medicare Fraud may be different from those for Medicaid Fraud, but a quick review suggests that much of the psychiatric drugging of the elderly submitted to Medicare is also fraud.

[67] http://psychrights.org/States/Alaska/GriffinvMartino.htm

(b) Informed Consent

A choice to take psychiatric drugs is truly voluntary only if people are told the truth about the drugs. This is called informed consent. The truth, however, is uniformly not told, which constitutes a lack of informed consent. Alaska has a relatively explicit statute on informed consent in an inpatient setting.[68] We have had a complaint against API drafted for six years now waiting for a suitable plaintiff and the resources to pursue it.[69]

(c) 42 USC 1983 Civil Rights Action(s)

Under the federal law, 42 USC §1983, it is illegal for anyone "acting under color of law" to deprive someone of their rights under the United States Constitution.[70] This law grants the right to injunctions and damages. In other words, API and its psychiatrists are liable for the way they violate the rights of their patients and an injunction against such violations should be available. To the extent these illegal behaviors are not corrected through the other efforts outlined here, we will seriously consider resort to "Section 1983" in federal court to seek redress. Challenging forced drugging in Alaska's prisons, for example, might be brought as such a civil rights case.

(d) Ethics Complaints

It seems apparent that the Public Defenders Office is violating its ethical obligation to vigorously assert its clients' rights. If other means to obtain effective representation are not successful, it is possible an ethics complaint(s) will be filed.

(8) *Strategy/Attorney Recruitment*

The cases described above are designed to set precedent and consequently be system changing in that way. In addition to this, however, just having one serious representation of an API inmate[71] per week or even per month would substantially increase demands on state resources to involuntarily commit and Force Drug its inmates. In other words, make Forced "Treatment" not necessarily the path of least resistance. Serious representations involve depositions of the psychiatrist(s) and other treating personnel as well as potentially other witnesses, filing motions, etc. I make it a practice to elect the hearing be held in a real courtroom under AS 47.30.735(b)[72] and, in my view, a jury trial should be demanded under AS 47.30.745(c)[73] for every 90-day commitment petition. The trials should last at least hours, if not days, rather than the approximately 15 to 30 minutes they do now. Objections should be made to

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[68] See AS 47.30.837, which can be accessed at http://touchngo.com/lglcntr/akstats/Statutes/Title47/Chapter30/Section837.htm.
[69] See http://psychrights.org/States/Alaska/CaseTwo/draftInformedConsentComplaint.htm.
[70] This is a simplification and more information about "Section 1983" rights can be found at http://psychrights.org/Research/Legal/1983/1983.htm.
[71] The American Heritage Dictionary, Fourth Edition, defines "inmate" as "A resident of a dwelling that houses a number of occupants, especially a person confined to an institution, such as a prison or hospital."
[72] See http://www.touchngo.com/lglcntr/akstats/Statutes/Title47/Chapter30/Section735.htm.
[73] See http://www.touchngo.com/lglcntr/akstats/Statutes/Title47/Chapter30/Section745.htm.

unfavorable Probate Master recommendations.[74] Requests for emergency stays against Forced Drugging should be made.[75] Appeals should be taken when appropriate.[76] In 2004, I met with the Public Defender and the Assistant Public Defenders who normally handle these cases.[77] I gave them copies of *Mad in America* and informed them what I thought it took to adequately represent psychiatric defendants. It does not appear anything changed and when the opportunity arose, PsychRights took the *Wetherhorn* appeal to try and obtain more than sham representation. That didn't work out, but there are other avenues to pursue effective representation that can be undertaken when resources permit. If even a relatively small number of cases were vigorously defended, it could go a long way toward changing the "path of least resistance" to support choice.

There is, of course, a limit to what I can do by myself, but it is hoped that the *Matsutani* case will provide sufficient funds to hire another attorney.

(a) Alaska *Pro Bono* Program

The Alaska Bar Association has a program to recruit *pro bono* attorneys to represent indigent people or people who otherwise can not afford legal representation. We have established contact with the Alaska *Pro Bono* Program, but time constraints have limited my ability to follow up.

(b) Private Bar

In my view, psychiatrists and organizations that are harming people through their prescribing practices, including not telling the truth about the drugs, should be held accountable for such harm. The Internal Revenue Service does not consider suing for money to be a "charitable activity" appropriate for PsychRights and has indicated if I took such cases in my own law practice they would consider that I was using PsychRights' tax-exempt status to further my own financial interests. In essence, I am prohibited from representing people in such cases. However, I can encourage and even assist other members of the private bar to do so. Medicaid Fraud cases are also potentially very financially attractive to the private bar.

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[74] Under Alaska Statutes, the State must go to the Superior Court for involuntary commitment and Forced Drugging Orders. However, under the Alaska Court Rules, they can be assigned to a "Master" to conduct the hearings. (See Alaska Probate Rule 2 & 2(b)(2)(C), which can be accessed at http://www.state.ak.us/courts/prob.htm#2.) The Master, however, has limited authority, which is primarily to make recommendations that have to be approved (or not) by a Superior Court judge. The recommendations can be objected to (See Probate Rule (2)(e)&(f)). It appears these recommendations are virtually never, if ever, objected to by the Public Defenders.

[75] Under Alaska Probate Rule 2(b)(3)(D), a Master's Forced Drugging order is effective prior to approval by the Superior Court, but under Alaska Probate Rule 2(f)(2) a stay may be requested. I question whether it is proper to make a Forced Drugging recommendation effective without a proper Superior Court order and this is a possible subject of appeal.

[76] An example of the lack of representation provided by the Public Defenders office is they have never appealed any involuntary commitment or Forced Drugging order.

[77] A copy of the discussion points for this meeting is available at http://psychrights.org/states/Alaska/CaseFour/PDONotes.pdf.

(9) *Educational Programs*

Part of PsychRights' program is to provide information and education to attorneys, mental health system personnel, and the public.

(a) Speaking Engagements

My policy is to accept as many speaking invitations as I can. Consistent with that, I have given many presentations in Anchorage, including those to the annual consumer conferences and various college classes.

(b) Website

PsychRights' website has a lot of substantive information of interest to the psychiatric rights community, including posting full articles and studies for use by attorneys and other interested people. The Scientific Research by Topic[78] and Articles[79] web pages are replete with important information from authoritative sources. There are many other informative sections of the website, which is hopefully organized in a user-friendly manner, including a section with relevant information unique to many individual states.[80]

(c) Law Review Article

In June of 2008, the *Alaska Law Review* published J. Gottstein, "Involuntary Commitment and Forced Psychiatric Drugging in the Trial Courts: Rights Violations as a Matter of Course," 25 *Alaska L. Rev.* 51 (2008), which lays out a number of ways in which Alaska's current involuntary commitment and forced drugging regime operates illegally.[81] The *Alaska Law Review* was considered a desirable place to publish this article because it goes to every lawyer and judge in the state.

(d) Mental Health Disability Law Conference

In September of 2003, with support from the Trust Authority, PsychRights brought up Robert Whitaker, author of *Mad in America*, and Professor Michael Perlin, for a two-day seminar on Mental Health Disability Law.[82] This seminar was well attended with a mix of mental health providers, mental health lawyers, judges, and psychiatric survivors participating.

VII. FINAL THOUGHTS, ACKNOWLEDGMENTS, AND PERSONAL NOTES

This Report seems far too much "me, me, me," "I did this" and "I did that" and I fear it doesn't adequately credit all of the other terrific people who have been tirelessly working on

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[78] http://psychrights.org/Research/Digest/Researchbytopic.htm
[79] http://psychrights.org/Articles/articles.htm
[80] http://psychrights.org/States/States.htm
[81] Available on the Internet at http://psychrights.org/Research/Legal/25AkLRev51Gottstein2008.pdf.
[82] See http://psychrights.org/Education/ak03CLE/Brochure.htm.

these issues and projects, such as Lisa Smith, Michele Turner, Susan Musante, Dr. Aron Wolf, Andrea Schmook, Barry and Cathy Creighton, Eliza and Ted Eller, Faith Myers and Dorrance Collins, Alma Menn, Mel Henry, Don Roberts, Esther Hopkins (may she rest in peace), Jamie Dakis, and Roslyn Wetherhorn. I have no doubt failed to mention people that I should have.

I hope this Report conveys the urgency of addressing the situation. The scale of harm being done every day is enormous. The gross violations of rights contribute greatly to the problem, because it is the initial involuntary commitment and Forced Drugging that channel so many people into lifelong disability, largely caused by the debilitating drugs they are authoritatively but erroneously told they must take for the rest of their lives. The failure of the system to address the problem reminds me of the reaction of the Alaska State Legislature in the early 80s when we told them their "redesignation" (theft) of Mental Health Trust Lands was illegal. Their response was essentially "We don't care if it is illegal — sue us." We did with great success.[83] This situation is far more important.

Of course, litigation is not a goal, it is a means to achieve a goal. In this case the goal is to bring about true change to Alaska's mental health system to achieve the dramatically improved outcomes and lives for those diagnosed with mental illness. Instead of litigation, it is greatly preferable to work cooperatively towards achieving this goal. CHOICES and Soteria-Alaska are directly aimed at achieving this goal, with Peer Properties playing more of a supporting role. It is my fervent hope we can begin taking these enormously important actions sooner rather than later. The stakes are too high, the human toll too great, to fail to do so.

[83] See http://www.touchngo.com/lglcntr/spclint/mht.htm.

VIII. GLOSSARY

- "AHFC" stands for the Alaska Housing Finance Corporation.

- "Alaska Mental Health Board" is "the planning and coordinating agency for the purposes of federal and state laws relating to the mental health program of the state of Alaska. The purpose of the board is to assist the state in ensuring an integrated comprehensive mental health program." See AS 47.30.661, which can be accessed at http://www.touchngo.com/lglcntr/akstats/Statutes/Title47/Chapter30/Section661.htm. The Alaska Mental Health Board is one of the four boards which provide funding recommendations to the Alaska Mental Health Trust Authority. See AS 47.30.666, which can be accessed at http://www.touchngo.com/lglcntr/akstats/Statutes/Title47/Chapter30/Section666.htm.

- "Alaska Mental Health Trust Authority." See "Trust Authority" below.

- "API" stands for the Alaska Psychiatric Institute, which is the sole state psychiatric hospital.[84]

- "Beneficiaries" means the beneficiaries of the Mental Health Lands Trust, which include (1) the mentally ill, (2) the mentally defective and retarded, (3) chronic alcoholics suffering from psychoses, and (4) senile people who as a result of their senility suffer major mental illness.[85]

- "Budget Summit Report" is the report by the Budget Committee of the Alaska Mental Health Board, adopted by the full board in August of 2003. See http://akmhcweb.org/Docs/AMHB/2003BudgetSummitReport.pdf.

- "Consumer" means someone who is or has received mental health services, normally after being diagnosed with a serious mental illness.

- "Consumers Consortium" was the statewide group consisting of all Consumer-run programs in the state that has evolved into the Alaska Peer Support Consortium.

- "Corpus" as employed herein is the principal amount of the Trust's endowment, as contrasted to the earnings or income. The corpus is not to be spent.

- "C/S/X" stands for **C**onsumers of mental health services, **S**urvivors of Psychiatry and e**X**-psychiatric patients and refers to people who have received mental health treatment. There has never been a consensus on what term should be used. Other terms that have been used

[84] There are, however, some "designated beds" in other hospitals and psychiatric units at other hospitals in Anchorage, Fairbanks, and Juneau.

[85] See AS 47.30.056(b)&(c), which can be accessed at http://www.touchngo.com/lglcntr/akstats/Statutes/Title47/Chapter30/Section056.htm. See also http://mhtrust.org/index.cfm?section=about_trust&page=Beneficiaries.

include "users," "recipients," "patients," and "psychiatrized." In Alaska, because of the Mental Health Lands Trust, they are often called "beneficiaries."

- "Department" means the Alaska Department of Health and Social Services.

- "Mental Health Board." See Alaska Mental Health Board.

- "Mental Health Lands Trust Litigation" refers to the 15-year-long litigation over the State of Alaska's "redesignation" (theft) of the 1 million acres of land granted to it in trust for Alaska's mental health program. See http://www.touchngo.com/lglcntr/spclint/mht.htm.

- "NAMI" stands for the National Association for the Mentally Ill, which touts itself as "the Nation's Voice on Mental Illness." NAMI was founded by parents of people diagnosed with serious mental illness, is heavily financed by the pharmaceutical industry, and vigorously pushes for more Forced Drugging.

- "NAMI-Alaska" is the statewide Alaska affiliate of NAMI. A majority of its board is currently Consumers, which allows it to access funding for Consumer-run programs. NAMI-Alaska, as most of NAMI's affiliates, does not understand the extent to which NAMI is controlled by pharmaceutical funding, nor the extent to which NAMI pushes Forced Drugging.

- "NARPA" stands for National Association of Rights Protection and Advocacy. See http://www.narpa.org/.

- "Polypharmacy" is defined as the use of several drugs or medicines together in the treatment of disease, suggesting indiscriminate, unscientific, or excessive prescription. See http://classes.kumc.edu/som/amed900/polypharmcay/polypharmdrug.htm.

- "Rasmuson Foundation" is the largest private foundation in Alaska and has made a number of mental health-related grants. See http://rasmuson.org/.

- "Trust Authority" stands for the Alaska Mental Health Trust Authority, which was created in the settlement of the litigation over the Alaska Mental Health Lands Trust. See http://mhtrust.org/.

- "Trust Settlement" refers to the settlement of the litigation over the State of Alaska "redesignating" (i.e., "stealing") the 1 million acres of land granted in trust to Alaska's mental health program by the federal government. See http://www.touchngo.com/lglcntr/spclint/mht.htm.