Exhibit 1

How the Legal System Can Help Create a Recovery Culture in Mental Health Systems

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II. Summary

The purpose of this paper is to show how strategic litigation can and should be a part of efforts to transform mental health systems to culture of recovery. Currently, involuntary commitment and forced drugging are by far the "path of least resistance" when society is faced with someone who is disturbing and their thinking does not conform to society's norms.[1] In other words, it is far easier for the system to lock people up and drug them into submission, then it is to spend the time with them to develop a therapeutic relationship and thus able to engage the person with voluntary humane alternatives leading to recovery.[2] I estimate that 10% of involuntary commitments in the United states and none of the forced drugging under the *parens patriae* doctrine[3] are legally justified. This presents a tremendous opportunity to use litigation to "encourage" the creation of voluntary, recovery oriented services.[4]

In my view, though, in order to be successful various myths of mental illness need to be debunked among the general public and humane, effective recovery oriented, non-

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[1] By phrasing it this way, I am not disputing that people become psychotic. I have been there. *See*, http://akmhcweb.org/recovery/jgrec.htm. However, there are lots of degrees -- a continuum, if you will -- and there are different ways of looking at these unaccepted ways of thinking, or altered states of consciousness. So, what I mean by this terminology is that people are faced with involuntary commitment and forced drugging when two conditions exist: One, they are bothering another person(s), including concern about the risk of suicide or other self-harm, and Two, they are expressing thoughts that do not conform to those accepted "normal" by society. Of course, this ignores the reality that a lot of both are often trumped up, especially against people who have previously been subjected to the system.

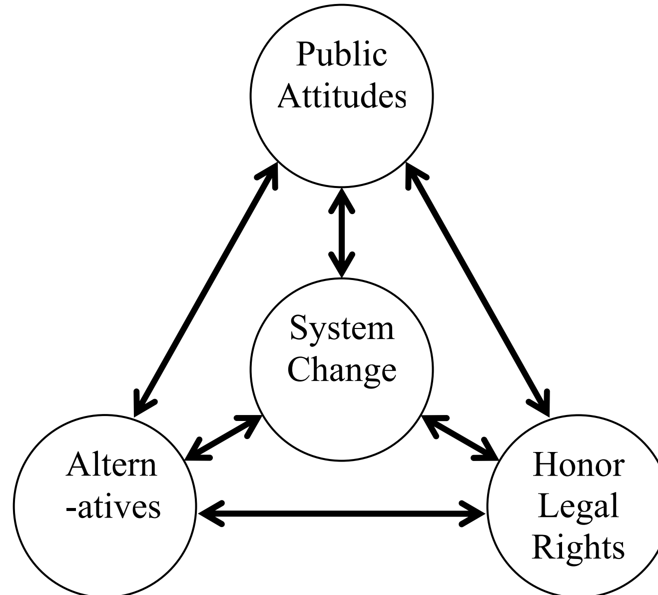
[2] The system believes it is also less expensive, but the opposite is actually true. The over-reliance on neuroleptics and, increasingly, polypharmacy, has at least doubled the number of people who become permanently reliant on government transfer payments. In Anatomy of an Epidemic: Psychiatric Drugs and the Astonishing Rise of Mental Illness in America, which is available at http://psychrights.org/Articles/EHPPPsychDrugEpidemic(Whitaker).pdf, Robert Whitaker demonstrates the rate of disability has increased six fold since the introduction of Thorazine in the mid '50s. The Michigan State Psychotherapy Project demonstrated extremely more favorable long-term outcomes for those receiving psychotherapy alone from psychotherapists with *relevant* training and experience. The short term costs were comparable to the standard treatment and the long term savings were tremendous. This study can be found at http://psychrights.org/Research/Digest/Effective/MIPsychProj.pdf.

[3] "Parens Patriae" is legal Latin, literally meaning "parent of his or her country". Black's Law Dictionary, Seventh Edition defines it as "the state in its capacity as provider of protection to those unable to care for themselves." It is invoked with respect to minors and adults who are deemed incompetent to make their own decisions. In the context of forced drugging under the *parens patriae* doctrine, it basically is based on the notion, "If you weren't crazy, you'd know this was good for you."

[4] At the same time there are impediments to doing so, primarily the lack of legal resources.

coercive alternatives must be made available. This conference, Alternatives, is focused on the creation of such alternatives and the thesis of this paper is that strategic litigation (and public education) are likely essential to transforming the mental health system to one of a recovery culture.

These three elements, (1) Creation of Alternatives, (2) Public Education, and (3) Strategic Litigation (Honoring Rights), each reinforce the others in ways that can lead to meaningful system change in a way that might be depicted as follows:



For example, debunking the myth among the general public that people do not recover from a diagnosis of serious mental health illness can encourage the willingness to invest in recovery oriented alternatives. Similarly, having successful, recovery oriented alternatives will help in debunking the myth that people don't recover from serious mental illness. In like fashion, judges and even counsel appointed to represent psychiatric defendants, believe the myth "if this person wasn't crazy, she would know these drugs are good for her" and therefore don't let her pesky rights get in the way of doing the "right thing," ie., forced drugging. The myth of dangerousness results in people being locked up. In other words, the judges and lawyers reflect society's views and to the extent that society's views change, the judges and lawyers' responses will change to suit. That leads to taking people's rights more seriously. The converse is true as well. Legal cases can have a big impact on public views. *Brown v. Board of Education*,[5] which resulted in outlawing segregation is a classic example of this. Finally, the involuntary

[5] U.S. 294, 75 S.Ct. 753, 99 L.Ed. 1083 (1955).

mental illness system[6] operates largely illegally, including through its failure to offer less restrictive alternatives.[7] Thus, litigation can force the creation of such alternatives. At the same time, as a practical matter, the availability of acceptable (to the person), recovery oriented, alternatives is necessary for anyone to actually be able to get such services when faced with involuntary commitment and forced drugging.

III. The Involuntary Mental Illness System Operates Largely Illegally

Involuntary "treatment"[8] in the United States largely operates illegally in that court orders for forced treatment are obtained without actual compliance with statutory and constitutional requirements. One of the fundamental constitutional rights that is ignored in practice is that of a "less restrictive alternative."[9] Thus, enforcement of this right through the courts can be instrumental in bringing about change. First, I will discuss the key constitutional principles.

A. Constitutional Protections

(1) Procedural Due Process

The 14th Amendment to the United States provides in pertinent part, that "No State shall . . . deprive any person of life, liberty, or property, without due process of law." Most, if not all, states have similar provisions. Under due process, the procedures used must meet a minimum level of fairness. Three essential elements of this procedural due process are (1) a neutral decisionmaker, (2) meaningful notice and (3) meaningful opportunity to respond. These were recently reiterated by the United States Supreme Court in the case involving a United States citizen who was being detained in Cuba as an enemy combatant, as follows:

> [D]ue process requires a 'neutral and detached judge in the first instance.' . . . For more than a century the central meaning of procedural due process has been clear: "Parties whose rights are to be affected are <u>entitled to be heard</u>; and in order that they may enjoy that right they <u>must first be notified</u>." It is equally fundamental that the right to notice and an

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[6] In light of the system basically creating massive numbers of people who become categorized as chronically mentally ill, I call it the mental illness system, rather than the mental health system.

[7] By saying the mental illness system operates largely illegally I mean that to the extent people are locked up and forcibly drugged when the statutory and constitutional requirements are not being met, that is illegal. Of course, this is done by filing paperwork and getting court orders, which looked at another way, makes it legal.

[8] "Treatment" is in quotes because it is both (1) pretty clear the current, virtually exclusive reliance on psychiatric drugs by the public mental illness system hinders recovery for the vast majority of people, and (2) if it isn't voluntary, it isn't treatment.

[9] *See*, e.g., *Sell v. United States*, 539 U.S. 166 (2003). However, not everyone agrees with my legal analysis of the right to the least restrictive alternative.

> opportunity to be heard "must be granted at a meaningful time and in a meaningful manner."

Hamdi v. Rumsfeld, 542 U.S. 507, 124 S.Ct. 2633, 2648-9 (2004)

In addition to these "procedural due process" rights, there can be "substantive due process" rights, which essentially involves balancing people's rights to life, liberty or property" against the government's interests in curtailing those rights. Thus, there are substantive constitutional due process rights with respect to both involuntary commitment and forced drugging.

(2) Constitutional Limits on Involuntary Commitment.

The United States Supreme Court has recognized for a long time that involuntary civil commitment is a "massive curtailment of liberty"[10] requiring substantive due process protection:

> Freedom from bodily restraint has always been at the core of the liberty protected by the Due Process Clause from arbitrary governmental action. "It is clear that commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection."[11]

The Supreme Court went on to say in this and other cases that involuntary commitment was permissible only when the following factors were present:

> (1) "the confinement takes place pursuant to proper procedures and evidentiary standards," (2) there is a finding of "dangerousness either to one's self or to others," and (3) proof of dangerousness is "coupled ... with the proof of some additional factor, such as a 'mental illness' or 'mental abnormality.' "[12]

Many states allow someone to be involuntarily committed for being "gravely disabled," but it seems this can only be constitutional if the "grave disability" means the person is a harm to self. While not ruling on this directly, in my view, the United States Supreme Court essentially said so as follows:

> Of course, even if there is no foreseeable risk of self-injury or suicide, a person is literally 'dangerous to himself' if for physical or other reasons he is helpless to avoid the hazards of freedom either through his own efforts or with the aid of willing family members or friends.[13]

To reiterate then, involuntary commitment is constitutional only (1) when done under proper procedures and evidentiary standards, (2) upon a finding of dangerousness

[10] *Humphrey v. Cady*, 405 U.S. 504 (1972).
[11] *Addington v. Texas*, 441 U.S. 418 (1979).
[12] *Kansas v. Crane*, 534 U.S. 407 (2002).
[13] Footnote 9, in *O'Connor v. Donaldson*, 422 U.S. 563, 95 S.Ct. 2486 (1975).

to self or others,[14] and (3) the dangerousness is a result of mental illness. Being committed for being gravely disabled is only permissible if the requisite level of dangerousness is found. As will be discussed below, even leaving aside the whole issue of the validity of mental illness diagnoses, proper procedures and evidentiary standards are generally not followed and people are committed without meeting the dangerousness threshold.

(3) Constitutional Limits on Forced Drugging

The United States Supreme Court has also held a number of times that being free of unwanted psychiatric medication is a fundamental constitutional right.[15] In the most recent case, *Sell*, the United States Supreme Court reiterated:

> [A]n individual has a "significant" constitutionally protected "liberty interest" in "avoiding the unwanted administration of antipsychotic drugs."[16]

The different contexts in which forced psychiatric drugging comes up makes a difference as to the extent of this right, however. *Sell* and *Riggins* are forced drugging to make someone competent to stand trial cases. *Harper* is a convicted person in prison case, where people have the least rights.

The only one of these cases involving forced drugging in the non-criminal (civil) context is *Mills v. Rogers*.[17] There, the United States Supreme Court assumed a person has United States Constitutional protection against forced psychiatric drugging under the Due Process Clause, but held the exact extent of these protections are intertwined with state law. The same day, June 18, 1982, the Court decided *Youngberg v. Romeo*[18] involving a civilly committed mentally retarded man, Nicholas Youngberg, whom all of the professionals agreed was not receiving appropriate services resulting in excessive physical restraints and the Court ruled he was entitled to the services that "professional judgment" dictated. The exact phrase the court used was "the Constitution only requires that the courts make certain that professional judgment in fact was exercised."[19] A few days later, on July 2, 1982, the Court remanded another case, *Rennie v. Klein*, to the United States Court of Appeals for the Third Circuit for further consideration in light of *Youngberg*.[20] This has (not universally) been interpreted to mean people can be force

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[14] The cases are not uniform on what level of dangerousness and how imminent it must be, but it seems clear that the level of dangerousness must meet a relatively high level of seriousness and the threat has to have some immediacy to it.
[15] *Mills v. Rogers*, 457 U.S. 291 (1982); *Washington v. Harper*, 494 U.S. 210 (1990; *Riggins v. Nevada*, 504 U.S. 127 (1992); and *Sell v. United States*, 539 U.S. 166 (2003).
[16] *Sell v. United States*, 539 U.S. 166, 177-8 (2003), citing to the Due Process Clause, U.S. Const., amend. 5, and *Washington v. Harper*, 494 U.S. 210, 110 S.Ct. 1028 (1990.
[17] 457 U.S. 291 (1982).
[18] 457 U.S. 307 (1982).
[19] *Mills* was not mentioned in this decision.
[20] 458 U.S. 1119 (1982).

drugged if "professional judgment" is exercised, ie., if the psychiatrist (exercising "professional judgment") says the person should be force drugged.[21]

I will get to this being an incorrect interpretation in my view and how *Sell* changes it, in any event in a bit, but as a result of the combination of *Mills* saying due process rights in state courts under the Fourteenth Amendment depends at least in part on state law and the interpretation that under *Rennie* and *Youngberg* federal constitutional protection was subject to the "professional judgment" rule, the action moved to state courts. The upshot in state courts has been mostly good, from a legal perspective, with such cases as the final result in *Mills (v. Rogers)*, being the Supreme Judicial Court of Massachusetts' ruling in *Rogers*,[22] which is that people have the absolute right to decline medication unless they are incompetent to make such a decision and if they are incompetent they can not be medicated against their will except by a court made Substituted Judgment Decision that includes the following factors:

1. The patient's expressed preferences regarding treatment.
2. The strength of the incompetent patient's religious convictions, to the extent that they may contribute to his refusal of treatment.
3. The impact of the decision on the ward's family -- this factor being primarily relevant when the patient is part of a closely knit family.
4. The probability of adverse side effects.
5. The prognosis without treatment.
6. The prognosis with treatment.
7. Any other factors which appear relevant.

In *Rogers*, the Court made clear that involuntary civil commitment, in and of itself, is insufficient to conclude the person is incompetent to decline the drugs. The *Rogers* court also specifically re-affirmed an earlier decision, *Guardianship of Roe,* that "No medical expertise is required [for making the substituted judgment decision], although medical advice and opinion is to be used for the same purposes and sought to the same extent that the incompetent individual would, if he were competent." The Massachusetts Supreme Court also held because of the inherent conflicts in interest, the doctors should not be allowed to make this decision.

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[21] I do not believe this is a correct interpretation. In *Rennie*, the Supreme Court never actually held that; instead it remanded it in light of its decision in *Youngberg v. Romeo*. However, *Youngberg* involved a mentally retarded man who was being subject to physical restraints under conditions that no professional judgment would support, especially because the person could have been trained in a way to minimize or even reduce the use of restraints. Thus, in a lot of ways it was a right to appropriate treatment holding, and definitely not a case authorizing forced drugging. I think the concurring opinion of Circuit Judge Weis on remand, which was joined by two other circuit judges, is a much better way to interpret the decision. ("I fear that the latitude the majority allows in 'professional judgment' jeopardizes adequate protection of a patient's constitutional rights.") *Rennie v. Klein*, 720 F.2d 266 (CA3 1983).
[22] *Rogers*, 458 N.E. 2d 308 (Mass 1983)

> The fact that a patient has been institutionalized and declared incompetent brings into play the factor of the likelihood of conflicting interests. The doctors who are attempting to treat as well as to maintain order in the hospital have interests in conflict with those of their patients who may wish to avoid medication.

This extremely favorable legal ruling has, however, been turned on its head and become a "Rogers Order" assembly-line.[23]

Similarly, in *Rivers v. Katz*[24], decided strictly on common law and constitutional due process grounds, New York's highest court held a person's right to be free from unwanted antipsychotic medication is a constitutionally protected liberty interest:

> "[i]f the law recognizes the right of an individual to make decisions about . . . life out of respect for the dignity and autonomy of the individual, that interest is no less significant when the individual is mentally or physically ill"
>
> * * *
>
> We reject any argument that the mere fact that appellants are mentally ill reduces in any manner their fundamental liberty interest to reject antipsychotic medication. We likewise reject any argument that involuntarily committed patients lose their liberty interest in avoiding the unwanted administration of antipsychotic medication.
>
> * * *
>
> If . . . the court determines that the patient has the capability to make his own treatment decisions, the State shall be precluded from administering antipsychotic drugs. If, however, the court concludes that the patient lacks the capacity to determine the course of his own treatment, the court must determine whether the proposed treatment is narrowly tailored to give substantive effect to the patient's liberty interest, taking into consideration all relevant circumstances, including the patient's best interests, the benefits to be gained from the treatment, the adverse side effects associated with the treatment and any less intrusive alternative treatments. The State would bear the burden to establish by clear and convincing evidence that the proposed treatment meets these criteria.

Just as in Massachusetts, however, in practice, people's rights are not being honored.[25] There are other states which have just as good legal rights and some that don't under state

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[23] I wrote a memo about this in early February of 2004, which can be found at http://psychrights.org/States/Massachusetts/RogersOrders/RogersOrdersMemo.pdf.
[24] *Rivers v. Katz*, 495 N.E.2d 337, 341-3 (NY 1986).
[25] *See*, Mental Hygiene Law Court Monitoring Project: Part 1 of Report: Do Psychiatric Inmates in New York Have the Right to Refuse Drugs? An Examination of Rivers

law, but the common denominator in all of them is whatever rights people have, they are uniformly ignored. Before getting to that, I want to get back United States Constitutional law under *Sell*.

In *Sell*, decided in 2003, the United States Supreme Court held someone could not be force drugged to make them competent to stand trial unless:

1. The court finds that *important* governmental interests are at stake.
2. The court must conclude that involuntary medication will *significantly further* those concomitant state interests.
3. The court must conclude that involuntary medication is *necessary* to further those interests. The court must find that any alternative, less intrusive treatments are unlikely to achieve substantially the same results.
4. The court must conclude that administration of the drugs is *medically appropriate*, i.e., in the patient's best medical interest in light of his medical condition. The specific kinds of drugs at issue may matter here as elsewhere. Different kinds of antipsychotic drugs may produce different side effects and enjoy different levels of success.

(italics in original) These are general constitutional principles and should apply in the civil context. Thus, for example, while in *Sell*, the "*important* governmental interest" is in bringing a criminal defendant to trial, the governmental interest in the civil context is (supposedly) the person's best interest, ie., the *parens patriae* doctrine.[26]

With respect to the second requirement that the forced drugging "will *significantly further*" those interests, the question in the competence to stand trial context is whether the forced drugging is likely to make the person competent to stand trial, while in the civil context, the question is whether it is in the person's best interest or is the decision the person would make if he or she were competent.

The third requirement that the forced drugging must be *necessary* and there is <u>no less restrictive alternative</u> is hugely important in the civil context because it is a

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Hearings in the Brooklyn Court, which can be accessed on the Internet at http://psychrights.org/States/NewYork/courtmonitoringreport.htm.

[26] I say, "supposedly," because in truth, controlling the person's behavior is a primary interest. "Police power" justification, which actually is based on controlling dangerous behavior, has also been used to justify forced drugging. *See*, *Rivers v. Katz*, 495 N.E.2d 337, 343 (NY 1986). However, the behavior presumably has to be very extreme to invoke "police power" and is not normally the stated basis for seeking forced drugging orders. It has been suggested there is an important government interest in ending indeterminate commitment and returning the individual to society, which can be done most effectively if the person is required to take the prescribed drugs. However, this is not the basis normally asserted and I would argue it is not a sufficient interest to override a person's rights to decline the drugs, particularly in light of the physical harms they cause.

potential lever to require less restrictive (ie., non-drug, recovery oriented alternatives). It is important to note here that failure to fund these alternatives does not give the government the right to force drug someone. If a less restrictive alternative could be made available, the forced drugging is unconstitutional.[27]

New York Law School professor, Michael L. Perlin agrees this is so:

> The Supreme Court's decisions in *Washington* v. *Harper*, *Riggins v. Nevada*, and, most recently, *Sell v. United State*s, make it clear that: a qualified right to refuse medication is located in the Fourteenth Amendment's Due Process Clause; the pervasiveness of side effects is a key factor in the determination of the scope of the right; the state bears a considerable burden in medicating a patient over objection, and the "least restrictive alternative" mode of analysis must be applied to right to refuse cases.[28]

The fourth requirement is also very important because it essentially requires the state to prove the drugging is in the person's best interest and not merely recite "professional judgment."

The take away message is, in my view, people are constitutionally entitled to non-coercive, non-drugging, recovery oriented alternatives before involuntary commitment and forced drugging can occur and even then forced drugging can only constitutionally occur if it is in the person's best interest. There are a couple of ways to look at this since the reality is so far from what the law requires. One is to see it as a tremendous opportunity to improve the situation. The other is that there are forces operating to totally defeat people's rights. Both are true and this paper suggests there are actions that can be taken to have people's rights honored that can play a crucial part in transforming the mental health system to one of a recovery culture.

B. Proper Procedures and Evidentiary Standards

Mentioned above is the United States Supreme Court rulings that involuntary commitment can occur only pursuant to proper procedures and evidentiary standards. In contrast to this legal requirement, involuntary commitment and forced drugging

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[27] There are likely limits on this, such as there being no requirement for Herculean efforts or where the cost is prohibitive. *See*, e.g., *Mathews v. Eldridge*, 424 U.S. 319, 334-35 (1976).

[28] Perlin, *"And My Best Friend, My Doctor/Won't Even Say What It Is I've Got": The Role And Significance Of Counsel In Right To Refuse Treatment Cases*, 42 San Diego Law Review 735 (2005)

proceedings can quite fairly be characterized as a sham, a farce, Kangaroo Courts, etc., in the vast majority of cases.[29]

(1) Proper Procedures

Ex Parte Proceedings. It will be recalled that the hallmarks of procedural due process are meaningful notice and meaningful opportunity to be heard (respond). There are a few situations, such as search and arrest warrants where prior notice are not required because giving warning would defeat the purpose. Proceedings where the person isn't given notice or an opportunity to respond are called "*ex parté*."[30] However, the mental illness system regularly takes people into custody without any advance notice and no opportunity to respond when there is no emergency that justifies the failure to notify and denial of any opportunity to respond. The Washington Supreme Court has explicitly ruled "The danger must be impending to justify detention without prior process."[31] However, I don't believe the legitimacy of *ex parté* procedures has been challenged much around the country, leading to what I believe are pervasive violations of due process rights in this regard.

There are many other ways in which proper procedures are not utilized in the various states and these should also be challenged.[32]

(a) Proper Evidentiary Standards.

As set forth above, involuntary commitment is constitutionally permissible only if the person is a harm to self or others as a result of a "mental illness." In *Addington v. Texas*[33] the United States held that this has to be proven by "clear and convincing evidence," which is less than "beyond a reasonable doubt," but more than the normal "preponderance of the evidence"[34] standard in most civil cases.

There are essentially two different evidence standards regarding expert witness testimony. The older "Frye"[35] standard is basically whether it has gained "general

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[29] An example is described in the recent Alaska Supreme Court brief we filed in *Wetherhorn v. Alaska Psychiatric Institute*, which can be found on the Internet at http://psychrights.org/States/Alaska/CaseFour/WetherhornBrief.pdf.

[30] *Ex Parte*, is Latin for "from the part" and Black's Law Dictionary, Seventh Edition defines it as "On or from one party only, usually without notice to or argument from the adverse party."

[31] *In re: Harris*, 654 P.2d 109, 113 (Wash. 1982)

[32] I have identified a number of them in Alaska and intend to raise them in appropriate cases.

[33] 441 U.S. 418 (1979)

[34] "Preponderance of the evidence," means more likely than not or, put another way, it only requires the balance to be slightly more on one side than the other. Yet another way to look at it is it just has to be more than 50% likely.

[35] *Frye v. United States*, 293 F. 1013 (D.C.Cir.1923)

acceptance in the particular field." The more modern standard, *Daubert*,[36] which was adopted by the United States Supreme Court for the federal courts and by many state courts, recognizes that "generally accepted" methods may not be valid and methods which have not yet gained general acceptance can be extremely valid, and therefore the proper focus is on scientific reliability.

Because psychiatry bases its "treatments" and pronouncements on scientifically dubious bases, but they are generally accepted within the field, the *Daubert* standard is better for challenging psychiatric practices in court, but there are still ways to get at them under the *Frye* standard. In practice, both standards are ignored and psychiatrists are allowed to offer opinions without satisfying either *Daubert* or *Frye*.

The truth is psychiatric testimony as to a person's dangerousness is highly unreliable with a high likelihood of over-estimating dangerousness.

> The voluminous literature as to the ability of psychiatrists (or other mental health professionals) to testify reliably as to an individual's dangerousness in the indeterminate future had been virtually unanimous: "psychiatrists have absolutely no expertise in predicting dangerous behavior -- indeed, they may be less accurate predictors than laymen -- and that they usually err by overpredicting violence."[37]

This is the primary reason why I estimate only 10% of involuntary commitments are legally justified. If people were only involuntarily committed when it can be shown, by clear and convincing evidence, under scientifically reliable methods of predicting the requisite harm to self or others, my view is 90% of current commitments would not be granted. One doesn't need to get into the legitimacy of mental illness diagnosing.

With respect to forced drugging, one of the pre-requisites is the person must be found to be incompetent to decline the drug(s). Here, too, psychiatrists, to be kind, over-estimate incompetence.

> [M]ental patients are not always incompetent to make rational decisions and are not inherently more incompetent than nonmentally ill medical patients.[38]

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[36] *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579 (1993).
[37] Michael L. Perlin, *Mental Disability Law: Civil and Criminal,* §2A-4.3c, p. 109 (2d. Ed. 1998), footnotes omitted. *See*, also, Morris, Pursuing Justice for the Mentally Disabled, 42 San Diego L. Rev 757, 764 (2005) ("recent studies confirm[] that psychotic symptoms, such as delusions or hallucinations, currently being experienced by a person, do not elevate his or her risk of violence."
[38] Perlin, "And My Best Friend, My Doctor/Won't Even Say What It Is I've Got: The Role And Significance Of Counsel In Right To Refuse Treatment Cases," 42 San Diego Law Review 735, 746-7 (2005), citing to Thomas Grisso & Paul S. Appelbaum, *The*

Not even the competency test against competency developed by Paul Appelbaum for the MacArthur Foundation[39] is used. Thus, psychiatric testimony concerning this threshold question of competency is very often invalid. However, this is not why I suggest no forced drugging in the civil context is legally justified.

The reason why I believe no forced drugging in the civil context is legally justified is it simply can not be scientifically proven it is in a person's best interest.[40] It would make this paper even more too long than it already is to fully support this assertion, but some will be presented. First, there is really no doubt the current over-reliance on the drugs is at least doubling the number of people becoming defined by the system as chronically mentally ill with it recently being estimated it has <u>increased the rate of disability due to "mental Illness" six-fold</u>.[41] In the case where we litigated the issue in Alaska, the trial court found

> The relevant conclusion that I draw from [the evidence presented by the Respondent's experts] is that there 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.

* * *

MacArthur Treatment Competence Study. III: Abilities of Patients to Consent to Psychiatric and Medical Treatments, 19 Law & Hum. Behav. 149 (1995).

[39] Thomas Grisso & Paul S. Appelbaum, *MacArthur Competence Assessment Tool-Treatment (MacCAT-T)*, Professional Resources Press (1998). My view is this test is at least somewhat biased against competency because disagreement with a diagnoses of mental illness is a basis for finding incompetence. I personally don't believe in that level of infallibility of psychiatric diagnosis and credit people's own interpretations more than psychiatrists tend to. I will allow, however, that this may be my own bias.

[40] While I believe this is true in the forced drugging context in terms of meeting the legal burden of justifying overriding a person's right to decline the medications, and I know this paper comes off as a polemic against psychiatric drugs, I absolutely believe people also have the right to choose to take them. I do think people should be fully informed about them, of course, which is normally not done, but that is a different issue. Not surprisingly, in a study of people who have recovered after being diagnosed with serious mental illness, those who felt the drugs helped them, used them in their recovery and those that didn't find them helpful, didn't use the drugs in their recovery. "How do We Recover? An Analysis of Psychiatric Survivor Oral Histories," by Oryx Cohen, in *Journal of Humanistic Psychology*, Vol . 45 No. 3, Summer 2005 333-35, which is available on the Internet at http://12.17.186.104/recovery/oryx_journal_of_humanist_psych.pdf.

[41] Anatomy of an Epidemic: Psychiatric Drugs and the Astonishing Rise of Mental Illness in America, by Robert Whitaker, *Ethical Human Psychology and Psychiatry*, Volume 7, Number I: 23-35 Spring 2005, which can be accessed on the Internet at http://psychrights.org/Articles/EHPPPsychDrugEpidemic(Whitaker).pdf.

> [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.[42]

A recent study in Ireland concluded the already elevated risk for death in schizophrenia due to the older neuroleptics was doubled with the newer, so-called "atypical" neuroleptics, such as Zyprexa and Risperdal.[43] More information on these drugs can be found on PsychRights' website at http://psychrights.org/Research/Digest/Researchbytopic.htm.

In sum, my view is the state can never (or virtually never) actually meet its burden of proving forced drugging is in a person's best interest (assuming that is required) because of the lack of long-term effectiveness and great harm they cause. Again, this raises the question of why forced drugging is so pervasive and what might be done about it. In other words, it is an opportunity for strategic litigation playing a key role in a transformation to a recovery oriented system.

(2) Corrupt Involuntary Mental "Treatment" System

As set forth above, people are locked up under judicial findings of dangerousness and force drugged based on it being in their best interests without any legitimate scientific evidence of either dangerousness or the drugs being in a person's best interests. As Professor Michael Perlin has noted:

> [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"

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[42] Order, in *In the Matter of the Hospitalization of Faith Myers,* Anchorage Superior Court, Third Judicial District, State of Alaska, Case No. 3AN-03-277 PR, March 14, 2003, pp. 8, 13, which can be accessed on the Internet at http://psychrights.org/States/Alaska/CaseOne/30-Day/Order.pdf.

[43] 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, by Maria G. Morgan , Paul J. Scully , Hanafy A. Youssef, Anthony Kinsellac, John M. Owensa, and John L. Waddingtona, *Psychiatry Research* 117 (2003) 127–135, which can be found on the Internet at http://psychrights.org/Research/Digest/NLPs/MM-PsychRes2003.pdf.

> 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.[44]

In other words, testifying psychiatrists lie,[45] the trial (but generally not appellate) courts don't care, and lawyers assigned to represent defendants in these cases, are "woefully inadequate--disinterested, uninformed, roleless, and often hostile. A model of "paternalism/best interests" is substituted for a traditional legal advocacy position, and this substitution is rarely questioned."[46] Counsel appointed to represent psychiatric defendants are, more often than not, actually working for the other side, or barely put up even a token defense, which amounts to the same thing.[47]

No one in the legal system is taking psychiatric defendants' rights seriously, including the lawyer appointed to represent the person. There are two reasons for this: The first is the belief that "if this person wasn't crazy, she'd know this is good for her." The second is the system is driven by irrational fear. All the evidence shows people who end up with psychiatric labels are no more likely to be dangerous than the general population and that medications increase the overall relapse rate, yet society's response has been to lock people up, and whether locked up or not, force them to take these drugs.[48]

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[44] *The ADA and Persons with Mental Disabilities: Can Sanist Attitudes Be Undone,?* Journal of Law and Health, 1993/1994, 8 JLHEALTH 15, 33-34.

[45] "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." Torrey, E. Fuller. 1997. *Out of the Shadows: Confronting America's Mental Illness Crisis*, New York: John Wiley and Sons, page 152. Dr. Torrey goes on to say this lying to the courts is a good thing. Of course, lying in court is perjury. 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."

[46] Perlin, "*And My Best Friend, My Doctor/Won't Even Say What It Is I've Got": The Role And Significance Of Counsel In Right To Refuse Treatment Cases*, 42 San Diego Law Review 735, 738 (2005)

[47] This is a violation of professional ethics. For example, the Comment to the Model Rules of Professional Conduct for attorneys, Rule 1.3, includes, "A lawyer should pursue a matter on behalf of a client despite opposition, obstruction or personal inconvenience to the lawyer, and take whatever lawful and ethical measures are required to vindicate a client's cause or endeavor. A lawyer must also act with commitment and dedication to the interests of the client and with zeal in advocacy upon the client's behalf."

[48] "Kendra's Law" in New York is a classic example of this. There a person who had been denied numerous attempts to obtain mental health services pushed Kendra in front of a moving subway and when he was grabbed, said something like "now maybe I will get some help." The response was to pass an outpatient commitment law requiring

(3) Legal Representation: This Is Where the Legal System is Broken.

I analogize the current situation of pervasive coercion to water seeking the path of least resistance and by making it hard enough to obtain involuntary commitment and forced drugging orders, it will no longer be the path of least resistance and the involuntary system will find other ways to deal with the people that come to its attention. As things stand now, obtaining involuntary commitment and forced drugging orders is by far the easiest thing for the system to do. It takes about 15 minutes of psychiatrist time in Alaska, for example. In California, in a study of 63 involuntary commitment hearings, which are not even done by the courts, eight hearings were one minute or less in duration; nineteen were between one and two minutes; nine were between two and three minutes in duration and only nine hearings were more than eight minutes in duration.[49]

As has been noted by New York Law School professor Michael L. Perlin, the lawyers appointed to represent psychiatric defendants are not doing their job.

> The assumption that individuals facing involuntary civil commitment are globally represented by adequate counsel is an assumption of a fact not in evidence. The data suggests that, in many jurisdictions, such counsel is woefully inadequate—disinterested, uninformed, roleless, and often hostile. A model of "paternalism/best interests" is substituted for a traditional legal advocacy position, and this substitution is rarely questioned. (at 738, footnotes omitted)
>
> * * *
>
> The track record of lawyers representing persons with mental disabilities has ranged from indifferent to wretched; in one famous survey, lawyers were so bad that a patient had a better chance of being released at a commitment hearing if he appeared pro se. (at 743, footnote omitted)
>
> * * *
>
> A right without a remedy is no right at all; worse, a right without a remedy is meretricious and pretextual—it gives the illusion of a right without any legitimate expectation that the right will be honored. . . . "Empirical surveys consistently demonstrate that the quality of counsel 'remains the single most important factor in the disposition of involuntary civil commitment cases." (at 745-6, footnotes omitted)

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people to take psychiatric drugs or be locked up in the hospital. This is a characterization, but when this was challenged, New York's high court ruled Kendra's Law didn't require people to take the drugs; that all it did was subject people to "heightened scrutiny" for involuntary commitment if they didn't. *See*, *In the Matter of K.L.*, 806 N.E.2d 480(NY 2004).

[49] Morris, Pursuing Justice for the Mentally Disabled, 42 San Diego L. Rev 757, 759-60 (2005).

* * *

> Without such [adequate] counsel, it is likely that there will be no meaningful counterbalance to the hospital's "script," and the patient's articulated constitutional rights will evaporate. (at 749)[50]

In a companion article to Professor Perlin's 2005 article in the San Diego Law Review, Professor Grant Morris states:

> If Michael Perlin spoke in a forest, and no one heard him speak, would he still make a sound? That is the question I ask you to consider as I respond to Michael's article.
>
> Lawyers who represent mentally disabled clients in civil commitment cases and in right to refuse treatment cases, Michael tells us, are guilty of several crimes. They are inadequate. They are inept. They are ineffective. They are invisible. They are incompetent. And worst of all, they are indifferent. Is Michael right in his accusations? You bet he is![51]

Professor Morris then goes on to note that this is a violation of lawyers' professional ethics.

The only case that has really come to grips with this issue is *KGF* out of Montana:[52]

> As a starting point, it is safe to say that in purportedly protecting the due process rights of an individual subject to an involuntary commitment proceeding—whereby counsel typically has less than 24 hours to prepare for a hearing on a State petition that seeks to sever or infringe upon the individual's relations with family, friends, physicians, and employment for three months or longer—our legal system of judges, lawyers, and clinicians has seemingly lost its way in vigilantly protecting the fundamental rights of such individuals.[53]

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[50] Perlin, "And My Best Friend, My Doctor/Won't Even Say What It Is I've Got: The Role and Significance of Counsel in Right to Refuse Treatment Cases," 42 San Diego Law Review 735 (2005)

[51] Morris, Pursuing Justice for the Mentally Disabled, 42 San Diego L. Rev 757, 757-8 (2005).

[52] However, PsychRights currently has a case before the Alaska Supreme on this issue. *See*, http://psychrights.org/States/Alaska/CaseFour.htm,

[53] *In re: K.G.F.*, 29 P.3d 485 (Mont. 2001). This case can be found on the Internet at http://www.lawlibrary.state.mt.us/dscgi/ds.py/Get/File-11399/00-144.htm.

The court in *KGF* then went on to lay down some very good requirements for the performance of the lawyers. However, it appears these have been largely ignored in practice.[54]

IV. The Requirement and Necessity of Alternatives

Hopefully it is apparent from the foregoing that people should be allowed (less restrictive) alternatives when they are faced with forced drugging. The same is basically true of involuntary commitment.[55] These alternatives, I suggest, should primarily include non-coercive, for sure, and non-drug alternatives that are known to lead to recovery for many people.[56] The reality is likely a "which came first, the chicken or the egg?" situation, because judges will be reluctant to deny petitions for forced drugging on the basis that a less restrictive alternative could be made available, but in fact is not available. Thus, the actual availability of alternatives is important. However, where sufficient legal pressure is applied, the courts will simply not be able to order forced drugging. I know these are contradictory statements, but that is why they reinforce each other as set forth above (and below).

This can be illustrated by the situation involving Advance Directives. As set forth above, everyone has the absolute constitutional right to decline psychiatric drugs, with one exception, which is if they are incompetent to do so. Currently, the competency determinations are not legitimate. One reason I would posit, is that the system simply does not know what else to do with people so the system deals with it by finding people incompetent when they are not.

More legal trouble for the system comes in if people were to have Advance Directives that were made when they were certifiably (I would even suggest certified) competent at the time they made them. The system still doesn't know what to do with them, so it has to come with some way to ignore them, but it is a lot harder to come up with a pretext for the forced drugging. This presents at least the theoretical possibility of getting the judge (or jury) to essentially say, "well since you can't force drug this person, you had better figure out something else to do." Again, however, having the alternatives available will immeasurably help in enforcing people's legal rights to them. Litigation can also support the economic viability of the alternatives, because people faced with involuntary commitment and forced drugging can argue since they have the right to the less restrictive alternative the state must pay for it. Thus, the way the availability of

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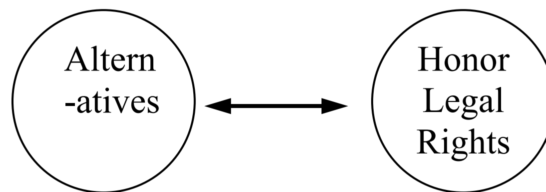
[54] *See*, February 28, 2005, letter from James B. Gottstein to the Chief Justice of the Montana Supreme Court, which can be accessed on the Internet at http://psychrights.org/States/Montana/CJGrayLtr.pdf.

[55] Many state statutes certainly require it, and I would suggest it is constitutionally required as well.

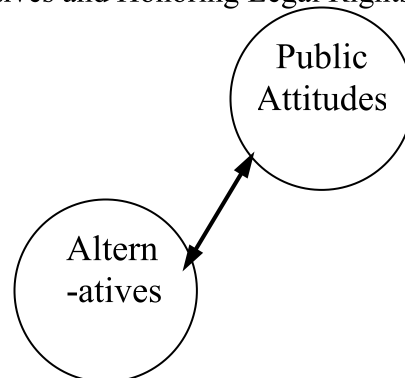
[56] *See*, Effective Non-Drug Treatments, which can be found on the Internet at http://psychrights.org/Research/Digest/Effective/effective.htm, for some specific examples.

recovery oriented alternatives and litigation reinforce each other can be broken out separately from the figure above as follows:



V. The Importance of Public Opinion

It is perhaps easier to see the same sort of process involved between Public Education and the Availability of Alternatives. Alternatives to the hopelessness driven, medication only, stabilization oriented, system are not available because our society believes it is the only possibility, in spite of all kinds of evidence to the contrary. Thus, to the extent effective alternatives become known to society in general, these alternatives will become desired by society because they produce much more desired outcomes. Not only do people get better, but huge amounts of money will be saved by more than halving the number of people who become a permanent ward of government. At the same time, having successful Alternatives will show society that they are viable. Thus, as with the Availability of Alternatives and Honoring Legal Rights, they reinforce each other:

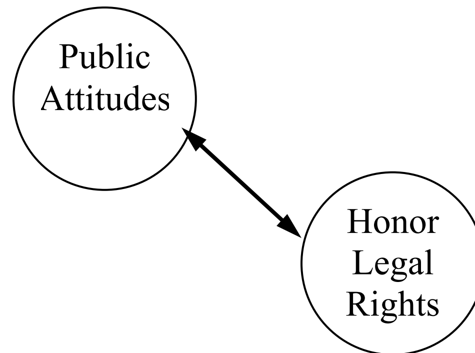


VI. Interplay Between Public Education and Honoring Legal Rights

As set forth above, the judges and even the lawyers representing people facing forced psychiatry accept the current societal view that people need to be locked up and forcibly drugged for society's and the person's own safety and best interests. To the extent society becomes aware this is not true, the judicial system will reflect that and be much more willing to honor people's rights. Perhaps harder to see, and maybe even a weaker link, is the extent to which successful litigation can impact public opinion. In order to illustrate that, however, I draw back upon *Brown v. Board of Education*,[57] which outlawed legal segregation and was one of the instrumental factors in changing public

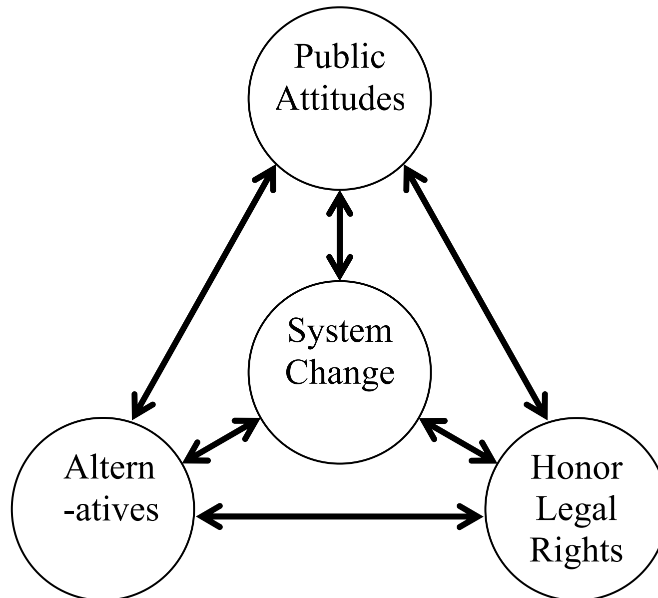
[57] U.S. 294, 75 S.Ct. 753, 99 L.Ed. 1083 (1955).

opinion from accepting segregation to one of finding it unacceptable. Thus, Public Attitudes and Honoring Legal Rights also reinforce each other.



VII. The Role of Litigation in Creating a Recovery Culture in Mental Health Systems

Putting these pieces together, we have the original figure set forth at the outset.



This is why I believe working on all three of these areas is important in transforming mental health systems to a recovery culture. Strategic litigation has an important, but not exclusive, role in this.

VIII. Requirements for Successful Litigation -- Attorneys & Expert Witnesses

The building blocks for mounting successful strategic litigation are recruiting attorneys who will put forth a serious effort to discharge their ethical duties to their clients and expert witnesses who can prove the junk science behind current "treatment" and the effectiveness of recovery oriented alternatives.

IX. Types of Legal Actions

There are a number of types of cases that can be brought to bear. All of these involve taking appeals where appropriate -- the appellate courts tend to take people's rights in these cases far more seriously than the trial courts. The following is by no means an exhaustive list.

A. Establishing the Right to Effective Assistance of Counsel

If people's rights were being honored, the problem of forced psychiatry would be mostly solved and this would absolutely force society to come up with alternatives -- hopefully recovery oriented. Thus, challenges to the effectiveness of counsel should be made. In light of the current state of affairs, there seems little downside to trying to get the United States Supreme Court to hold it is a right under the United States Constitution. I also believe that ethics complaints should be brought against the attorneys who do not discharge their duty to zealously represent their clients. If every involuntary commitment and forced drugging hearing were zealously represented, each case should take at least half a day. In my view it takes that long to fully challenge the state's case and present the patient's. This, in itself, would encourage the system to look for alternatives (the "path of least resistance" principle).

B. Challenges to State Proceedings.

States that proceed under the "professional judgment" rule should be challenged. The right to state paid expert witnesses should be pursued. The right to less restrictive alternatives should be pursued. Challenges to "expert witness" opinion testimony regarding dangerousness and competence should be made. Challenges to *ex parté* proceedings should be made. There are a myriad of challenges that can be made in the various states, depending on the statutes and procedures utilized in them.[58]

C. 42 USC §1983 Claims

The federal civil rights statute, 42 USC §1983, often known simply as "Section 1983" provides:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress, except that in any action brought against a judicial officer for an act or omission taken in such officer's judicial capacity, injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable. For the purposes of this

[58] For example, I have identified a lot of things under Alaska law where I think valid challenges to what is going on can and should be made.

> section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia.

This statute allows people to go into federal court and obtain injunctions against the constitutional violations that have been outlined here as well as money damages. This is a potentially very fruitful avenue, especially with respect to states where their supreme courts are not honoring people's constitutional rights.[59]

X. Organizing Legal Challenges

At the Action Conference for Human Rights in Mental Health put on by MindFreedom in Washington, DC, last spring,[60] the Legal Track decided it would focus on fighting forced treatment as a single action item that outweighed everything else and certainly a large enough task.[61] It was further decided to establish a State Coordinator system whereby the various states (& countries) would have a single person (or group) that would coordinate efforts for such states with PsychRights offering assistance and over-all coordination as able. There are currently coordinators for eight states and two countries,[62] and coordinators for the other states are wanted. There is not a huge amount going on in any state except Alaska because of the problem of finding an attorney(s) willing to really work zealously on these types of cases, but some progress has been made.

A. Alaska

Since I get to represent people in Alaska and have been active for twenty years, I have been able to pursue the types of actions laid out here, with two challenges to what is going on currently in the Alaska Supreme Court and serious efforts being made to establish effective, recovery-oriented alternatives.[63] A report on these activities as of August 2, 2005, is available on the Internet at http://akmhcweb.org/News/AKEfforts.pdf and if there are any significant developments by the time I present this information at NARPA in November in Hartford, they will be presented there.[64] The two Alaska Supreme Court cases are *Myers v. Alaska Psychiatric Institute*, in which we are seeking to establish that the State must prove forced drugging is in the person's best interest and people have the right to the least restrictive alternative, neither of which are contained in

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[59] One can ask the United States Supreme Court to take cases where a state supreme court does not honor people's federal constitutional rights, but very few cases are heard. By utilizing 41 USC §1983, direct access to the federal courts is possible.
[60] *See*, the Final Report of the Conference, which can be found on the Internet at http://psychrights.org/Education/2005ActionConference/FinalReport.pdf.
[61] *See*, the web page for the Legal Track at http://psychrights.org/Education/2005ActionConference/Legal.htm.
[62] *See*, http://psychrights.org/States/Coordinators.htm for a list of current states (& countries) with coordinators.
[63] Descriptions of such alternatives can be found on the Internet at http://psychrights.org/Research/Digest/Effective/effective.htm.
[64] For information on the NARPA conference, *see*, http://www.narpa.org/narpa.2005.htm.

Alaska Statutes.[65] *Wetherhorn v. Alaska Psychiatric Institute* dramatically illustrates the sham nature of civil commitment and forced drugging proceedings and seeks to establish the right to effective assistance of counsel.[66]

B. Massachusetts

Massachusetts has the very active Freedom Center,[67] which is doing a lot of effective work through its grass roots organizing. Aby Adams from the Freedom Center is the Massachusetts State Coordinator. As mentioned above, in February of 2004, I wrote a memo on how the *Rogers* case has been turned on its head and become a forced drugging assembly line.[68] Next month, Robert Whitaker, author of *Mad in America*, Grace Jackson, MD, author of *Rethinking Psychiatric Drugs: A Guide to Informed Consent*, Dan Kreigman, a local psychologist, Will Hall of the Freedom Center, and I will be presenting a Continuing Legal Education (CLE) program to lawyers representing people in these types of proceedings. I feel changing these lawyers' attitudes is more important than the legal information, which is why the other people presenting are so key.

It turns out that just last week, I was contacted by someone in a Massachusetts hospital and faced with an involuntary commitment and forced drugging petition. I was trying to jack up his attorney and sent her an e-mail with the following:

> Do you have a good expert(s) lined up? Are you going to take the doc's deposition? Any others? In Alaska I just asserted the right to take depositions and got away with it (I think I have the right). Do you know what the asserted grounds of dangerousness are? Have you thought about challenging the proposed guardian, if there is one and suggesting someone else who will be more likely to follow what _______ wants with respect to the drugs? Are you going to move to dismiss the petition? Are you going to make any constitutional challenges? Have you talked to the hospital about what it might take to let him out? I have found here that really challenging what they are doing by these types of steps and especially by taking depositions, they become much more willing to consider a discharge.

Apparently, hospital staff saw the patient's copy of this e-mail and decided to discharge him. The patient believes this was instrumental in his release and supports the concept that making it harder to commit and force drug people, in itself, can be a successful strategy. Here, just contemplating facing a real challenge was enough to have the person released.

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[65] *See*, http://psychrights.org/States/Alaska/CaseOne.htm.
[66] *See*, http://psychrights.org/States/Alaska/CaseFour.htm.
[67] *See*, http://www.freedom-center.org/.
[68] http://psychrights.org/States/Massachusetts/RogersOrders/RogersOrdersMemo.pdf.

C. Minnesota

In Minnesota, we have a State Coordinator, Lousie Bouta, other interested people and a psychiatrist who is willing to testify as an expert witness. We are working on obtaining some good legal assistance and then putting together a case(s).

D. New York

In New York, we have a State Coordinator, Anne Dox and there has recently been some other organizing. We have identified a couple of good attorneys -- especially one -- but financing, as always, is a problem. It seems like we should be able to put something together there.

E. Other States

As mentioned, we also have state coordinators in other states and want them in the states that don't have them.[69]

XI. Public Attitudes

Even though this paper is about the court's potential role in transforming mental health systems to a recovery culture, it seems worthwhile to also make a few comments about changing public attitudes. There is an historic opportunity right now to make substantial inroads against the Psychopharmacology/Psychiatric hegemony because of the revelations in the media regarding dangerous, ineffective drugs, but this must be seized or it will be lost. **A serious public education program must be mounted**.

A. An Effective Public Relations Campaign

In the main, perhaps unduplicated for any other issue, the power of the Psychopharmacology/Psychiatric Hegemony has so controlled the message that the media tends not to even acknowledge there is another side. For most issues, the media will present at least one spokesperson from each side. However, when the latest bogus breakthrough in mental illness research or "treatment" is announced, the other side is not even presented. One might want to pass this off as Big Pharma advertising money infecting the news departments, but I think that is way too simplistic and perhaps even largely untrue.

In order to get our side presented, we need to have established relationships before stories break so they know who to call. An illustration of this is that David Oaks, the Executive Director of MindFreedom, was recently quoted in a recent, important Washington Post article about the NIH study finding "atypical" neuroleptics are neither more effective, nor safer than the older ones.[70] David has worked on his relationship

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[69] *See*, http://psychrights.org/States/Coordinators.htm for a list of current states (& countries) with coordinators.

[70] The article in which David was quoted was "New Antipsychotic Drugs Criticized: Federal Study Finds No Benefit Over Older, Cheaper Drug," *Washington Post*, Tuesday,

with Shankar Vedantam, the person who wrote the story, educating him to the issues, and the result was that when the story broke, David was one of the people Mr. Vedantam called.

There should be an organized, ongoing and sustained public relations effort. There needs to be a person who is able to spend a considerable amount of their time devoted to organizing and coordinating this effort. I've mentioned establishing relationships so that the media will know who to call. As part of this there needs to be a list of potential speakers. These folks are often referred to in the media as "talking heads." Stories also need to be promoted.

B. Potential Talking Heads

The following is a list of people, I believe would be good spokespeople for the major media outlets. It is by no means comprehensive and I apologize in advance to people I no doubt should have included. Also, I don't know everyone on the list well and there may be some people listed, who perhaps would serve the effort better in another capacity(ies). Very importantly, everyone can and should position themselves as spokespeople in their own communities.

Psychiatrists/MDs	Ph.D.s		Survivors*	Attorneys
Peter Breggin	David Cohen	Al Galves	David Oaks	Michael Perlin
Grace Jackson	Bert Karon	Paula Caplan	Judi Chamberlin	Jim Gottstein*
David Healy	Ron Bassman*	Rich Shulman	Celia Brown	Susan Stefan
Joseph Glenmullen,	Bruce Levine	Sarah Edmonds	Laurie Ahern	William Brooks
Dan Fisher*	Larry Simon	Gail Hornstein	Darby Penny	Tom Behrendt
Dan Dorman	Al Siebert*	John Breeding	Pat Deegan	Kim Darrow
Kurt Langsten	Ann Blake Tracy	John Read	Bill Stewart	Dennis Feld
Ann Louise Silver	Barry Duncan	Cloe Madanes	Pat Risser	Maureen Gest
Stuart Shipko	Dominick Riccio	Edward Albee	Francesca Allan	Grant Morris
Ron Leifer	Jonathon Leo	Courtenay Harding	Krista Erickson	
Thomas Szasz	Jay Joseph	David Antonuccio	Linda Andre	
Fred Baughman	Diane Kern	Dathan Paterno	Oryx Cohen	
Karen Effrem	Keith Hoeller	Toby Watson	Catherine Penney	
	Tomi Gomory		Will Hall	

*People in other categories who are also self-identified survivors, are designated with an asterisk. I may have missed some.

C. Promoting and Making Stories

In addition to establishing relationships, and in fact also a way to establish relationships, is to pitch, promote and make stories. The 2003 Fast for Freedom in

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September 20, 2005. The study, itself, can be found at http://psychrights.org/Research/Digest/NLPs/NEJoMAtypicalsnobetter.pdf.

Mental Health put on by MindFreedom was an example of making a story.[71] The most significant coverage it received was in the Washington Post and the LA Times Magazine, but there were a number of other stories and op ed pieces.[72] The Hunger Strike was incredibly successful in one way, which was the brave fasters actually got the American Psychiatric Association to admit it has no evidence for psychiatry's claims that mental illness is a biologically based brain defect.[73] Ultimately, though, the Hunger Strike should have garnered much more media and the reason it didn't was that the prior relationship building had not been done.[74]

XII. Alternatives

It also seems worthwhile to spend a little bit of space here on creating alternatives. Ultimately, in order to be successful, alternatives need to be funded by the public system.[75] One argument in its favor that should be attractive to government (but has not heretofore been) is the current system is breaking the bank. As Whitaker has shown, the disability rate for mental illness has increased six-fold since the introduction of Thorazine.[76] Making so many people permanently disabled and financially supported by the government, rather than working and supporting the government, is not only a huge human tragedy, but is also a massive, unnecessary governmental expense.

One of the simplest, but very important things that should be done is to compile a readily accessible, accurate, list of existing alternatives and efforts to get them going. I have seen lists of alternatives, but then I hear that this program or that is really not a true non-drugging and/or non-coercive alternative. It would be extremely helpful for there to be a description of each such program with enough investigation to know what is really happening. The following are some of the current alternatives and efforts to get more going:

- INTAR[77]
- Action Conference[78]
- Alaska -- Soteria-Alaska, CHOICES, Peer Properties[79]

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[71] *See*, http://mindfreedom.org/mindfreedom/hungerstrike.shtml.
[72] *See*, http://www.mindfreedom.org/mindfreedom/hungerstrike22.shtml.
[73] *See*, http://mindfreedom.org/mindfreedom/hungerstrike1.shtml.
[74] This is not a criticism at all. From my perspective the Hunger Strike was wildly successful.
[75] However, I am also in favor of non-system alternatives and especially "Underground Railroad" and "Safe Houses" types of efforts to which people facing involuntary commitment and forced drugging can escape.
[76] *See*, Anatomy of an Epidemic: Psychiatric Drugs and the Astonishing Rise of Mental Illness in America, which is available at http://psychrights.org/Articles/EHPPPsychDrugEpidemic(Whitaker).pdf.
[77] *See*, http://intar.org/
[78] *See*, Choices Track at http://psychrights.org/Education/2005ActionConference/FinalReport.pdf
[79] http://akmhcweb.org/News/AKEfforts.pdf.

- Arizona -- Meta Services[80]
- California -- Golden State Psychological Health Center[81]
- Illinois -- Associated Psychological Health Services[82]
- Massachusetts -- Freedom Center -- Soteria-New England, Zuzu's Place[83]
- New Hampshire -- The Cypress Center[84]
- Washington -- Ani'sahoni Consulting (Dr. David Walker)[85]
- Wisconsin -- Associated Psychological Health Services[86]

XIII. Conclusion

A final word about the importance of the potential role of the courts and the forced psychiatry issue. While it is true that many, even maybe most, people in the system are not under court orders at any given time, it is my view that the forced psychiatry system is what starts a tremendous number of people on the road to permanent disability (and poverty) and drives the whole public system. Of course, coercion to take the drugs is pervasive outside of court orders too, but again I see the legal coercion as a key element. If people who are now being dragged into forced psychiatry were given, non-coercive, recovery oriented options, they would also become available for the people who are not subject to forced psychiatry. I hope this paper has conveyed the role that strategic litigation can play in transforming mental health systems to a culture of recovery.

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[80] *See*, http://metaservices.com/. They have done a lot of very interesting things, although at this point a lot of their clients are medicated.
[81] *See*, http://www.gsphc.net/.
[82] *See*, http://www.abcmedsfree.com/.
[83] *See*, http://www.freedom-center.org/.
[84] *See*, http://psychrights.org/States/NewHampshire/NewHampshire.htm.
[85] *See*, http://www.anisahoni.com/about/.
[86] *See*, http://www.abcmedsfree.com/.

Exhibit 2

REPORT

MULTI-FACETED GRASS-ROOTS EFFORTS TO BRING ABOUT MEANINGFUL CHANGE TO ALASKA'S MENTAL HEALTH PROGRAM

by

Jim Gottstein

August 2, 2005
with some updates to
September 29, 2006

The August 2, 2005 version of this Report was updated in February, 2006 and again in August and September of 2006, because of significant developments. Both Soteria-Alaska and CHOICES, Inc., have received funding since the original report was issued and the Alaska Supreme Court decided the *Myers* case in June, 2006. Some other minor updates have occurred, such as to the *Wetherhorn* case description, but a comprehensive review and update has not been made.

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II. INTRODUCTION

A number of people both in and out of Alaska have heard of various efforts in Alaska which attempt to create alternatives to the current virtually exclusive reliance on medication for people diagnosed with serious mental illness and have asked for a description of these efforts. I have also been thinking for quite a while that I should describe the various efforts I, along with others, are working on in Alaska. This will not be entirely new to everyone because in 2005 Jeff Jessee, the Executive Director of the Alaska Mental Health Authority (Trust Authority) called me into a meeting where he basically asked what the heck the idea was for four recently formed non-profits: CHOICES, Inc., Soteria-Alaska, Peer Properties and the Law Project for Psychiatric Rights (PsychRights®).[1] Thus, the basic vision was conveyed to the group of people at that meeting. Also, I have described it at Consumers Consortium meetings, where it has been met uniformly with great enthusiasm. I hope it will be helpful to have it laid out in writing.[2]

The four non-profits serve complementary roles in the effort to create alternatives to our mental illness system's[3] virtually exclusive focus on the administration of psychiatric drugs for "treatment" of people diagnosed with serious mental illness. The drugs are of dubious, at best, <u>over all</u> effectiveness, are extremely harmful, and are <u>at least</u> halving the number of people who recover from a diagnosis of serious mental illness. Another way to put it is our system is creating large numbers of people[4] who become seriously and persistently mentally ill,[5] most of whom become permanent burdens on government financial resources. More importantly from my perspective, they lead much less satisfying, shorter, and less fulfilling lives than they otherwise could.

There is a huge debate over this assertion and it is not my purpose to engage in that debate here[6] because the efforts described here are to <u>allow choice</u>. 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.[7] 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 is designed to play a role in this, although one of them, Soteria-Alaska, could be rolled into CHOICES, Inc., depending on timing and funding.

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[1] Due to sustainability problems, multiplicity of administrative departments, and human resources constraints, both the Trust and the Rasmuson Foundation, which is the largest private foundation in Alaska, are discouraging the proliferation of non-profits.
[2] This Report suffers from speaking to different audiences. For example, the section on Alaska isn't necessary for people in Alaska and the names are of no relevance to people outside of Alaska. Hopefully, it will be sufficient unto the day for all readers.
[3] 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, rather than a mental health system.
[4] At least doubling.
[5] Also known as "chronically mentally ill."
[6] However, there are references and links which demonstrate these are the facts.
[7] 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[8] to improve the outcomes of people diagnosed with serious mental illness by making available alternatives to the coercive, substantially illegal, essentially exclusive, over-medication regime now in effect.

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

The report is extensively footnoted for those who wish to explore the topics in greater depth, and a glossary is included to define unfamiliar terms and acronyms.

III. BACKGROUND

The underlying premise is the mental illness system's over-reliance on medication is at least doubling the number of people who become seriously and persistently mentally ill and causing great harm to a great number of people,[9] including death,[10] and that by offering various alternatives to medication, many of which have been proven to work,[11] substantially better outcomes will result.[12] 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 US for involuntary commitment and medication are

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[8] I live in Alaska and as will be described below, it has some unique potential advantages, which makes it a good place to attempt to effect the type of meaningful change described here. The general ideas, however, can be used by people around the country (and to a certain extent, around the world) and I am also working with people around the country on various such efforts.

[9] It would unacceptably increase the length of this Report to support this statement here, and readers are directed to 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. I have no doubt about the accuracy of the statement. If only one book is to be read on this topic, *Mad in America: Bad Medicine, Bad Science and the Enduring Mistreatment of the Mentally Ill*, by Robert Whitaker is recommended. *Toxic Psychiatry*, by Peter Breggin would be the next one.

[10] *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.

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

[12] 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 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.

essentially a sham[13] 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 these pesky rights get in the way of what we know is in the person's best interests."

If people's rights were actually honored, my sense is *at least* 90% of court orders for Forced Drugging would not occur.[14] However, it is recognized (a) that society will not tolerate just letting people go 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 to get 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 must become 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 previously, acute and community based services could be performed by one agency. There would be a number of benefits to this, the most important perhaps being that people would not lose the community based support system they have when they need acute services and *vice versa*. In other words, they can continue working with the people whom they have grown to trust.

IV. Alaska Attributes

There are several attributes in Alaska that are fairly important in perhaps making it a more favorable place to accomplish the goals presented here than other places.

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 things. 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 many of the key players, and have a certain amount of credibility and respect. As will be evident, however, while all of this may be true, the goals are still not easy to accomplish.

B. Alaska Mental Health Trust Authority

A totally unique attribute of Alaska is the Trust Authority, which was created as a result of the settlement of litigation (Trust Settlement) over the state of Alaska stealing one million

[13] *See*, Section VI. D(3) below.

[14] This is based on the premise that people may not constitutionally be Force Drugged unless it can be scientifically proven it is in their best interests and there is no less restrictive alternative that could be made available. Involuntary commitments are perhaps legally justified a greater percentage of the time under the current state of the law, but not therapeutically.

acres of land granted in trust for Alaska's mental health program (Trust).[15] The Trust now has about $300 million in cash corpus, makes some money off its land corpus, and spends about $20 million a year on what it considers innovative programs and to facilitate major initiatives, such as constructing a new state hospital. In addition to people diagnosed with mental illness, the Trust's beneficiaries include chronic alcoholics with psychosis, the mentally retarded and mentally defective, and people with Alzheimer's Disease and related dementias. The influence and ability of the Trust Authority to impact Alaska's mental health program far exceeds the relatively small amount of money it has to spend on it and should not be underestimated.[16]

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.[17] Appointments to the board are by the Governor, though, and are thus political to a greater or lesser extent.[18]

D. Consumers 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.[19] *See*, http://akmhcweb.org/Announcements/2002rfr/consortiumproposals.htm for its initial set of proposals. It seems 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

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[15] 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 $1.1billion 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.

[16] Having said that, the current state Administration is generally disinterested in any outside input, which has diminished the Trust's influence since 2003.

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

[18] I was on the Mental Health Board from 1998 to 2004, but was not reappointed after I sued the State regarding the interpretation of the Trust Settlement. *See*, http://psychrights.org/States/Alaska/4bdSuit/4bdSuit.htm. Being re-appointed under the Murkowski Administration was always unlikely because I was not of the right political party.

[19] A Consumer membership organization, Mental Health Advocates of Alaska (MHAAK), was formed in 2004/05 with the intent of representing Consumers (as contrasted with Consumer run programs) statewide to policy makers. It is too early to tell if it will attract enough members to legitimately claim such status.

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[20] this was no longer possible, which resulted in the more typical free-for-all competition process with winners and losers.

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 totally works for them.[21] They now have over 40 people living there, including many children. I don't think they have had a psychiatric crisis in well over ten years, perhaps not since the community was founded. 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 any issues. A few years ago, they needed some grant funding to expand their agricultural operation and build a community building they call the "Longhouse." The grant application brought what they were doing to the attention of policy makers, and Ionia became an example of 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.

V. GENESIS OF EFFORT

While I have been involved in mental health policy in Alaska for quite a long time in various capacities[22] and had a pretty good sense of the failure of the mental illness system to truly help most people diagnosed with serious mental illness, this particular effort 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 revealed vast numbers of people are being greatly harmed by the current "treatment" paradigm.[23] Of course, there have actually been many books documenting the same thing, including Dr. Peter Breggin's seminal book *Toxic Psychiatry*. *Toxic Psychiatry* is also a compelling and well documented indictment of the current system, but I found it was when people read *Mad in America* that they really "got" on an almost visceral level the scientific and moral bankruptcy of the current system and the scope of the harm being done.

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[20] 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 now calls its "Trust Beneficiary Group Initiative" or "TBGI."

[21] *See*, http://akmhcweb.org/recovery/ioniaadn.html and http://ionia.org/.

[22] A brief bio can be found at http://psychrights.org/about/Gottstein.htm.

[23] 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.

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*, exhorting them to take action to improve the outcomes for people diagnosed with serious mental illness by providing alternatives to medication.[24] PsychRights brought Bob 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, Whitaker also spoke to the Alaska Psychiatric Institute and to the state-wide organization of community mental health centers. The Mental Health Board's reaction was mostly positive, though 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. No such changes to Alaska's mental health program have occurred.

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

> 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, although I can't say for sure because I am no longer on the board. Much of this can be attributed to the animosity of the Murkowski administration to the Alaska Mental Health Board and to its attempts to enfeeble the board by reducing its funding and combine it with the Alaska Board on Alcoholism and Drug Abuse.[25]

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

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[24] 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.

[25] When the Administration discovered it could not do this without breaching the Trust Settlement, it accomplished much the same thing by forcing the Alaska Mental Health Board and the Alaska Board on Alcoholism and Drug Abuse to share staff and hold joint meetings and by refusing to appoint the person they selected as their joint Executive Director.

VI. SPECIFIC EFFORTS: STATUS & PROSPECTS

A. Acute Care: Soteria-Alaska

Dr. Loren Mosher's Soteria-House project and study in the 1970's proved that people who are in acute psychiatric crisis, who would normally be hospitalized, can be at least as successfully treated and have better long term outcomes (lives) if they are allowed to get through their initial psychotic episode(s).[26] The Michigan State Psychotherapy study proves the same thing.[27] The Michigan study also shows that in the short term there are significant cost savings and the long-term cost savings are enormous.[28]

Soteria-Alaska, Inc. was incorporated in January of 2003 as a vehicle to create a Soteria-like program in Alaska.[29] 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 he was (and continues to be) very supportive of people 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, Inc., as a separate entity trying to do so was put on hold. However, as the 15 month deadline approached for filing for tax exempt status approached with no concrete progress towards ACMHS establishing a Soteria-like program, 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.[30]

In the summer of 2004, there was an indication of interest in Soteria-Alaska from at least one member of the Trust Authority, and it was suggested a proposal should be put together for

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[26] *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.

[27] *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. Also, *see*, 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.

[28] 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 insurance. 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." 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.

[29] Soteria-Alaska was not envisioned as necessarily being a Consumer run program, which is in contrast to CHOICES, Inc., described below.

[30] 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 medication, which is its corporate culture.

presentation to the Alaska Mental Health Board for its recommendation. The Consumers Consortium had a modest amount of funding available for planning and an agreement was made with Dr. Aron Wolf for assistance in preparing such a proposal.[31] A proposal was prepared and submitted to the Alaska Mental Health Board, which recommended it for funding to the Trust.[32] The prospect of a Soteria-Alaska has generated a lot of interest and support from outside Alaska. For example, psychiatrists Ann- Louise Silver,[33] Peter Stastny,[34] Dan Dorman,[35] Luc Ciompi,[36] Nathaniel Lehrman,[37] and Grace Jackson,[38] all of whom have experience in treating people without drugs have indicated a willingness to help. Non-psychiatrist experts who also indicated a willingness to help include Alma Menn,[39] the administrator of the original Soteria-House project, John Bola, who collaborated with Dr. Mosher in a number of studies and papers and Judy Schreiber, Dr. Mosher's widow. In addition to myself, Eliza Eller of Ionia and Andrea Schmook currently comprise Soteria-Alaska's board of directors.

In October of 2005, Soteria-Alaska was granted $10,000 from the Trust, to continue the planning. This enabled it to make another proposal to the Trust in January of 2006 and the Trust granted $78,000 to support further development of the Soteria-Alaska program in preparation for

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[31] Dr. Wolf has been Ionia's psychiatrist for many years, has been practicing psychiatry in Alaska since 1967, was the Regional Medical Director of Providence Health System, and holds a Masters of Medical Management Degree, which is the equivalent of a Masters of Business Administration for medical management. Especially exciting from our perspective is Dr. Wolf had experience at Chestnut Lodge in Maryland, which pioneered psychotherapeutic treatment of people diagnosed with serious mental illness. Dr. Wolf's CV can be found at http://choices-ak.org/grants/05TBGIOperating/AWolfCV.pdf.

[32] A copy of the proposal can be found at http://soteria-alaska.com/Soteria-Alaskawapdx.pdf. The initial business plan can be found at http://soteria-alaska.com/grants/05TBGI/SoteriaInitialBizPlan.pdf

[33] Dr. Silver practiced at Chestnut Lodge when it did not use medications and has written a number of articles about treating people with psychosis without drugs. For example, she has reported that when she first worked at Chestnut Lodge, her schizophrenic patients were not medicated. Later, all of her patients were medicated as a matter of policy. In the premedication days, she had patients who got romantically involved, got married, had children, and related to their spouses and children. None of her medicated patients ever formed a new relationship. *See*, http://psychrights.org/Articles/KaronMedication.htm.

[34] Dr. Stastny is a driving force behind the international effort to create more programs like Soteria-House through an organization known as International Network of Treatment Alternatives for Recovery (INTAR). *See*, http://www.intar.org/.

[35] Dr. Dorman has treated people diagnosed with serious mental illness without drugs for many years and is the author of the fantastic book, Dante's Cure, a true account of a young woman's descent into psychosis and then, through hard work, understanding and most importantly, having a psychiatrist willing to spend the time and have a true caring relationship, her journey back from madness into full recovery.

[36] Dr. Ciompi has run Soteria-Berne in Switzerland for a long time.

[37] Dr. Lehrman is the former Clinical Director, Kingsboro Psychiatric Center, Brooklyn, NY and has published extensively on successful non-medication treatment. *See*, e.g., The Rational Organization of Care for Disabling Psychosis -"If I Were Commissioner," which can be accessed at http://akmhcweb.org/articles/iflehrmancommissioner.htm. Dr. Lehrman identifies having the same person involved in both the community and acute settings as being extremely important.

[38] Dr. Jackson was described by Dr. Mosher as the most knowledgeable person he knew of about the actual effects of psychiatric drugs. Her book definitive book on the topic, *Rethinking Psychiatric Drugs: A Guide to Informed Consent* has just been published.

[39] Ms. Menn is currently a consultant to the project.

a full business plan presentation to the Trust in September, 2006.[40] Susan Musante was hired as the Project Manager[41] and the Business Plan was submitted on August 4, 2006.[42] Because the long-term viability of Soteria-Alaska depends on State of Alaska financial participation and there are a number of other hurdles, making it hard to determine when Soteria-Alaska might be ready to open, the Trust staff recommended the Trust fund continued planning and pre-development efforts with the idea that it will fund the start-up when all of the pieces are in place, including inclusion in the state's budget. This recommendation was accepted and on September 6, 2006, the Trust passed a motion approving the following:

Fiscal Year 2007 (ending June 30, 2007)

$120,000 in Trust Funds for continued development work.

Fiscal Year 2008 (ending June 30, 2008)

$160,000 in Trust Funds.
Recommendation that $220,000 in State of Alaska General Fund/Mental Health (GF/MH) be appropriated for Soteria-Alaska operations.

Fiscal Year 2009 (ending June 30, 2009)

$160,000 in Trust Funds.
It doesn't appear the Trust actually passed a motion regarding FY 2009 GF/MH, but it is understood the plan is if the State does appropriate the $220,000 in FY 2008, that it would go up to $470,000 in FY 2009

The key then, to opening Soteria-Alaska is getting the Legislature to include it in the state budget. Because of all of the support for it the chances are reasonable for that to happen. In addition to the Trust's support, the Alaska Division of Behavioral Health is supporting state funding as is the Executive Director of the state hospital. It appears the earliest Soteria-Alaska could possibly open would be January or February of 2008, and that is probably too optimisitic.

B. Community Based Services: CHOICES, Inc.

CHOICES, Inc., which stands for Consumers Having Ownership In Creating Effective Services (hereafter referred to as CHOICES), was formed at the same time as Soteria-Alaska to provide an alternative to the drug-only treatment modality in the community. It is a Consumer run program. On its website, CHOICES describes its program as follows:[43]

[40] The planning proposal funded by the Trust can be found at http://soteria-alaska.com/grants/FY06-07PreDev/TrustFinanceCmtee4Feb7-806.pdf.
[41] Ms. Musante has proven to be terrific. A brief bio can be found at http://soteria-alaska.com/Info/AnnounceSMusante.htm
[42] A copy of the Business Plan can be obtained from http://soteria-alaska.com/Grants/FY06-07PreDev/SoteriaSept06BizPlan.pdf
[43] *See*, http://choices-ak.org/.

Consumers
Having
Ownership
IN
Creating
Effective
Services

CHOICES, Inc., was formed to provide alternatives in the community to the current medication dominated mental health system. Tax exempt status was received on March 15, 2005, and CHOICES is now able begin operations.

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. More specifically, Article III, §2, of the Bylaws requires, "at least 2/3rds of the members of the Board of Directors shall be a past or present recipient of mental health services of such a nature that inpatient care may have been necessary."

The philosophy behind CHOICES is reflected in both its name and the words which create the acronym CHOICES -- **C**onsumers **H**aving **O**wnership **I**n **C**reating **E**ffective **S**ervices -- which is people having options of their own creation and choosing.

CHOICES anticipates three primary modes of operation. The first is to provide people the types of services or other resources they **choose** to help them recover. The second is 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. The third is 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.

To reiterate, there are three basic components to the CHOICES program as currently envisioned:

(1) Helping people (and parents of younger children) get what they want.

(2) Providing the types of services Loren Mosher describes in Chapter 9 of his and Lorenzo Burti's excellent book, Community Mental Health: A Practical Guide, which can be found at http://choices-ak.org/grants/05TBGIOperating/Ch9.pdf (9 Megabytes).

(3) Being a conduit for pass-through grants for consumer run programs that have not obtained 501(c)(3) status.

It is not envisioned that Soteria-Alaska would provide community services, but there are scenarios where CHOICES could/would run a Soteria-like program. In other words, if CHOICES is able to commence operations and moves to a position to accomplish it, it could establish a Soteria-like program as part of its programming. As mentioned above, this would have the major advantage of more easily allowing people to retain the support people they have come to trust, even when they move between acute and non-acute situations.[44]

[44] It should be pointed out here, however, that the goal and expectation is that people will recover and come to rely on the mental health system much less, if at all.

Andrea Schmook, who has tremendous, successful experience with consumer run programs and is currently working on ACMHS' consumer driven section,[45] serves as CHOICES' initial executive director on a part-time basis under contract from ACMHS. In addition to myself, Eliza Eller of Ionia and Michele Turner currently comprise CHOICES' board of directors.

CHOICES is designed to access current financing mechanisms, such as Medicaid, which would make it self-sustaining. CHOICES has received a $150,000 grant to provide Independent Case Management and Flexible Support Services.[46] It is hoped that this grant will be the start to allow CHOICES to become a self-sustaining part of Alaska's mental health system.

CHOICES also serves as "pass-through" agency or "fiscal agent" for a number of organizations and grants.

C. Housing: Peer Properties

Peer Properties, Inc., was formed by myself and Katsumi Kenaston to provide housing for people diagnosed or diagnosable with serious mental illness and homeless, 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.

It has long been recognized that being homeless or in a bad living situation contributes to psychiatric symptoms and prevents recovery.[47] 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. Peer Properties neither encourages nor discourages the use of psychiatric medications; instead, it supports its tenants' choices in the matter.

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.[48] After some initial difficulties, four women now share the house and it is operating very well, although finances are very tight.

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[45] Ms. Schmook's resume can be found at http://choices-ak.org/grants/05TBGIOperating/ASchmookResume-9-24-04.pdf.

[46] Both Independent Case Management and Flexible Support Services were in the Consumers Consortium 2002 package of budget proposals (http://akmhcweb.org/Announcements/2002rfr/casemanagement.pdf and http://akmhcweb.org/Announcements/2002rfr/flexible.pdf).

[47] 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.

[48] *See*, http://peerproperties.org/Properties/outside.jpg

In 2004, Peer Properties was also awarded a pre-development grant to apply for a Special Needs Housing Grant (SNHG). Peer Properties teamed up with a very sophisticated and experienced developer, the Venture Development Group, and submitted an application under the SNHG program as well as for Low Income Housing Tax Credits. Peer Properties was awarded both a SNHG Grant and tax credits to build an 11 unit apartment building, including one for a resident manager (called "Peer One"), aimed at housing people who repeatedly cycle through the Alaska Department of Corrections and the Alaska Psychiatric Institute (API). Unfortunately, this project proved just too difficult to pull off.

Peer Properties is currently operated entirely by its volunteer board of directors, Andrea Schmook,[49] Mel Henry,[50] Barry Creighton and myself. In the final analysis, the Peer One Project proved too complicated and/or ambitious for Peer Properties' organizational capacity at that time and it is no doubt a good thing that the project was abandoned rather than have it built and become a failure. Such a failure would certainly have been a black eye for Peer Properties and also a blow to Consumer run programs in Alaska, generally. Many people worked with good faith on the project and no one should be blamed that it was not completed. Nor should people cease working on providing housing for the very challenging population it was intended to serve. Peer Properties is willing to increase the housing it is providing, but only if there is sufficient capacity and operating support.

D. Legal: Law Project for Psychiatric Rights (PsychRights)[51]

PsychRights is a non-profit, tax exempt, 501(c)(3), public interest law firm whose mission is to bring fairness and reason into the administration of legal aspects of the mental health system, particularly unwarranted court ordered psychiatric drugging. Its purpose is to promote and implement a legal campaign in support of psychiatric rights and against unwarranted court ordered psychiatric medication akin to what Thurgood Marshall and the NAACP mounted in the 40's and 50's on behalf of African American civil rights. 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.[52]

In addition to myself, Don Roberts and Chris Cyphers serve on its board of directors.[53] I donate all my services *pro bono publico*.

(1) Development

Prior to reading *Mad in America*, while I had a general sense of what was happening with Forced Drugging, I didn't feel I had anything in particular to contribute. In addition to *Mad in*

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[49] Ms. Schmook's resume can be found at http://choices-ak.org/grants/05TBGIOperating/ASchmookResume-9-24-04.pdf.

[50] Dr. Henry's Resume can be found at http://peerproperties.org/grants/O5TBGI/MHenryResume.pdf.

[51] Since this Report is about Alaska efforts, PsychRights' efforts in other states is not covered.

[52] 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.

[53] Bios of the board of directors and other key personnel can be found at http://psychrights.org/about.htm.

America being a great book, to me it was 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) Bob Whitaker, the author of *Mad in America*, (2) Loren Mosher, M.D., of Soteria House fame, and (3) Professor Michael Perlin, the 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,[54] and Psychiatry: Force of Law,[55] attended the November 2002, NARPA conference and arranged for an off-agenda presentation.[56] There I met Mr. Whitaker, Dr. Mosher and Michael Perlin. Mentioned above is bringing Bob Whitaker to Alaska 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 Internet to make them more accessible, and particularly so other attorneys could download and attach them as exhibits when fighting Forced Drugging cases.[57]

(2) Finances

PsychRights has a general policy against taking government funding because it is felt 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 has been accepted from it to help present a seminar on Mental Health Disability Law in September of 2003 by Professor Perlin and Robert Whitaker[58] and a $10,000 Small Project grant for representation expenses, such as filing fees, deposition costs, expert witness fees, etc. Otherwise, PsychRights is entirely sustained by private donations.[59] PsychRights submitted a TBGI systems change grant application to fund one attorney and assistant, which was not awarded.[60] PsychRights' finances are completely transparent, with financial information being 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 1950's and '60's 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 exists with our mental illness system, where governmental policies are supported by large economic interests, litigation is often a necessary element in eliminating the abuses.

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[54] http://psychrights.org/calltoaction.htm.
[55] http://psychrights.org/force_of_law.htm.
[56] PsychRights provided a number of free copies of *Mad in America* to people who could not afford to purchase it, which helped with attendance.
[57] http://psychrights.org/Research/Digest/Chronicity/NeurolepticResearch.htm
[58] *See*, http://psychrights.org/Education/ak03CLE/Brochure.htm.
[59] Regular financial statements may be found at http://psychrights.org/about.htm#financial.
[60] The operating grant application can be found at http://psychrights.org/grants/05tbgi/PsychRightsOperating.htm and the companion capital grant application at http://psychrights.org/grants/05tbgi/PsychRightsCapital.htm.

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[61] 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.[62]

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 involuntary 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.63

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."[64]

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[61] This is perjury, a crime.

[62] "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

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

[64] 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."

It is also well known that:

> Traditionally, lawyers assigned to represent state hospital patients have failed miserably in their mission.[65]

The sham nature of Forced "Treatment" proceedings, supported by the meretricious and overwhelming financial juggernaut of the pharmaceutical industry, has resulted in Forced Drugging being by far the "path of least resistance."[66] 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".[67] PsychRights' goal 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 medication[68] and provides the choices to which they are entitled before they can legally be forced 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.

(4) Undertaken Litigation

(a) Myers -- Forced Drugging

PsychRights' first case, *Myers v. Alaska Psychiatric Institute*,[69] directly challenging Alaska's Forced Drugging procedures, was decided by the Alaska Supreme Court on June 30, 2006.[70] 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:

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

[66] While court ordered involuntary psychiatric drugging is the most dramatic, coercion to take these harmful drugs is pervasive. As mentioned before, 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 and then they are taken away because the parent takes the drugs and becomes too mentally ill. And, of course, all of the current financing systems are primarily for medications.

[67] *See*, http://psychrights.org/States/Alaska/CaseOne/30-Day/ExhibitRLRMosherAff.htm.

[68] One normally sees this phrased as the right to "refuse" medication, but I find that a misleading and pejorative term that assumes exercising the right is a bad thing. People have the right to decline a medication recommendation and it should be phrased that way, in my view.

[69] See, http://psychrights.org/States/Alaska/CaseOne.htm for more information on this case, including the briefs and transcripts of some of the hearings. A video of the oral argument before the Alaska Supreme Court is also available upon request.

[70] 138 P.3d 238. A copy of the Decision is available at http://psychrights.org/States/Alaska/CaseOne/MyersOpinion.pdf.

> [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.[71] We argued the Alaska and US constitutions require at least that there must be 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 restrictive alternative could be offered.

The Alaska Supreme Court agreed, holding:

> [B]efore a state may administer psychotropic drugs to a non-consenting mentally ill patient in a non-emergency setting, an independent judicial best interests determination is constitutionally necessary to ensure that the proposed treatment is actually the least intrusive means of protecting the patient.[72]

This 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. 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.

(b) Wetherhorn -- Ineffective Assistance of Counsel

The *Wetherhorn* appeal is primarily about such representation, although there are a couple other issues in the case.[73] If people actually had vigorous representation, only a small fraction of those currently subjected to Involuntary Commitment and Forced Drugging would lose their cases. We are hoping 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. Other issues include the legally insufficient nature of the proceedings and the unconstitutionality of part of Alaska's "gravely disabled" grounds for Involuntary Commitment. We are also attempting to establish the right to attorneys fees in the event the State does not prevail on its petition(s) for involuntary commitment and/or forced drugging because if we can do so, it will

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[71] *See*, http://psychrights.org/States/Alaska/CaseOne/30-Day/Order.pdf, pages 8 and 13.
[72] 138 P.3d at 250.
[73] More information on this case can be found at http://psychrights.org/States/Alaska/CaseFour.htm.

encourage members of the private bar to take some of these cases and adequately represent their clients.

(c) Bavilla -- Forced Drugging in Prison

In the *Bavilla* case, which challenges the procedures for Forced Drugging in prison, the Alaska Department of Corrections admitted to facts constituting violations of the United States Constitution.[74] 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 and a client, we have the admissions of the State regarding their illegal procedures and can commence a new case challenging Forced Drugging in prison here.

(5) Prospective Litigation

We also have a number of prospective issues identified for system changing litigation.

(a) Kids in Custody/Out of State Placements

The state takes custody of a large number of children, and is paying for over 400 in out of state facilities.[75] Based on what is happening in other states, one can assume well over half are being subjected to psychiatric drugging. Polypharmacy, which has never been approved, is rampant with kids 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,[76] but no one has any idea what these drugs are doing to the developing brains of our children. Whenever children 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 are blaming the children and subjecting them to the horrors of psychiatric drugging. When the resources are available to litigate, an appropriate case to challenge child in custody drugging practices may present itself. For example, is it legal for the state to drug kids in its custody with drugs that are not approved for pediatric use?

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

[75] *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.

[76] 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.

(b) In-State Residential Treatment Centers

In addition to kids who are in out of state residential treatment centers, many children are drugged on inpatient units or other residential settings in Alaska. North Star here in Anchorage is notorious for heavily drugging kids and engaging in polypharmacy. An appropriate case to challenge such practices when the resources are available to do so may present itself at any time. For example, is it child abuse to medicate kids with drugs that are not approved for pediatric use in the way it is now done?

(c) 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.

(d) 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.[77] We have had a complaint against API drafted for over two years now waiting for a suitable plaintiff.[78]

(6) 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 legal rights.[79] 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.[80] To the extent these illegal behaviors are not corrected through the other efforts outlined here, resort "Section 1983" in federal court to seek redress will be indicated. Challenging forced drugging in Alaska's prisons, for example, might be brought as such a civil rights case.

(7) Ethics Complaints.

It is apparent that the public defenders assigned to represent psychiatric respondents in Involuntary Commitment and Forced Drugging cases are violating their ethical obligations. If

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[77] *See*, AS 47.30.837, which can be accessed at http://touchngo.com/lglcntr/akstats/Statutes/Title47/Chapter30/Section837.htm.

[78] *See*, http://psychrights.org/States/Alaska/CaseTwo/draftInformedConsentComplaint.htm.

[79] This is a simplification and more information about "Section 1983" rights can be found at http://psychrights.org/Research/Legal/1983/1983.htm.

[80] Yesterday PsychRights filed a Reply re: Motion for Attorney's Fees, which detail such illegal deprivation of rights in that case. This can be found at http://psychrights.org/States/Alaska/CaseFour/AttysFees/attyFeeReply.pdf. It is apparent such violations of rights are pervasive at API.

other means to obtain effective representation are not successful, it is likely ethics complaints 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[81] per week, or even per month will 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)[82] and, in my view, a jury trial should be demanded under AS 47.30.745(c)[83] for every 90-day commitment petition. The trials should last at least hours, if not days, rather than the approximately 15 minutes they do now. Objections should be made to unfavorable Probate Master recommendations.[84] Requests for emergency stays against Forced Drugging should be made.[85] Appeals should be taken when appropriate.[86] In 2004, I met with the Public Defender and the Assistant Public Defenders who normally handle these cases.[87] 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 appealed an involuntary commitment and Forced Drugging Order to try and obtain more than sham representation.[88]

I think it is fair to say the all-out, four month legal battle that was the *Myers* case at the trial court[89] has had at least a minor impact. I have gotten people out or stopped Forced Drugging with a phone call or an e-mail in a few situations since then by suggesting the person

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[81] 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."
[82] *See*, http://www.touchngo.com/lglcntr/akstats/Statutes/Title47/Chapter30/Section735.htm.
[83] *See*, http://www.touchngo.com/lglcntr/akstats/Statutes/Title47/Chapter30/Section745.htm.
[84] 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.
[85] 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.
[86] 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.
[87] A copy of the discussion points for this meeting is available at http://psychrights.org/states/Alaska/CaseFour/PDONotes.pdf.
[88] *See*, http://psychrights.org/States/Alaska/CaseFour.htm.
[89] *See*, http://psychrights.org/States/Alaska/CaseOne.htm.

did not meet the legal criteria in a way that let the hospital know I would be getting involved in the case if they proceeded. 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.

(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 who 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 damages cases (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.

(c) Attorney's Fees.

In the Wetherhorn case, which is an involuntary commitment and Forced Drugging case, we are asking for enhanced or full attorney's fees to try and establish that as a precedent as a way to discourage API's illegal practices and encourage other attorneys to take these cases.[90]

(9) Educational Programs

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

(a) Website

PsychRights' website is very deep with information, including posting full articles and studies for use by attorneys and other people. Its Scientific Research by Topic[91] and Articles[92] web pages are particularly replete with important information from accepted sources. There are many other sections of the website, which is hopefully organized in a user-friendly manner and includes a section with information about various states.[93]

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[90] *See*, http://psychrights.org/states/Alaska/CaseFour/FeeAppeal/Brief.pdf.
[91] http://psychrights.org/Research/Digest/Researchbytopic.htm.
[92] http://psychrights.org/Articles/articles.htm.
[93] http://psychrights.org/States/States.htm.

(b) 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.[94] 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 these issues and projects, such as Michele Turner, Susan Musante, Andrea Schmook, Barry and Cathy Creighton, Eliza and Ted Eller, George Stone, Dr. Aron Wolf, Alma Menn, Mel Henry, Carl Ipock, Kelly Behen and Scot Wheat, Don Roberts, Esther Hopkins, Jamie Dakis, Roslyn Wetherhorn, Aleen Smith, Jerry Jenkins and Richard Rainery. 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. Having become aware of this great harm, I am personally unwilling to stand by and am resolved to do everything I can to reduce, or better yet, eliminate it. 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 late 70's 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. This situation is far more important.

Of course, litigation is not a goal, it is a means to achieve a goal -- the goal of honoring people's right to choose a non-medication alternative to drugs that so many find debilitating, harmful and counter-productive. 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.

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[94] *See*, http://psychrights.org/Education/ak03CLE/Brochure.htm.

VIII. GLOSSARY

- "ACMHS" stands for Anchorage Community Mental Health Services, also known as Southcentral Counseling Center.

- "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.[95]

- "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.[96]

- "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" is the statewide group consisting of all Consumer run programs in the state. *See*, http://akmhcweb.org/Announcements/2002rfr/consortiumproposals.htm for its initial set of proposals to the Alaska Mental Health Board.

- "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.

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

[96] *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.

- "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 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 one million acres of land granted to it in trust for Alaska's mental health program. http://www.touchngo.com/lglcntr/spclint/mht.htm.

- "MHAAK" stands for Mental Health Advocates of Alaska, a new member organization for Consumers intended to have substantial statewide membership.

- "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/.

- "RECA" stands for Recovery Education Center for Alaska, which was formed to teach Mary Ellen Copeland's WRAP (Wellness Recovery Action Plan) program in Alaska. *See*, http://copelandcenter.com/whatiswrap.html.

- "RFP" means Request for Proposal, which is a notice of opportunity to apply for a grant.

- "Section 8 Vouchers" are United States Department of Housing and Urban Development low income housing subsidies.

- "SNHG" stands for Special Needs Housing Grant, which is funded by the Trust Authority and administered by the Alaska Housing Finance Administration.

- "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/.

- "TBGI" stands for Trust Beneficiary Group Initiative, which is an expansion by the Trust Authority of eligibility for funding of Consumer run programs formerly restricted to beneficiaries classified as mentally ill.

- "Trust Settlement" refers to the settlement of the litigation over the state of Alaska "redesignating" (i.e., "stealing") the one 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.

Exhibit 3

Reply-To: <degilman@egilman.com>
From: "David Egilman" <degilman@egilman.com>
To: "'Jim Gottstein'" <jim@psychrights.org>
Subject: faxed
Date: Wed, 6 Dec 2006 15:40:57 -0500
Organization: nac
X-Mailer: Microsoft Office Outlook, Build 11.0.5510
Thread-Index: AccZaZCBeWtFomOCQOuxLrSwzAi7MQADTPzg
X-OriginalArrivalTime: 06 Dec 2006 20:41:17.0254 (UTC) FILETIME=[E0D99660:01C71976]

subpoena notice and subpoena.pdf

December 6, 2006

Robert A. Armitage
General Counsel
Eli Lilly and Company
Lilly Corporate Center
Indianapolis, IN 46285
Phone: (317) 433-5499
FAX: (317) 433-3000

Dear Mr. Armitage:

I am a consulting witness in the Zyprexa litigation and have access to over 500, 000 documents and depositions which Lilly claims are "Confidential Discovery Materials." Lilly defines these as "any information that the producing party in good faith believes properly protected under Federal Rule of Civil Procedure 26(c)(7)."

Lilly has claimed that newspaper articles and press releases fit this definition. I have received a subpoena attached that calls for the production of all these documents and depositions. In compliance with the protective order I am supplying a complete copy of the subpoena which notifies you of all the following:

(1) the discovery materials that are requested for production in the subpoena;
(2) the date on which compliance with the subpoena requested;
(3) the location at which compliance with the subpoena is requested;
(4) the identity of the party serving the subpoena; and
(5) the case name, jurisdiction and index, docket, complaint, charge, civil action or other identification number or other designation identifying the litigation, administrative proceeding or other proceeding in which the subpoena or other process has been issued:

David Egilman MD
8 North Main Street
Suite 404
Attleboro, MA 02703
degilman@egilman.com
508-226-5091 ext 11
cell 508-472-2809

IN THE ~~DISTRICT~~/SUPERIOR COURT FOR THE STATE OF ALASKA
AT ANCHORAGE

In the Matter of the Guardianship
of B.B.
Respondent ~~PLAINTIFF,~~
~~vs.~~

~~DEFENDANT(S)~~

CASE NO. 3AN-04-545 P/G

SUBPOENA FOR TAKING DEPOSITION

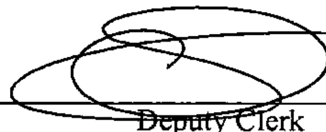
To: **David Egilman, MD, MPH**
Address: **8 North Main Street, Attleboro, Massachusetts 02703**

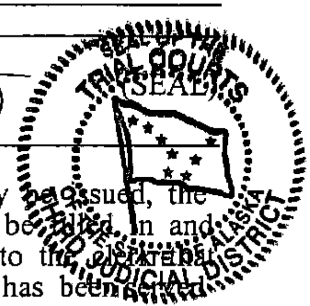
You are commanded to appear and testify /telephonically under oath in the above case at:

Date and Time: **December 20, 2006 at 10:00 AST, 2:00 PM EST**
~~Offices of~~ **Telephone No. 907) 274-7686**
Address: **n/a**

Notice, as required by Civil Rule 45(d), has been served upon James H. Parker on December 6, 2006. You are ordered to bring with you See attached

12/6/06
Date


Deputy Clerk



Subpoena issued at request of
James B. Gottstein, Esq.
Attorney for Respondent
Address: 406 G Street, Suite 206
Telephone: 274-7686
If you have any questions, contact the person named above.

Before this subpoena may be issued, the above information must be filled in and proof must be presented to the clerk that a notice to take deposition has been served upon opposing counsel.

RETURN

I certify that on the date stated below, I served this subpoena on the person to whom it is addressed, ____________, in ____________, Alaska. I left a copy of the subpoena with the person named and also tendered mileage and witness fees for one day's court attendance.

Date and Time of Service

Signature

Service Fees:
Service $
Mileage $
TOTAL $

Print or Type Name

Title

If served by other than a peace officer, this return must be notarized.

Subscribed and sworn to or affirmed before me at ____________, Alaska on ____________.

(SEAL)

Clerk of Court, Notary Public or other person authorized to administer oaths.
My commission expires ____________

Attachment to Subpoena Duces Tecum
(Production of Documents)
David Egilman MD, MPH

1. Your curriculum vitae.

2. Subject to any applicable restrictions, all expert reports prepared by you within the last five years pertaining to psychiatric medications.

3. Subject to any applicable restrictions, all documents you have in your possession, or have access to, including those in electronic format, and have read, reviewed or considered, pertaining to the testing, marketing, efficacy, effectiveness, risks and harms of commonly prescribed psychiatric drugs in the United States, including but not limited to Haldol, Thorazine, Mellaril, Clozaril, Risperdal, Zyprexa, Seroquel, Abilify, Geodon, Lithium, Depakote, Prozac, Paxil, Zoloft, and Wellbutrin.

R. Armitage

DEC 0 6 2006

December 6, 2006

Robert A. Armitage
General Counsel
Eli Lilly and Company
Lilly Corporate Center
Indianapolis, IN 46285
Phone: (317) 433-5499
FAX: (317) 433-3000

Dear Mr. Armitage:

I am a consulting witness in the Zyprexa litigation and have access to over 500, 000 documents and depositions which Lilly claims are "Confidential Discovery Materials." Lilly defines these as "any information that the producing party in good faith believes properly protected under Federal Rule of Civil Procedure 26(c)(7)."

Lilly has claimed that newspaper articles and press releases fit this definition. I have received a subpoena attached that calls for the production of all these documents and depositions. In compliance with the protective order I am supplying a complete copy of the subpoena which notifies you of all the following:

(1) the discovery materials that are requested for production in the subpoena;
(2) the date on which compliance with the subpoena requested;
(3) the location at which compliance with the subpoena is requested;
(4) the identity of the party serving the subpoena; and
(5) the case name, jurisdiction and index, docket, complaint, charge, civil action or other identification number or other designation identifying the litigation, administrative proceeding or other proceeding in which the subpoena or other process has been issued:

David Egilman MD
8 North Main Street
Suite 404
Attleboro, MA 02703
degilman@egilman.com
508-226-5091 ext 11
cell 508-472-2809

Exhibit 4

PsychRights®
Law Project for Psychiatric Rights, Inc.

December 21, 2006

Special Master Peter H. Woodin
JAMS
280 Park Avenue, 28th Floor
New York, New York 10017

Re: Zyprexa Prooducts Liability Litigation, MDL 1596 ("Federal Litigation")
Certification of James Gottstein

I, the undersigned, James B. Gottstein, make the following representations concerning compliance with the order signed by Hon. Brian Cogan on December 19, 2006, ("Order") in the above-referenced federal litigation, directing the return of documents provided to me by Dr. David Egilman pursuant to subpoena ("Egilman Documents") issued by the Superior Court for the State of Alaska, Third Judicial District, in *In the Matter of the Guardianship of B.B.*, Case No. 3AN-04-545 P/G. and specified other relief, as that Order has been amended in the course of the Status Hearing conducted before Judge Cogan on December 20, 2006 ("Status Hearing").

For the record, I wish to note my continuing objection to the court's assertion of authority over me and the propriety of the issuance of this Order, including but not limited to objections relating to the court's jurisdiction to issue the Order, to the denial of due process with respect to proceedings culminating in the Order, and in particular to certain "findings" made in the Order. Dr. Egilman provided the documents at issue pursuant to my subpoena in the above-referenced state court litigation, only after following my instruction to give immediate notice of my subpoena to him to Eli Lilly and Company ("Lilly") as a party that had produced a portion of the subpoenaed documents in the Federal Litigation, and affording Lilly a reasonable opportunity to direct him to object to production. It was and remains my belief that I was doing nothing wrong when I received and made use of the documents thereafter produced to me by Dr. Egilman. I understand the parties to the Federal Litigation may see this differently, though I would note that to my knowledge, neither Judge Cogan, Judge Weinstein, nor any other court has ever ruled that disclosure of the Egilman Documents is not in the public interest. That may be a matter for another day. My purpose here is simply to note, as my counsel did in the Status Hearing, the continuing nature and reservation of this objection, and the fact that in voluntarily undertaking the steps outlined in the Order, I am not thereby submitting to the jurisdiction of the court or waiving my objections.

All representations herein are made in good faith, in an effort to fully cooperate with the court and parties to the Federal Litigation, and are based on what I know or recall at this time, having made diligent and extensive efforts considering the time allotted to ensure the accuracy hereof. To my knowledge, I have made all disclosures and undertaken all activities encompassed by the Order. Should I subsequently discover or recall any information which, had I been aware of it at this time, should have been provided pursuant to the Order, I will promptly supplement this document by communicating it to the Special Discovery Master.

The Order specifies the return of documents produced by Lilly pursuant to CMO-3 and which were provided to me by Dr. David Egilman "or any other source." I have no independent knowledge of the source of the documents sent to me by Dr. Egilman, but am assuming for

406 G Street, Suite 206, Anchorage, Alaska 99501 ~ (907) 274-7686 Phone ~ (907) 274-9493 Fax
http://psychrights.org

present purposes that all of the Egilman Documents were provided to him pursuant to CMO-3. To my knowledge, I have not obtained documents provided pursuant to CMO-3 from any other source, subject to the caveat set forth in section 6 below.

1. I certify that after issuance of Judge Cogan's Order I did not further disseminate the Egilman Documents (and in fact had voluntarily refrained from further distribution of Egilman Documents after receiving a letter from Lilly's counsel requesting this in the preceding week).

2. All documents provided by Dr. Egilman to me pursuant to my subpoena were received electronically. I do not have, and have not had, paper copies of any of the Egilman Documents. On December 20, 2006, after receiving clarification that the court and counsel for Lilly were dropping the requirement that I create a "Bates stamp" index of documents so that I no longer needed to preserve copies for that purpose, I deleted all Egilman Documents from my computer. Before doing so, I made a copy these documents on a DVD, labeled "All Z Docs 12/20/06." I have delivered this DVD today to my counsel, D. John McKay, for forwarding to you. Except as specified in items 5 and 6 below, I no longer have in my possession or control any copies of the Egilman Documents.

3. In addition to the aforementioned copies of the Egilman Documents sent electronically to and residing in my computer, I made a number of copies of these documents on DVDs, burned from my computer and distributed these copies. As noted further in section 7 below, I have retrieved or made a good faith effort to retrieve all of these copies. Those DVDs that I have been able to retrieve myself, or that were still in my possession, were turned over to local counsel for Eli Lilly yesterday for forwarding to the Special Master, per agreement. I have asked all others to whom I distributed the DVDs to turn over what I gave them to the Special Master and ensure that no copies exist. In addition, I happen to have copied one of the Egilman Documents onto a "flash drive." I have deleted it, and before doing so, I burned a copy of it onto a DVD that was among those delivered yesterday to counsel for Lilly, on a DVD labeled "from flash drive."

4. I have located the .pdf file Mr. McKay referred to in the December 20 status hearing, a word-searchable compilation of the Egilman Documents and the dozen or so files that were added together to make that file that I had created. As Mr. McKay promised, I have deleted that document from my computer.

5. While the Order does not specifically mention or address back-up copies, in an effort to fully cooperate in good faith with the intent of the order, I have taken steps to secure the removal of any copies of the Egilman Documents that might exist in any medium, in any location, where my computer is routinely backed up. I do not have the necessary access or technical expertise to accomplish this, but I have given directions to the individual who does have it to accomplish this as soon as practicable, and to ensure the security of the backup media in the meanwhile. Earlier this week I provided you with a copy of communication with this technician to this effect, and when the task is completed, my counsel will secure a certification to this effect and forward it to you.

6. In the course of my longstanding representation of clients and other advocacy work with respect to a variety of mental health-related issues, including but not limited to my work for the Law Project for Psychiatric Rights (PsychRights) and my successful prosecution of litigation culminating in the Alaska Supreme Court's ruling in *Myers v. Alaska Psychiatric Institute*, 138 P.3d 238 (Alaska 2006) restricting forced drugging, I have had occasion to acquire and publicly disseminate many, many documents relating to mental health treatment and related issues. These

documents, and the litigation and other activities to which they relate, have often specifically concerned the use of drugs, including but not limited to Eli Lilly's drug Zyprexa, which is the subject of your above-referenced MDL products liability litigation. I have routinely made such documents available publicly to anyone interested in the rights of people diagnosed with serious mental illness, and will continue to do so, on my website and otherwise. I know that such documents collected and utilized in the past include a substantial number of documents specifically concerning Zyprexa, including but not limited to numerous Zyprexa-related documents that have previously been produced pursuant to the Federal Freedom of Information Act. Because of the voluminous nature of these documents previously in my possession, and the fact that due to the Order I am unable to ascertain the identity of all the items contained in the Egilman Documents that were temporarily in my possession, I wish to note that it is possible that contained within the Egilman Documents are items that I and others have previously, and entirely appropriately, possessed and used. I simply do not know, and compliance with the court's order makes it impossible for me to determine this now. I suspect that it is not unlikely, however, since it is my understanding that some of the files encompassed by the court's protective order include a number of documents such as newspaper articles and other items that are already public and may well be in my independently and previously existing collection of documents. Therefore, while I can certify in complete good faith that I have deleted and/or returned all of the Egilman Documents, I cannot warrant that I have no copies of any documents that might coincidentally be found among the hundreds and hundreds of files comprising the Egilman Documents.

7. The lists in the subsections below identify, to the best of my ability, the persons, organizations or entities who obtained copies of Egilman Documents through me. I am informed that in the course of the Status Hearing, the court amended its Order to eliminate the requirement that I create an index identifying by Bates stamp number which documents were disseminated to whom. All those who received copies of the Egilman Documents from me or through me received all or a portion of one of two datasets. OnTuesday, December 12, 2006, Dr. Egilman first sent me documents I had requested in my subpoena to him. When I received these, comprising 356 documents, I burned copies of them onto one or more identical DVDs labeled "356 ZDocs" or "Zdocs 356" (hereinafter referred to as "DVD 1") On the following day, Dr. Egilman electronically sent me additional documents pursuant to the subpoena, and when I received these I burned new identical DVDs, labeled "ZDocs 12/13/06," or "12/13/06 ZDocs" (hereinafter referred to as "DVD 2") which new DVD 2 contained both the documents that arrived that day, and the documents that arrived the day before. (A .pdf file showing a photocopy of each of the aforementioned DVDs delivered to local counsel for Lilly yesterday, for forwarding to the Special Master is attached hereto as Exhibit 1.) All those who received DVD copies of Egilman Documents from me received one of these two datasets, either by getting one of the DVDs, or accessing the document electronically from my computer. I cannot recall with absolute certainty who got which of the two datasets.

Those to whom copies were provided received these copies either in person, on DVDs, or via U.S. Mail, on DVD, or by accessing an Internet FTP server(s), as FTP files. Before the Order was signed, I began the process of contacting those to whom I had provided copies to secure their return. As to those I contacted by e-mail for this purpose, I copied the Special Discovery Master and counsel. Those to whom I gave copies to in person, I personally met with to retrieve their copies.

a) Those to whom I provided copies in person, and from whom I was subsequently able to personally retrieve these copies, all in DVD format, are as follows:

Recipient	Format
• Terrie Gottstein	DVD 1
• Jerry Winchester	DVD labeled "from J. Winchester," provided to Lilly counsel

To the best of my memory, I distributed no other copies in person.

b) Those who did not receive copies from me in person include the following. The notation indicating whether they received DVD 1 or DVD 2 or both, and/or whether they accessed the documents from an Internet FTP Server, reflects the best of my knowledge at this time:

Recipient	Affiliation or Other Identification	Format
Alex Berenson	New York Times	DVD 1. DVD 2, FTP Access.
Dr. Peter Breggin	Prominent psychiatrist of conscience, expert witness, and prolific author	DVD 1, possibly DVD 2.
Dr. Grace Jackson	Perhaps the most knowledgeable psychiatrist expert on psychopharmacology in the US, if not world, with respect to mechanisms of action in the brain and body	Both DVDs
Dr. David Cohen	Florida International University	Both DVDs, I believe
Bruce Whittington	PsychRights Executive Director	DVD 1
Dr. Stephen Kruszewski	Psychiatrist	Only DVD 2, I believe, maybe both
Laura Ziegler	Psychiatric Survivor/Activist	DVD 1 only, I believe
Judi Chamberlin	Psychiatric Survivor/Activist Icon, author of "On Our Own."	DVD 1 only, I believe
Vera Sherav	Alliance for Human Rights Protection	DVD 2, two copies
Robert Whitaker	Former medical/science journalist, and author of *Mad In America: Bad Science, Bad Medicine and the Enduring Mistreatment of the Mentally Il*l	Both DVDs, I think.
Steve Cha	House Committee on Government Reform (Minority Office)	DVD 2
Will Hall	Psychiatric Survivor/Activist, co-founder of the Freedom Center in Northamton, MA	Either or both DVDs and I believe FTP
Singeha Prakash	National Public Radio	DVD 2

c) Also, a .pdf file containing the FTP logs from my computer relating to the Egilman Documents is attached hereto as Exhibit 2, insofar as it may in some cases constitutes the best evidence, or supplemental evidence, of to whom Egilman Documents were provided, and/or of which documents were provided to whom.

Finally, I certify that I have taken steps to preserve, until further order of the court, all documents, voice mails, emails, materials and information, including but not limited to all

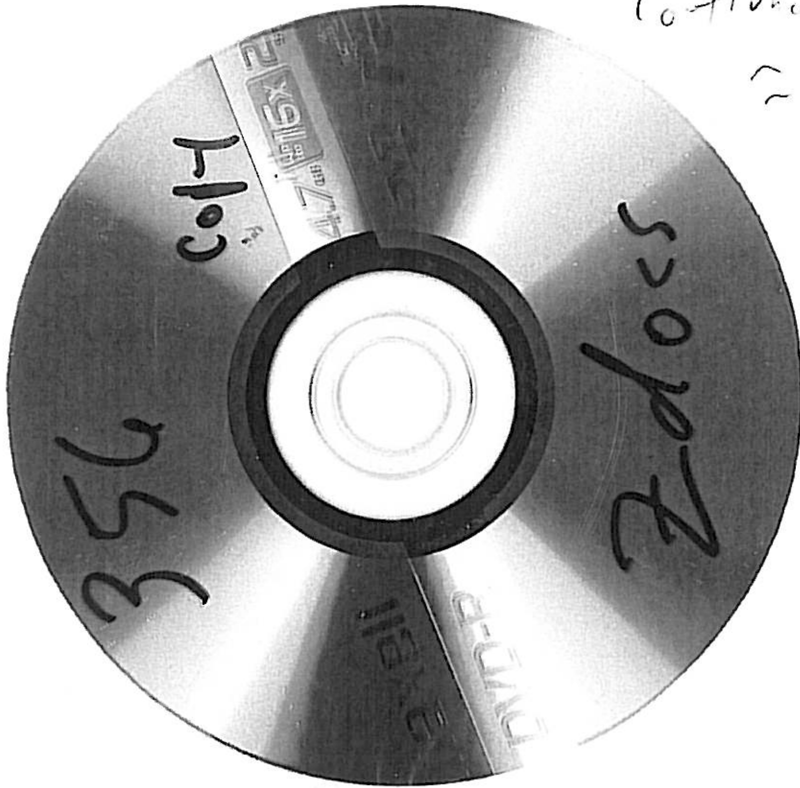
communications that refer to, relate to or concern Dr. Egilman or any other efforts to obtain documents produced by Eli Lilly and Company in the Federal Litigation, reserving all rights and without waiving any objections that might be made to actually producing such documents based on any privilege or other provision of law, and subject to the caveat set forth in section 6.

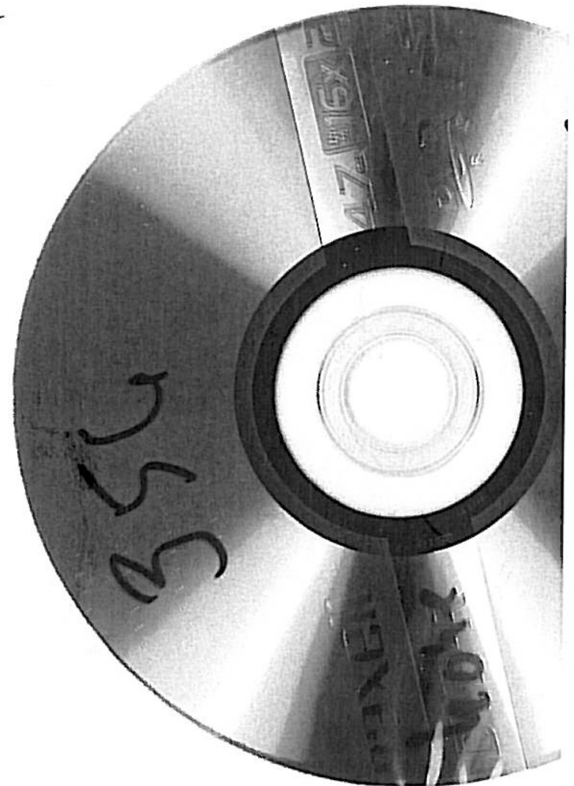
____

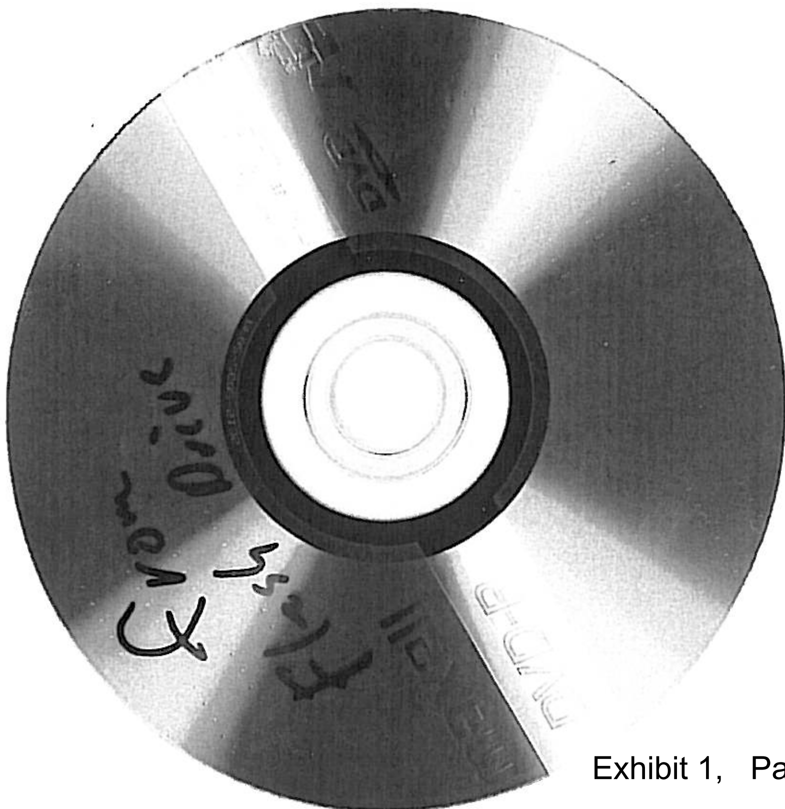
James B. Gottstein

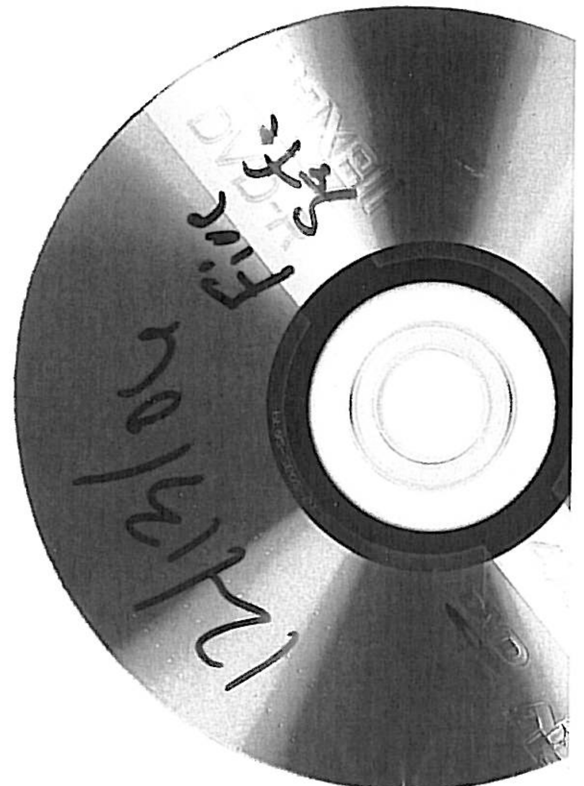
To Brewster Jamieson
12/20/06

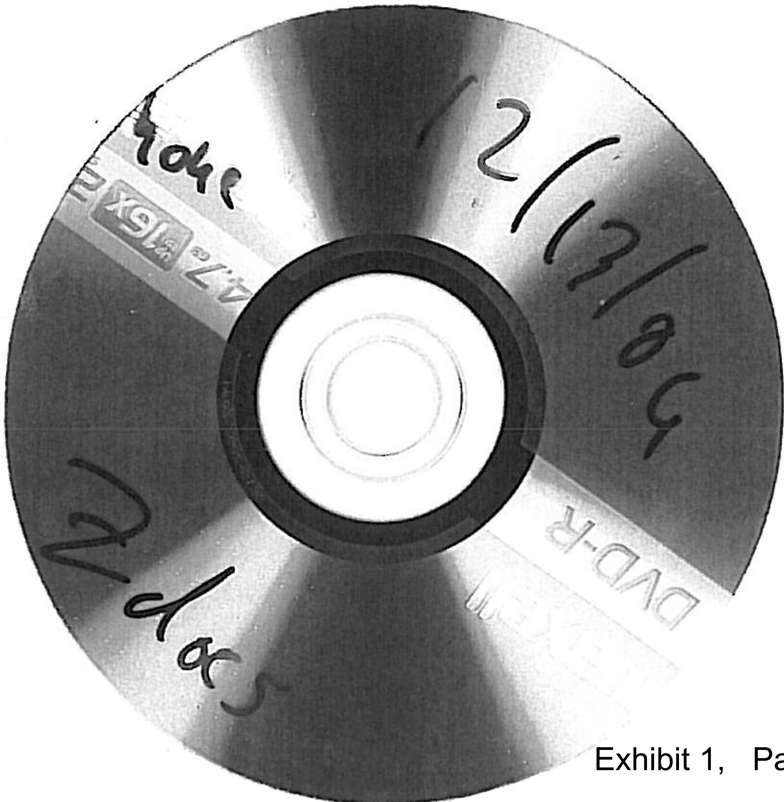
Continued delivery
≈ 12:05

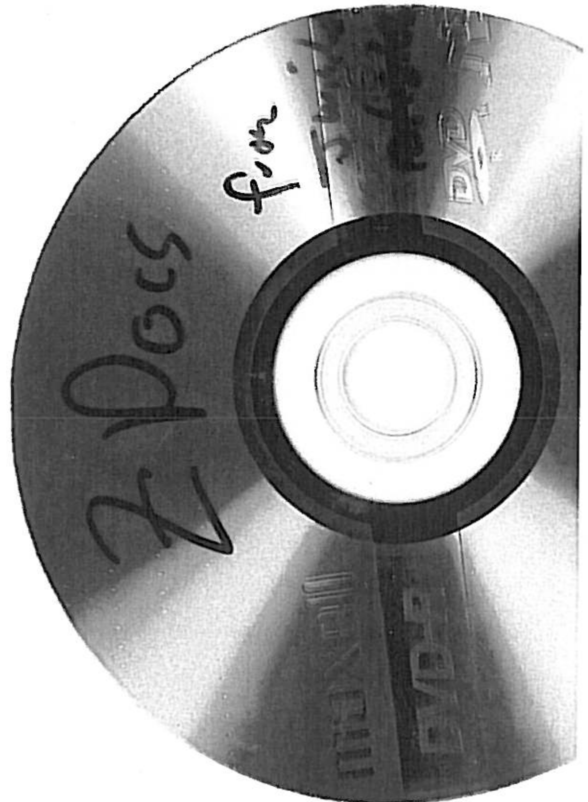












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schizophrenia 331 - - - -
00:18:06 172.16.2.245 - MSFTPSVC2 PENTA1 172.16.1.129 21 [489]PASS - 530 - - - -
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- - - -
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- - - -
00:21:55 172.16.2.245 - MSFTPSVC2 PENTA1 172.16.1.129 21 [490]PASS - 530 - - - -
00:22:19 172.16.2.245 EliLilly MSFTPSVC2 PENTA1 172.16.1.129 21 [490]USER EliLilly
331 - - - -
00:22:19 172.16.2.245 - MSFTPSVC2 PENTA1 172.16.1.129 21 [490]PASS - 530 - - - -
00:22:29 172.16.2.245 EliLilly MSFTPSVC2 PENTA1 172.16.1.129 21 [490]USER EliLilly
331 - - - -
00:22:29 172.16.2.245 - MSFTPSVC2 PENTA1 172.16.1.129 21 [490]PASS - 530 - - - -
00:58:08 172.16.2.245 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [491]USER
schizophrenia 331 - - - -
00:58:08 172.16.2.245 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [491]PASS - 230
- - - -
00:58:31 172.16.2.245 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [491]sent
/356/ZY1+++00008867.TIF 226 - - - -
00:59:03 172.16.2.245 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [491]created
CONNECT.wav 550 - - - -
00:59:03 172.16.2.245 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [491]created
CONNECT.wav 550 - - - -
00:59:10 172.16.2.245 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [491]QUIT - 226
- - - -
02:07:41 172.16.2.245 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [492]USER
schizophrenia 331 - - - -
02:07:41 172.16.2.245 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [492]PASS - 230
- - - -
02:07:50 172.16.2.245 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [492]QUIT - 350
- - - -
02:08:25 172.16.2.245 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [493]USER
schizophrenia 331 - - - -
02:08:25 172.16.2.245 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [493]PASS - 230
- - - -
02:08:30 172.16.2.245 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [493]created
COMPLETE.wav 550 - - - -
02:08:30 172.16.2.245 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [493]created
COMPLETE.wav 550 - - - -
02:08:47 172.16.2.245 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [493]QUIT - 226
- - - -
```

ex061214a.log

```
#Software: Microsoft Internet Information Services 6.0
#Version: 1.0
#Date: 2006-12-14 17:15:58
#Fields: time c-ip cs-method cs-uri-stem sc-status sc-win32-status
17:15:58 172.16.2.245 [1719]USER schizophrenia 331 0
17:15:58 172.16.2.245 [1719]PASS - 530 1326
17:16:12 172.16.2.245 [1719]USER schizophrenia 331 0
17:16:12 172.16.2.245 [1719]PASS - 230 0
17:18:59 172.16.2.245 [1719]closed - 421 121
```

```
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#Version: 1.0
#Date: 2006-12-14 03:33:09
#Fields: time c-ip cs-username s-sitename s-computername s-ip s-port cs-method
cs-uri-stem sc-status cs-host cs(User-Agent) cs(Cookie) cs(Referer)
03:33:09 71.127.1.55 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [342]USER
schizophrenia 331 - - - -
03:33:09 71.127.1.55 - MSFTPSVC2 PENTA1 172.16.1.129 21 [342]PASS - 530 - - - -
03:33:57 71.127.1.55 anonymous MSFTPSVC2 PENTA1 172.16.1.129 21 [343]USER anonymous
331 - - - -
03:33:57 71.127.1.55 - MSFTPSVC2 PENTA1 172.16.1.129 21 [343]PASS
mozilla@example.com 530 - - - -
03:34:13 71.127.1.55 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [343]USER
schizophrenia 331 - - - -
03:34:13 71.127.1.55 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [343]PASS - 230
- - - -
03:34:14 71.127.1.55 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [343]sent / 550
- - - -
03:34:14 71.127.1.55 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [343]sent / 426
- - - -
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- - - -
03:34:14 71.127.1.55 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [343]sent / 426
- - - -
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- - - -
03:34:14 71.127.1.55 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [343]sent / 426
- - - -
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550 - - - -
03:34:36 71.127.1.55 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [343]sent /356
426 - - - -
03:34:36 71.127.1.55 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [343]sent /356
550 - - - -
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426 - - - -
03:34:36 71.127.1.55 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [343]sent /356
550 - - - -
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426 - - - -
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03:34:51 71.127.1.55 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [343]sent
/Zyprexa+Amended+Complaint/Documents+Cited+in+Zyprexa+Amended+Complaint 550 - - - -
03:34:51 71.127.1.55 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [343]sent
/Zyprexa+Amended+Complaint/Documents+Cited+in+Zyprexa+Amended+Complaint 426 - - - -
03:34:51 71.127.1.55 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [343]sent
/Zyprexa+Amended+Complaint/Documents+Cited+in+Zyprexa+Amended+Complaint 550 - - - -
03:34:51 71.127.1.55 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [343]sent
```

/Zyprexa+Amended+Complaint/Documents+Cited+in+Zyprexa+Amended+Complaint 426 - - - -
03:35:00 71.127.1.55 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [343]sent /Zyprexa+Amended+Complaint 550 - - - -
03:35:00 71.127.1.55 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [343]sent /Zyprexa+Amended+Complaint 426 - - - -
03:35:00 71.127.1.55 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [343]sent /Zyprexa+Amended+Complaint 550 - - - -
03:35:00 71.127.1.55 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [343]sent /Zyprexa+Amended+Complaint 426 - - - -
03:35:00 71.127.1.55 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [343]sent /Zyprexa+Amended+Complaint 550 - - - -
03:35:00 71.127.1.55 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [343]sent /Zyprexa+Amended+Complaint 426 - - - -
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03:35:02 71.127.1.55 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [343]sent / 426 - - - -
03:35:02 71.127.1.55 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [343]sent / 550 - - - -
03:35:02 71.127.1.55 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [343]sent / 426 - - - -
03:35:02 71.127.1.55 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [343]sent / 550 - - - -
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03:35:07 71.127.1.55 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [343]sent / 550 - - - -
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03:35:07 71.127.1.55 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [343]sent / 550 - - - -
03:35:07 71.127.1.55 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [343]sent / 426 - - - -
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03:35:32 71.127.1.55 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [343]sent /356
426 - - - -
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550 - - - -
03:35:32 71.127.1.55 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [343]sent /356
426 - - - -
03:35:32 71.127.1.55 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [343]sent /356
550 - - - -
03:35:32 71.127.1.55 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [343]sent /356
426 - - - -
03:35:43 71.127.1.55 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [343]sent / 550
- - - -
03:35:43 71.127.1.55 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [343]sent / 426
- - - -
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- - - -
03:35:43 71.127.1.55 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [343]sent / 426
- - - -
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- - - -
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- - - -
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- - - -
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- - - -
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- - - -
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- - - -
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- - - -
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- - - -
03:38:24 71.127.1.55 - MSFTPSVC2 PENTA1 172.16.1.129 21 [342]closed - 421 - - - -
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331 - - - -
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schizophrenia 331 - - - -
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- - - -
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- - - -
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- - - -
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schizophrenia 331 - - - -
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14:48:28 71.127.1.55 [1711]CWD / 250 0
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ZY651894.tif 226 0
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18:39:50 207.31.197.88 [1715]created
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18:40:01 207.31.197.88 [1715]created
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18:40:06 207.31.197.88 [1715]created
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18:41:24 207.31.197.88 [1715]created
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ZY7119739.tif 226 0
18:41:28 207.31.197.88 [1715]created
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ZY7119856.tif 226 0
18:41:35 207.31.197.88 [1715]created
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18:41:40 207.31.197.88 [1715]created
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18:42:12 207.31.197.88 [1715]created
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18:42:59 207.31.197.88 [1715]created
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ZY7300229.tif 226 0

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18:45:42 207.31.197.88 [1715]created
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ZY84131233.tif 226 0
18:48:53 207.31.197.88 [1715]created
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ZY8413151.tif 226 0
18:50:22 207.31.197.88 [1715]created
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18:50:30 207.31.197.88 [1715]created
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18:51:50 207.31.197.88 [1715]created
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ZY8509825.tif 226 0
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ZY89301567.tif 226 0
18:53:08 207.31.197.88 [1715]created
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ZY89502179.tif 226 0
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```
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ZYP478414.tif 226 0
19:25:18 172.16.2.245 [1717]USER schizophrenia 331 0
19:25:18 172.16.2.245 [1717]PASS - 530 1326
19:25:38 172.16.2.245 [1717]USER schizophrenia 331 0
19:25:38 172.16.2.245 [1717]PASS - 230 0
19:26:32 172.16.2.245 [1717]CWD 356 250 0
19:28:48 172.16.2.245 [1717]closed - 421 121
22:40:52 172.16.2.245 [1718]USER schizophrenia 331 0
22:40:52 172.16.2.245 [1718]PASS - 230 0
22:40:52 172.16.2.245 [1718]CWD 356 250 0
22:40:55 172.16.2.245 [1718]CWD .. 250 0
22:40:57 172.16.2.245 [1718]CWD Zyprexa+Amended+Complaint 250 0
22:40:59 172.16.2.245 [1718]CWD Documents+Cited+in+Zyprexa+Amended+Complaint 250 0
22:41:17 172.16.2.245 [1718]QUIT - 226 0
```

ex061213.log

```
#Software: Microsoft Internet Information Services 5.0
#Version: 1.0
#Date: 2006-12-13 23:19:16
#Fields: time c-ip cs-username s-sitename s-computername s-ip s-port cs-method
cs-uri-stem sc-status cs-host cs(User-Agent) cs(Cookie) cs(Referer)
23:19:16 172.16.2.245 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [341]USER
schizophrenia 331 - - - -
23:19:24 172.16.2.245 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [341]PASS - 230
- - - -
23:25:00 172.16.2.245 schizophrenia MSFTPSVC2 PENTA1 172.16.1.129 21 [341]closed -
421 - - - -
```

ex061212.log

```
#Software: Microsoft Internet Information Services 6.0
#Version: 1.0
#Date: 2006-12-12 01:02:07
#Fields: time c-ip cs-method cs-uri-stem sc-status sc-win32-status
01:02:07 172.16.2.245 [1632]USER anonymous 331 0
01:02:07 172.16.2.245 [1632]PASS mozilla@example.com 530 1326
01:02:29 66.31.155.99 [1633]USER anonymous 331 0
01:02:29 66.31.155.99 [1633]PASS mozilla@example.com 530 1326
01:02:32 66.31.155.99 [1633]USER schizophrenia 331 0
01:02:32 66.31.155.99 [1633]PASS - 230 0
01:02:33 66.31.155.99 [1633]sent /docs 550 2
01:02:33 66.31.155.99 [1633]CWD /docs 550 2
01:02:42 172.16.2.245 [1632]USER schizophrenia 331 0
01:02:42 172.16.2.245 [1632]PASS - 530 1326
01:02:57 172.16.2.245 [1634]USER anonymous 331 0
01:02:57 172.16.2.245 [1634]PASS mozilla@example.com 530 1326
01:03:13 172.16.2.245 [1634]USER schizophrenia 331 0
01:03:13 172.16.2.245 [1634]PASS - 230 0
01:03:13 172.16.2.245 [1634]sent /docs 550 2
01:03:13 172.16.2.245 [1634]CWD /docs 550 2
01:03:31 66.31.155.99 [1635]USER anonymous 331 0
01:03:31 66.31.155.99 [1635]PASS mozilla@example.com 530 1326
01:03:35 66.31.155.99 [1635]USER schizophrenia 331 0
01:03:35 66.31.155.99 [1635]PASS - 230 0
01:03:36 66.31.155.99 [1635]sent /docs/xx.html 550 3
01:03:36 66.31.155.99 [1635]CWD /docs/xx.html 550 3
01:03:49 66.31.155.99 [1636]USER anonymous 331 0
01:03:49 66.31.155.99 [1636]PASS mozilla@example.com 530 1326
01:03:52 66.31.155.99 [1636]USER schizophrenia 331 0
01:03:52 66.31.155.99 [1636]PASS - 230 0
01:03:54 66.31.155.99 [1636]sent /docs/xx.doc 550 3
01:03:54 66.31.155.99 [1636]CWD /docs/xx.doc 550 3
14:52:52 207.31.197.88 [1660]USER anonymous 331 0
14:52:52 207.31.197.88 [1660]PASS IEUser@ 530 1326
14:52:52 207.31.197.88 [1661]USER anonymous 331 0
14:52:52 207.31.197.88 [1661]PASS IEUser@ 530 1326
16:30:00 207.31.197.88 [1662]USER schizophrenia 331 0
16:30:00 207.31.197.88 [1662]PASS - 230 0
16:30:23 207.31.197.88 [1662]created /sand.jpg 226 0
16:31:31 207.31.197.88 [1662]DELE sand.jpg 250 0
16:50:06 207.31.197.88 [1663]USER schizophrenia 331 0
16:50:06 207.31.197.88 [1663]PASS - 230 0
16:54:20 207.31.197.88 [1663]created /sand.jpg 226 0
16:55:09 207.31.197.88 [1663]DELE sand.jpg 250 0
21:50:32 90.19.8.216 [1679]USER anonymous 331 0
21:50:32 90.19.8.216 [1679]PASS Lgpuser@home.com 530 1326
```

ex061211.log

```
#Software: Microsoft Internet Information Services 6.0
#Version: 1.0
#Date: 2006-12-11 20:56:57
#Fields: time c-ip cs-method cs-uri-stem sc-status sc-win32-status
20:56:57 172.16.2.245 [1612]USER schizophrenia 331 0
20:57:15 172.16.2.245 [1612]PASS - 230 0
20:57:27 172.16.2.245 [1612]created /CONNECT.wav 226 0
20:57:40 172.16.2.245 [1612]DELE CONNECT.wav 250 0
20:57:52 172.16.2.245 [1612]QUIT - 226 0
21:04:45 172.16.2.245 [1613]USER schizophrenia 331 0
21:04:55 172.16.2.245 [1613]PASS - 230 0
21:04:59 172.16.2.245 [1613]created /COMPLETE.wav 226 0
21:05:16 172.16.2.245 [1613]DELE COMPLETE.wav 250 0
21:05:20 172.16.2.245 [1613]QUIT - 226 0
```

Date: Fri, 22 Dec 2006 15:16:21 -0900
To: Peter Woodin <pwoodin@jamsadr.com>
From: John McKay <mckay@alaska.net>
Subject: Supplemental Information Re: Gottstein Compliance
Cc: "Fahey, Sean P." <Faheys@pepperlaw.com>,
Brewster Jamieson <JamiesonB@LanePowell.com>,
"Richard D. Meadow" <RDM@lanierlawfirm.com>,
Evan Janush <EMJ@lanierlawfirm.com>,
Jim Gottstein <jim.gottstein@psychrights.org>
X-ACS-Spam-Status: no
X-ACS-Scanned-By: MD 2.57; SA 3.1.6; spamdefang 1.117

Master Woodin,

In the filing submitted to you yesterday regarding Mr. Gottstein's compliance with Judge Cogan's Order, we omitted two items, and I appreciate Mr. Fahey drawing this to my attention.

First, I inadvertently failed to include addresses for those listed in section 7 of the response, although Mr. Gottstein had timely compiled and forwarded them to me.

Second, with regard to when the documents were provided to the listed recipients, as Mr. Gottstein indicates in his certificate, he cannot be completely certain as to every individual. However, he informed me before leaving today on a long-scheduled trip with his family that to the best of his knowledge and recollection, all copies of the "DVD 1" that he mailed or gave to those listed were sent or given on December 12, 2006, and most of the copies of "DVD 2" that he mailed or gave to those listed were sent or given on December 13, 2006.

At this point, Mr. Gottstein has taken the steps that he can to retrieve any copies of the Egilman documents he made available to others. Thank you for updating us on the responses of those he has contacted and directed to return documents to you. Before he left, I was able to confirm with Mr. Gottstein that no one on the list has informed him that they are refusing to return the Egilman documents.

I believe that addresses all pertinent matters, and I don't anticipate being in the office for the remainder of the afternoon. Happy holidays to all.

John McKay

Addresses.pdf

The following are the addresses Mr. Gottstein has for those persons listed in his December 21, 2006, certificate of compliance.

Alex Berenson
New York Times
3rd Floor
229 West 43rd Street
New York, NY 10036

Peter Breggin, MD
101 East State Street, PMB 112
Ithaca, New York 14850-5543

Judi Chamberlin
67 Magnolia St. (h)
Arlington, MA 02474

David Cohen
6039 Collins Ave.
Miami Beach, FL 33140

Will Hall
3 Edwards Square
Northampton MA 01060

Steve Shaw (s/b "Cha")
Committee on Government Reform
2032 Belmont Rd, NW, #605
Washington, DC 20009

Grace Jackson, MD
4021 Brookstone Dr
Winterville NC 28590

Stefan Kruszewski, MD
PMS 777 East Park Drive
Harrisburg, PA 17105

Singeha Prakash
2939 Northampton St
Washington, DC 20015

Vera Sherav
142 West End Ave
Suite 28P
New York, NY 10023

Robert Whitaker
19 Rockingham Street
Cambridge, MA 02139

Bruce Whittington
1044 Gatensbury Rd.
Port Moody, BC V3H 2P2
Canada

Jerry Winchester
406 G Street, Suite 205
Anchorage, Alaska 99501

Laura Ziegler
PO Box 722
Montpelier, Vt. 05601

To: "Peter Woodin" <pwoodin@jamsadr.com>
From: Jim Gottstein <jim.gottstein@psychrights.org>
Subject: Return of Zyprexa documents
Cc: "'Jim Gottstein'" <jim.gottstein@psychrights.org>, "'John McKay'" <mckay@alaska.net>, "'Fahey, Sean P.'" <Faheys@pepperlaw.com>, "'Brewster Jamieson'" <JamiesonB@LanePowell.com>, "'Richard D. Meadow'" <RDM@lanierlawfirm.com>, "'Evan Janush'" <EMJ@lanierlawfirm.com>, "'Bill Audet'" <waudet@alexanderlaw.com>, "'Andy Rogoff'" <rogoffa@pepperlaw.com>
Bcc:
Attached:

Dear Special Master Woodin,

To my horror, I discovered a DVD of the documents in my laptop this morning. I have sent it to you *via* Federal Express, although I was not surprisingly told by the front desk that it would not be picked up by Fed Ex until Tuesday.

D. JOHN McKAY
Attorney at Law
117 E. Cook Ave.
Anchorage, Alaska 99501

Telephone
(907) 274-3154

Fax
(907) 272-5646

January 13, 2007

By E-mail

Peter Woodin, Special Master
JAMS
280 Park Ave., 28th Floor
New York, New York 10017

Re: Zyprexa Prooducts Liability Litigation, MDL 1596 ("Federal Litigation")
Supplemental Response of James Gottstein

Dear Mr. Woodin,

The following is an update and supplement to James Gottstein's December 21, 2006, Compliance Certification ("Compliance Certification"). Mr. Gottstein has cut short his vacation with his family and has now returned to help ensure that these matters are addressed before further proceedings scheduled in this matter.

1. Mr. Gottstein's office received, in his absence, the DVD he had sent in December to Mr. Will Hall, returned to him by Mr. Hall pursuant to the court's order. This DVD is being delivered to you.

2. On December 26, 2006, I sent a transmittal letter to you, accompanying the DVD provided to you with the items burned from Mr. Gottstein's computer before they were erased, as described in ¶2, p. 2 of the Compliance Certification. It is not clear that a copy of this transmittal letter was copied to counsel. In case it was not, I am attaching a .pdf copy with the e-mail transmission of this letter to you.

3. As noted in our earlier filings, Mr. Gottstein made his best, good faith efforts to fully comply with the court's order, notwithstanding that he was in the middle of religious holidays and preparing to leave with his family on vacation, with an extended absence from his office. Since taking the steps described in the Compliance Certification, Mr. Gottstein has discovered one

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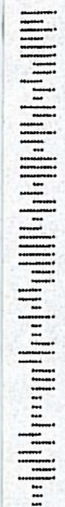
additional document from Dr. Egilman that should have been erased from his computer, and would have been erased with the rest in accordance with the procedure set forth in ¶2, p.2 had it been noticed at the time. The reason it was overlooked had to do with the fact that it was in an isolated e-mail as an attachment. Mr. Gottstein wishes to emphasize that this document was never distributed by him to anyone else, at all, in any medium. This document may or may not be among those already burned to DVDs and delivered to you. Erring on the side of caution, though, instead of simply deleting it, Mr. Gottstein has preserved this long enough that it could be burned to another DVD. Now that he is back and has been able to do this, he has deleted this final "Egilman Document" from his computer. The DVD containing this one document will be delivered to you.

Sincerely,

/s/djmckay/

D. John McKay
Attorney for James Gottstein

cc: Sean Fahey (via e-mail)
Evan Janush (via e-mail)
James Gottstein (via e-mail)



Office DEPOT Moisture Resistant Bubble

Size- CD / DVD

To: P. Rights

FROM:
Will Hall
3 edwards Square
Northampton MA 01060

RECEIVED
DEC 27 2006

Handle With Care

$1.42 US POSTAGE
MEDIA MAIL
OCT 22 2004
Mailed from ZIP 95050

071V00509433

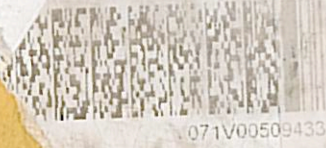
USP[illegible] MAIL

Old Orchard Bo[illegible]
1709 Grant St
Santa Clara, C[illegible]

SHIP TO:

FROM
WH
8 EDWARDS SQ.
NORTHAMPTON MA
01060

TO



PsychRights®
Law Project for
Psychiatric Rights
406 G Street, Suite 206
Anchorage, Alaska 99501

X-Mailer: QUALCOMM Windows Eudora Version 7.0.1.0
Date: Fri, 12 Jan 2007 07:49:00 -0900
To: Jim Gottstein <jim.gottstein@psychrights.org>
From: Heather Crouse <heather@gottsteinlaw.com>
Subject: Re: DVD from Will Hall

No I don't think so, I believe I opened it and there wasn't any transmittal so I left it in the envelope.
HHC

At 08:19 PM 1/11/2007, you wrote:

> Hi Heather,
>
> Had the envelope from WIll Hall with the DVD in it been opened when we received it?
>
> **Note New E-mail Address**
>
> James B. (Jim) Gottstein, Esq.
>
> Law Project for Psychiatric Rights
> 406 G Street, Suite 206
> Anchorage, Alaska 99501
> USA
> Phone: (907) 274-7686) Fax: (907) 274-9493
> jim.gottstein@psychrights.org
> http://psychrights.org/
>
> **Psych Rights ®**
> **Law Project for Psychiatric Rights**
>
> The Law Project for Psychiatric Rights is a public interest law firm devoted to the defense of people facing the horrors of unwarranted forced psychiatric drugging. We are further dedicated to exposing the truth about these drugs and the courts being misled into ordering people to be drugged and subjected to other brain and body damaging interventions against their will. Extensive information about this is available on our web site, http://psychrights.org/. Please donate generously. Our work is fueled with your IRS 501(c) tax deductible donations. Thank you for your ongoing help and support.

ZY20677053
– 058
maxell
DVD-R
4.7
16x
2Hrs
DVD