IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
THIRD JUDICIAL DISTRICT, AT ANCHORAGE

In The Matter of the Hospitalization	)	
	)	
of	)	
	)	
FAITH J. MYERS	)	
	)	Case No. 3AN 03-277 P/S
STATE OF CALIFORNIA	)	
	) ss	
SAN DIEGO COUNTY	)	

Affidavit of Loren R. Mosher, M.D.

Credentials:

I am born and raised in California, a board-certified psychiatrist who received an M.D., with honors, from Harvard Medical School in 1961, where I also subsequently took psychiatric training. I was Clinical Director of Mental Health Services for San Diego County from 7/96 to 11/98and remain a Clinical Professor of Psychiatry at the School of Medicine, University of California at San Diego. From 1988-96 I was Chief Medical Director of Montgomery County Maryland's Department of Addiction, Victim and Mental Health Services and a Clinical Professor of Psychiatry at the Uniformed Services University of the Health Sciences, F. Edward Herbert School of Medicine, Bethesda, Maryland.

From 1968-80 I was the first Chief of the NIMH's Center for Studies of Schizophrenia. While with the NIMH I founded and served as first Editor-in-Chief of the Schizophrenia Bulletin.

From 1970 to 1992 I served as collaborating investigator, then Research Director, of the Palo Alto based, NIMH funded Soteria Project – "Community Alternatives for the Treatment of Schizophrenia". In this role, I was instrumental in developing and researching an innovative, home-like, residential treatment facility for acutely psychotic persons. Continuing my interest in clinical research (1990 - 1996), I was the Principal Investigator of a Center for Mental Health Services (CMHS) research/demonstration grant for the first study to compare clinical outcomes and costs of long term seriously mentally ill public-sector clients randomly assigned (with no psychopathology based exclusion criteria) to a residential alternative to hospitalization or the psychiatric ward of a general hospital (the McPath project). This study's findings, comparable clinical effectiveness with a 40% cost saving favoring the alternative, have important acute care implications.

In 1980, while based at the University of Verona Medical School, I conducted an in-depth study of Italy's revolutionary new mental health system. I documented that the new National Health Service supported system of catchmented community care could stop admissions to large state hospitals, enabling them to be phased down and closed. It

was also concluded that where the legally mandated community system was properly implemented there were no adverse consequences for patients or the community.

In addition to over 120 articles and reviews, I have edited books on the Psychotherapy of Schizophrenia and on Milieu Treatment. Our book, Community Mental Health: Principles and Practice, written with my Italian colleague, Dr. Lorenzo Burti, was published by Norton in 1989. A revised, updated, abridged paperback version, Community Mental Health: A Practical Guide, appeared in 1994. It has been translated into five languages. Most recently I founded a consulting company, Soteria Associates, to provide individual, family and mental health system consultation using the breadth of experience described above.

INTRODUCTION:

In many parts of the country thinking about public mental health systems has moved away from the biomedical model, initially to a psychosocial rehabilitation orientation, and more recently to a recovery based model. Each change represents a move toward a more holistic view, increased self-management in treatment, greater emphasis on independent living and community integration and protection of rights of system users. As a whole it means much less hierarchical systems and greater equality of staff and users.

When considering mental health reform it must be recognized that mental health care is a system. Programs making up mental health systems share the following characteristics: They are labor intensive, relationship based and relatively low technology. The system's elements should include: Prompt, accessible, client centered, recovery oriented, quality mental health and rehabilitation services; decent affordable housing; and appropriate, ongoing self-help focused social supports. Because they address basic human needs systems that contain an array of these services have been shown to be both cost effective and voluntarily used. Such systems must be adequately funded but reform must also include attitude change and reorganization into less institutional, human sized programs.

Reform to produce co-ordinated community based systems of care needs guidelines: (1) a shared set of values and (2) common organizational (3) interpersonal and (4) clinical principles. These four elements of a systemic organizational framework can guide the committee's reform deliberations. Because they are non-specific, they are nearly universally applicable.

1. PROGRAM VALUES

- Do no harm
- Treat, and expect to be treated, with dignity and respect.
- Be flexible and responsive
- In general the "user" (client, patient) knows best. We each know more about ourselves than anyone else. This is usually a vast untapped reservoir of valuable information.
- Choice, the right to refuse, informed consent, and voluntarism are essential to program functioning. Without options, freedom of choice is illusory. Involuntary

treatment should be difficult to implement and used only in the direst of circumstances.

- Expression of strong feelings and development of potential are acceptable and expected – and are not usually signs of "illness".
- Whenever possible, legitimate needs (e.g. housing, social, financial etc.) should be filled. Without adequate housing, mental health "treatment" is mostly a waste of time and money.
- Risks are part of the territory; if you don't take chances nothing ever happens.

2. ADMINISTRATIVE PRINCIPLES

- Reliable funding stream
- Catchmented responsibility – no "shift and shaft" allowed
- Responsible, multi-disciplinary, multi-function, mobile teams
- Decentralized authority and responsibility to allow on the spot decision making
- Use of existing community resources
- Multi-purpose mental health/social services centers.
- Non-institutionalization: Residential care (i.e., hospitals and IMD's) is expensive and often creates or reinforces problems. They are, by definition, abnormal environments and should be used sparingly.
- Multi-dimensional outcomes must be monitored and fed back rapidly.
- Citizen/"user" participation is vital for program planning and oversight.

3. RELATIONAL PRINCIPLES

(All help facilitate the development of relationships)

- Positive Expectations
- Atheoretical need to understand – try to find an explanation for what is going on
- Continuity of relationships across contexts
- "Being with"., "standing by attentively" – getting oneself into the other's shoes to better understand "the problem"
- Concrete problem focus (problems, in contrast to diagnoses, generate questions and possible solutions)
- Relational "partnership", doing together (preserves "user" power)
- Expectation of self-help ("users" need not be so in perpetuity)

4. CLINICAL PRINCIPLES

- Contextualization– we all have histories that can only be understood by considering the contexts within which they developed.
- Preservation and enhancement of "user" personal power and control. Mental health professionals do not necessarily know what is best for their clients/patients – their role should be to keep them continually involved as the treatment process unfolds.

- Normalization (Usualization): Culturally sensitive societal norms should be applied when treatment plans are developed. The most "normal", least restrictive, alternative should always be tried first. If you treat people as normal they tend to behave normally.

We have a more than adequate knowledge base to implement reform. More studies and dust gathering reports are not needed. What is needed is the political will, community involvement and financial resources necessary to make change happen.

Loren R Mosher, MD

SUBSCRIBED AND SWORN TO before me this __5th__ day of March, 2003.

Notary Public in and for California
My commission expires: 11.4.04

OFFICIAL SEAL
JANE M. REILLY
NOTARY PUBLIC-CALIFORNIA
COMM. NO. 1279794
SAN DIEGO COUNTY
MY COMM. EXP. NOV. 4, 2004

State of Alaska)
)ss
Third Judicial District)

I, James B. Gottstein, hereby swear that this reproduction of Affidavit of Loren R. Mosher, M.D., to which this is appended, is a true, correct and complete photocopy of the original document, currently in my possession.

Dated: 10/27/2008

James B. Gottstein

SUBSCRIBED AND SWORN TO before me this 27th day of October, 2008.

STATE OF ALASKA
NOTARY PUBLIC
Lisa E. Smith
My Commission Expires April 23, 2011

Notary Public in and for Alaska
My Commission Expires: 4/23/2011