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IN THE SUPREME COURT FOR THE STATE OF ALASKA

ROSLYN WETHERHORN, Appellant, vs. ALASKA PSYCHIATRIC INSTITUTE Appellee.	)	Supreme Court No. S-11939

Trial Court Case No. 3AN 05-459 PR

SUPPLEMENTAL MEMORANDUM: Re APPLICATION FOR FULL REASONABLE FEES

By Order, dated May 22, 2007, this Court requested supplemental briefing regarding the effect of *State v. Native Village of Nunapitchuk*,[1] on the pending request for full, reasonable attorney's fees, including whether appellant's counsel should be required to apportion his fees, as well as an accounting of the portion of full fees that is attributable to the successful constitutional claims.

In addition to discussing whether *Nunapitchuk* applies to Appellate Rule 508(e), Ms. Wetherhorn asserts there are other, independent, constitutionally, based grounds for granting her motion for full reasonable attorneys fees, to wit: (1) her constitutional right

[1] 156 P.3d 389 (Alaska 2007)

to counsel on appeal, (2) this Court's supervisory authority over the administration of justice in its courts, and (3) not restricting her access to the courts.

I. The Impact of *Nunapitchuk* on The Pending Attorney Fee Request

Ch. 86 SLA 2003,[2] added subsections (b)-(e) to AS 09.60.010 with the stated purpose being to overrule this Court's "public interest" exception to the attorney's fee rule in Civil Rule 82. AS 09.60.010(b), added by Ch86/HB 145 provides:

> (b) Except as otherwise provided by statute, a court in this state may not discriminate in the award of attorney fees and costs to or against a party in a civil action or appeal based on the nature of the policy or interest advocated by the party, the number of persons affected by the outcome of the case, whether a governmental entity could be expected to bring or participate in the case, the extent of the party's economic incentive to bring the case, or any combination of these factors.

In *Nunapitchuk*, the question was whether this was a legislative enactment regarding practice or procedure, in which case a super majority was required for it to be valid under Article 4, §15 of the Alaska Constitution,[3] or whether it was an enactment of substantive law, which required a simple majority. This Court held:

> The purpose of section 2 of HB 145 is "to expressly overrule" the decisions of this court establishing the public interest litigant exception. We conclude that this purpose falls within the legislature's authority. HB 145 therefore is valid insofar as it abrogates the public interest litigant exception

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[2] Ch. 86 SLA 2003, was HB 145 in the Legislature and referred to as HB 145 in the *Nunapitchuk* decision. Here, it is being referred to as Ch86/HB145.

[3] Article 4, §15 of the Alaska Constitution provides:

> The supreme court shall make and promulgate rules governing the administration of all courts. It shall make and promulgate rules governing practice and procedure in civil and criminal cases in all courts. These rules may be changed by the legislature by two-thirds vote of the members elected to each house.

> developed by the decisions of this court.
>
> A potentially more difficult question is whether HB 145 could validly change provisions of Rule 82 either as written or as interpreted.[4]

In reaching this conclusion, this Court held that the public interest exception to Civil Rule 82 was a substantive policy-based nontextual exception to Civil Rule 82, rather than an interpretation of Civil Rule 82.[5]

A. Does *Nunapitchuk's* Holding Extend to Appellate Rule 508?[6]

That the State agreed Ch86/HB145 does not change Civil Rule 82 or Appellate Rule 508 was highly significant in this Court's conclusion that it validly abrogated the public interest exception to Civil Rule 82:

> On appeal the State takes the position that, although HB 145 changes the public interest litigant exception, it does not modify Rule 82. . . .
>
> The State makes the same point again in the paragraph that follows this statement: "HB 145 does not modify Rules 82 or 508, but rather a common law doctrine that limited where those rules would be applied." . . . Because it amounts to a binding concession made by a party litigant and is reasonable in light of the foregoing considerations, we accept the State's position that HB 145 should be interpreted as not modifying Rule 82.[7]

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[4] 156 P.3d at 404, footnote omitted.
[5] *See, e.g.*, 156 P.3d at 392.
[6] At n. 11 of *City of Kenai v. Friends of Recreation Ctr.*, 129 P.3d 452 (Alaska 2006), this Court indicated the legislative history "may inform the interpretation of the term 'appeal'" in Ch86/HB145, citing to testimony at the May 7, 2003, minutes of the House Judiciary Commmittee commenting on an April 21, 2003 letter from the Alaska Attorney General's office. This testimony and letter refer to HB 145 applying only to administrative appeals and lawsuits initiated in state court. However, HB 145 went through substantial change prior to enactment and it is difficult to see where the April 21, 2003, letter and May 7, 2003 testimony relate to the language of the bill, as enacted.
[7] 156 P.3d at 404-5.

It is apparent this binding concession by the State applies to Appellate Rule 508, as well as Civil Rule 82.

This raises the question of whether awards of full attorney's fees to public interest litigants under Appellate Rule 508(e), arises from the text of the rule itself, rather than a non-textual exception. Unlike Civil Rule 82, which is very explicit as to how the trial courts are to determine attorney's fees, Appellate Rule 508(e) is completely discretionary: "Attorney's fees may be allowed in an amount to be determined by the court". The discretionary nature of Appellate Rule 508, as distinct and different from the specific criteria in Civil Rule 82, has been confirmed by this Court in *Agen v. Alaska Child Support Enforcement Division*, 945 P.2d 1215, 1221 (Alaska 1997):

> The State concedes that its request for attorney's fees should have been made under Appellate Rule 508, rather than Civil Rule 82. However, the State argues that "since there are no specific guidelines in Appellate Rule 508, an analogy to, and use of, Civil Rule 82 is appropriate." . . .
>
> We reverse the award of attorney's fees. As a general matter, a superior court acting as an intermediate appellate court has broad discretion to award costs and attorney's fees pursuant to Appellate Rule 508. Indeed, we have held that the superior court need not articulate its reasons for awarding attorney's fees. Such broad discretion notwithstanding, . . . we [have] held that it is error for a superior court acting as an intermediate appellate court to award fees under Civil Rule 82, rather than under Appellate Rule 508. [W]e focused on the different directives in the fee award provisions: "[A]ttorney's fees need not be awarded as a matter of course under (Appellate Rule 29(d), now Appellate Rule 508(e)). This differs from Civil Rule 82, which requires that some portion of attorney's fees be awarded to the prevailing party...." In this case, the superior court based its award on Civil Rule 82. Since the superior court based its award on an incorrect rule, the case must be remanded to the superior court for recalculation in accordance with the correct rule.

(citations and footnotes omitted).

In *Nunapitchuk*, this court acknowledged that "Appellate Rule 508 provides full discretionary powers to determine whether an award of fees should be ordered on appeal."[8] Thus, the award of full attorney's fees to public interest litigants under Appellate Rule 508, may derive from the text of the rule itself, rather than being a substantive, policy based, nontextual exception. In such case, Ch. 86/HB 145 validly abrogates the public interest exception to Civil Rule 82, but does not validly change the provision of Appellate Rule 508 allowing full attorney's fees to public interest litigants.

In *Thomas v. Bailey*, 611 P.2d 536, 539 (Alaska 1980), though, this Court held the same considerations for affording public interest status are applicable under then Appellate Rule 29(d)[9] as at the trial level under Civil Rule 82. Nonetheless, even though the same considerations might apply under Civil Rule 82 and Appellate Rule 508, the broad discretion contained in the text of Appellate Rule 508 can result in such considerations being textually based under Appellate Rule 508 even though they are not textually based under Civil Rule 82.

In order to so find, the following limitation contained in *Nunapitchuk* pertaining to the discretion under Civil Rule 82(b)(3)(K) for *equitable factors* must not be applicable to the broad grant of discretion found in the text of Appellate Rule 508:

> Specifically, although we recognize that subsection (b)(3)(K) gives courts discretion to consider a broad range of *equitable* factors in awarding fees, we believe that courts must take care to avoid using this equitable power as

[8] 156 P.3d at 394.

[9] The relevant language of former Appellate Rule 29(d) and current Appellate Rule 508(e) are very similar.

> an indirect means of accomplishing what HB 145 has now disallowed-using awards of attorney's fees to encourage litigation of claims that can be characterized as involving the public interest.[10]

This Court's holding that the discretion contained in Civil Rule 82(b)(3)(K) to consider *equitable* factors should not be used to circumvent Ch. 86/HB 145, does not apply to Appellate Rule 508 if awards of full fees to prevailing public interest litigants under Appellate Rule 508 are based on the text of Appellate Rule 508 or interpretation thereof.

However one gets there, if the award of full attorney's fees to public interest litigants under Appellate Rule 508 derives from the text of the rule, then Art. 4, §15 of the Alaska Constitution required a 2/3rds majority for the legislature to change it, which did not occur.

B. <u>There Are Non-Public Interest Litigant Status Grounds for Awarding Full Attorney's Fees Here.</u>

Even if *Nunapitchuk* applies, in general, to Appellate Rule 508, awarding full attorney's fees on bases not prohibited by AS 09.60.010(b) is permitted. Moreover, to the extent the United States or Alaska constitutions mandate full attorney's fees awards, AS 09.60.010(b) must fall. Here, full attorney's fees are required to vindicate Ms. Wetherhorn's right to effective representation by counsel on appeal. In addition *Nunapitchuk*, itself, suggests at least two additional bases upon which such fees could, or should, be granted. One is the right of access to the courts.[11] The other is this Court's

[10] 156 P.3d at 405, emphasis added.
[11] 156 P.3d at 405.

authority over the administration of justice.[12] All of these derive from the Alaska Constitution and are related to each other.

(1) Right to Representation on Appeal

In the Decision on the merits in this case, this Court held AS 47.30 involuntary commitment and forced psychiatric drugging respondents have a right to effective counsel under the Alaska Constitution.

> Because, as we have already noted, a respondent's fundamental rights to liberty and to privacy are infringed upon by involuntary commitment and involuntary administration of psychotropic medication proceedings, the right to counsel in civil proceedings is guaranteed by the due process clause of the Alaska Constitution. As we noted in V.F. v. State, "whenever the right to counsel is constitutionally guaranteed in a particular proceeding, the effective assistance of counsel is also constitutionally required."[13]

This right to counsel is based on the fundamental rights to liberty and bodily integrity which is infringed when someone is locked up on the grounds the person is mentally ill and a danger to self or others, or gravely disabled, and forcibly drugged on the grounds it is in their best interests. In the merits decision in this case, this Court recognized that involuntary commitment is a "massive curtailment of liberty,"[14] citing to *Addington v. Texas.*[15]

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[12] 156 P.3d at 397, 398.
[13] *Wetherhorn v. Alaska Psychiatric Institute*, 156 P.3d 371, 383-4 (Alaska 2007), footnote omitted.
[14] 156 P.3d at 375.
[15] *Addington v. Texas*, 441 U.S. 418, 425, 99 S.Ct. 1804, 60 L.Ed.2d 323 (1979)

In *Myers v. Alaska Psychiatric Institute*[16], this Court held that the right to be free from unwanted psychiatric drugging was a fundamental constitutional right, describing the interests as follows:

> [T]he truly intrusive nature of psychotropic drugs may be best understood by appreciating that they are literally intended to alter the mind. Recognizing that purpose, many states have equated the intrusiveness of psychotropic medication with the intrusiveness of electroconvulsive therapy and psychosurgery.

In *Addington*, the question before the United States Supreme Court was what standard of proof is required by the Fourteenth Amendment to the U.S. Constitution in a civil proceeding brought under state law for involuntary commitment. There, the U.S. Supreme Court held the normal civil preponderance of the evidence standard insufficient, but the criminal beyond a reasonable doubt standard not constitutionally required. In reaching this conclusion the Court stated:

> We conclude that the individual's interest in the outcome of a civil commitment proceeding is of such weight and gravity that due process requires the state to justify confinement by proof more substantial than a mere preponderance of the evidence.[17]

In *Allen v. Illinois*, 478 US 364, 373, 106 S.Ct. 2988, 2994 (1986), the United States Supreme Court recognized that *Addington* required some but not the entire range of criminal procedural protections in involuntary commitment proceedings. This raises the question of which such protections are constitutionally required.

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[16] 138 P.3d 238, 242 (Alaska 2006)
[17] 441 US at 427, 99 S. Ct. at 1810.

The *Addington* court made clear the purpose is to minimize the risk of an erroneous deprivation of the liberty interest in being free of confinement under a civil commitment.[18] In declining to require the beyond a reasonable doubt standard, the Court opined that the "layers of professional review and observation of the patient's condition, and the concern of family and friends generally will provide continuous opportunities for an erroneous commitment to be corrected."[19]

The U.S. Supreme Court's reliance in *Addington* on hospital personnel and family members to correct erroneous commitments is not supported by any data to suggest it is in any way effective. In fact, just the opposite is true. The psychiatric profession explicitly acknowledges psychiatrists and patients' family members regularly lie to the courts in order to obtain involuntary commitment orders.

> 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.
>
> Families also exaggerate their family member's symptoms to get the person committed to a hospital. . . . In fact a number of local officials with the Alliance for the Mentally Ill (AMI),[20] a nationwide support group for families, say they privately counsel families to lie, if necessary, to get acutely ill relatives hospitalized.

Torrey, E. Fuller. 1997, *Out of the Shadows: Confronting America's Mental Illness Crisis*. New York: John Wiley and Sons, 152. Dr. Torrey also quotes Psychiatrist Paul

[18] 441 US at 425, 99 S.Ct at 1809.
[19] 441 US at 428-9, 99 S.Ct at 1811.

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." *Id*., at 151.

This corruption of the legal process has been aptly described by noted scholar Michael Perlin,[21] as follows:

> [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.

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

Ms. Wetherhorn suggests here, that rather than relying on

(i) the psychiatrists who obtain the involuntary commitment and forced drugging orders, or

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[20] This organization's name is now known as the National Alliance on Mental Illness, and commonly known as "NAMI."

(ii) family members who often want their family members committed even if they don't meet commitment criteria,

to correct erroneous determinations, adopting a rule allowing full reasonable attorney's fees on appeal is perhaps the only effective way "for an erroneous commitment [and forced drugging order] to be corrected." Certainly, the most direct way to correct an erroneous commitment is for it to be overturned on appeal.

Ms. Wetherhorn suggests here that state payment for representation in at least certain appeals is just such a requirement. In *Douglas v. California*, 372 US 353, 83 S.Ct. 814 (1963), the U.S. Supreme Court required the states to pay for representation in the first appeal of indigent criminal defendants. In doing so at n.2, citing to *Coppedge v. United States*, 369 U.S. 438, 449, 82 S.Ct. 917 (1962), the Court stated:

> When society acts to deprive one of its members of his life, liberty or property, it takes its most awesome steps. No general respect for, nor adherence to, the law as a whole can well be expected without judicial recognition of the paramount need for prompt, eminently fair and sober criminal law procedures. The methods we employ in the enforcement of our criminal law have aptly been called the measures by which the quality of our civilization may be judged.

The same must also be true for people subjected to being locked up and forcibly drugged "for their own good." In this regard, Justice Brandeis' observation in dissent in *Olmstead v. US*[22] almost 80 years ago, rings as true now as it did then:

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[21] *See, Martin v. Taft*, 222 F.Supp.2d 940, 965 (S.D. Ohio 2002), where the court referred to Prof. Perlin as such.
[22] 277 US 438, 479, 48 S.Ct. 564, 572-3 (1928).

> Experience should teach us to be most on our guard to protect liberty when the government's purposes are beneficent. Men born to freedom are naturally alert to repel invasion of their liberty by evil-minded rulers. The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding.

With respect to appeals of civil commitments, in *In re Richard A*, 771 A.2d 572, 576 (NH 2001), the New Hampshire Supreme Court held the right to counsel on appeal is governed by due process and recognized that "the private interests at stake in civil commitment proceedings . . . are substantial and parallel those at risk in the criminal context."

The extremely harmful effects of an erroneous involuntary commitment was acknowledged by this Court in *Wetherhorn*,[23] and described by the Montana Supreme Court in *Matter of KGF*:[24]

> Due to the potentially "socially debilitating" stigma that results from the "irrational fear of the mentally ill," the court posited that "[i]t is implausible that a person labeled by the state as so totally ill could go about, after his release, seeking employment, applying to schools, or meeting old acquaintances with his reputation fully intact." Thus, the "former mental patient is likely to be treated with distrust and even loathing; he may be socially ostracized and victimized by employment and educational discrimination ... the experience may cause him to lose self-confidence and self-esteem."

In both *Wetherhorn* and *Myers*, as set forth above, this Court recognized that forced psychiatric drugging can be equated with forced lobotomy ("psychosurgery") and

[23] 156 P.3d at 379.
[24] 29 P.3d 485, 495 (2001), citing to *Conservatorship of Roulet* 425, 590 P.2d 1 (1979).

electroshock ("electroconvulsive therapy").[25] The extreme negative consequences of forcing people to take psychiatric drugs they do not want is also illustrated by a recent study concluding that the use of neuroleptics[26] reduces the recovery rate from 40% to 5%.[27] In Anatomy of an Epidemic: Psychiatric Drugs and the Astonishing Rise of Mental Illness in America,[28] Robert Whitaker summarizes his exhaustive review of the scientific literature:

> Over the past 50 years, there has been an astonishing increase in severe mental illness in the United States . The percentage of Americans disabled by mental illness has increased fivefold since 1955, when Thorazine-remembered today as psychiatry's first "wonder" drug-was introduced into the market . . . . A review of the scientific literature reveals that it is our drug-based paradigm of care that is fueling this epidemic . The drugs increase the likelihood that a person will become chronically ill, and induce new and more severe psychiatric symptoms in a significant percentage of patients.

Thus, the stakes for the victims of erroneous court ordered forced psychiatric drugging are extremely high; Ms. Wetherhorn respectfully suggests even higher than for erroneous criminal convictions.

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[25] 156 P.3d at 382; and 138 P.3d at 242, respectively.
[26] This is the class of drugs which are almost universally the subject of forced drugging petitions under AS 47.30.839.
[27] M. Harrow and T. Jobe, Factors Involved in Outcome and Recovery in Schizophrenia Patients Not on Antipsychotic Medications: A 15-Year Multifollow-Up Study, *Journal of Nervous and Mental Disease*, Vol 195, May, 2007, No. 5: 407-414, a copy of which is attached hereto as Exhibit A for the Court's convenience.
[28] *Ethical Human Psychology and Psychiatry*, Volume 7, Number I: 23-35 Spring 2005, a copy of which has been attached hereto as Exhibit B for the Court's convenience.

In *Douglas*, in which the United States Supreme Court required the states to provide representation to criminal appellants in their first appeal of rights under the United States Supreme Court it stated:

> The present case, where counsel was denied petitioners on appeal, shows that the discrimination is not between 'possibly good and obviously bad cases,' but between cases where the rich man can require the court to listen to argument of counsel before deciding on the merits, but a poor man cannot. There is lacking that equality demanded by the Fourteenth Amendment where the rich man, who appeals as of right, enjoys the benefit of counsel's examination into the record, research of the law, and marshalling of arguments on his behalf, while the indigent, already burdened by a preliminary determination that his case is without merit, is forced to shift for himself. The indigent, where the record is unclear or the errors are hidden, has only the right to a meaningless ritual, while the rich man has a meaningful appeal.[29]

In *Nichols v. State*,[30] this Court discussed *Douglas* and held these same considerations required the provision of counsel beyond what the US Supreme Court had required:

> Although the United States Supreme Court has not held that constitutional standards require the appointment of counsel for an indigent prisoner at a hearing of his motion to vacate sentence, we believe that that Court's concern for the constitutional rights of indigent defendants, as exemplified by the cases we have discussed, points the way to that result. We say this because of the fact that the type of hearing a criminal defendant is afforded under Criminal Rule 35(b) depends to a large extent upon whether he can pay for the assistance of counsel. If he can, the trial court passes upon the merits of the motion to vacate only after having the full benefit of a trained lawyer's examination into the record, his research of law, his examination and cross-examination of witnesses, including the defendant, and his marshalling of arguments on the defendant's behalf. If the defendant cannot afford to hire counsel, then he must shift for himself,

[29] 372 US at 358, 83 S.Ct. at 817.
[30] 425 P.2d 247, 254 (Alaska 1967), footnote citation to *Douglas* omitted.

> and because of his lack of knowledge and skill in the law is placed at a distinct disadvantage which may well result in his not being given a complete and meaningful hearing. Any real chance the defendant may have had of showing that his motion had hidden merit is effectively denied him because he must go without a champion in the proceedings. We believe that such a situation draws an unconstitutional line between the rich and the poor, and that when an indigent is forced to handle his own Rule 35(b) motion, the right to a hearing which is granted him does not comport with fair procedure.
>
> We hold that in such circumstances, an indigent defendant who is not afforded counsel to represent him, is denied 'equal rights, opportunities and protection under the law', to which he is entitled under article I, section 1 of the state constitution.

In *Grinols v. State*, 74 P.3d 889 (Alaska 2003), this Court confirmed that this right to the provision of counsel to indigents was constitutionally based; that the right to such counsel on appeal of the denial of a first petition for post conviction relief was also required under the Alaska Constitution; and extended it to the right to the provision of counsel to indigents challenging the effectiveness of representation during the first post conviction relief proceeding in a second petition for post conviction relief.

Ms. Wetherhorn respectfully suggests these cases hold that where the deprivation of liberty involves confinement, such as here, the right to provision of counsel attaches to proceedings of right to challenge the erroneous deprivation of the person's right to be free of confinement. Ms. Wetherhorn suggests that the deprivation of liberty involved in forced psychiatric drugging requires the same level of protection.

Appellate Rule 508(e) provides, "Attorney's fees may be allowed in an amount to be determined by the court." This certainly allows the grant of fees upon the basis suggested here and does not run afoul of Ch86/HB145 in any way. Such an award should

be based on Ms. Wetherhorn's right to representation on appeal, rather than her status as prevailing party.[31] It is respectfully suggested Alaska's Constitution so requires. Such an award does not involve either prevailing party or public interest status and Ch86/HB145 does not come into play.

(2) Administration of Justice

In *Nunapitchuk*, citing to *Leege v.Martin*, 379 P.2d 447, 450 (Alaska 1963), this Court reiterated that "The administration of justice is the day to day business of the courts" (rather than the Legislature).[32] In *Grinols*, *supra*., citing to Justice Rabinowitz's concurrence in *Nichols v. State*,[33] this Court held that this Court's *supervisory powers of the criminal justice system* require appointment of counsel to all indigent defendants in a hearing to set aside or vacate a sentence:

> First, the supervisory powers of this court over the criminal justice system require appointment of counsel to all indigent defendants in a hearing to set aside or vacate a sentence, thereby "giv[ing] recognition to the paramount importance of insuring the integrity and accuracy of [this court's] fact-finding processes." Alternatively, Justice Rabinowitz stated that denying appointment of counsel in this case was "fundamentally unfair and violative of the due process clause of article [I], section 7 of the Alaska Constitution."

AS 47.30 involuntary commitment and forced drugging respondents are not only subject to confinement like convicted criminals, they are also subjected to the additional extreme deprivation of liberty of being forcibly administered dangerous, mind-altering

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[31] Ms. Wetherhorn is indigent as recognized by this Court in granting her motions to appeal at public expense and to waive cost bond.
[32] 156 P.3d at 397.

drugs against their will.[34] Surely this Court's supervisory powers over its court system similarly extends to the administration of justice in *civil commitment and forced drugging* proceedings as much as it does to criminal proceedings.[35] This must just as surely be within the scope of Appellate Rule 508(e).

It appears the Alaska Public Defender Agency has never filed a single appeal of any involuntary commitment or medication order in the entire history of the State of Alaska. The only such appeals that have ever been filed have been by the Law Project for Psychiatric Rights (PsychRights®) after its formation in late 2002 to mount a strategic litigation campaign against unwarranted forced psychiatric drugging and electroshock around the country.[36]

The failure of the Alaska Public Defender Agency to file any appeals has led to a number of evils.[37] First, there can be no doubt that many people have been involuntarily committed and forcibly drugged in violation of their rights. Second, until PsychRights filed the appeal on behalf of Faith Myers in early 2003, there had been absolutely no appellate supervision of the Superior Court determinations, which have been delegated

(Cont.----------)
[33] 425 P.2d 247 (Alaska 1967).
[34] *See*, *Myers* and *Wetherhorn* and §I.B.(1), *supra*.
[35] The short shrift that the Superior Court and the Public Defender Agency give to the rights of AS 47.30 respondents to be free of involuntary commitment and forced psychiatric drugging is a significant contributor to the population of people who do not recover after being diagnosed with serious mental illness as described in *Factors Involved in Outcome and Recovery* and *Anatomy of an Epidemic*, Exhibits A & B, respectively.
[36] Forced electroshock is not allowed in Alaska, but is common in a number of other states.

to the Probate Masters in Anchorage for summary disposition. Third, these proceedings have become a travesty of justice, exemplifying the evil described by Professor Perlin in §I.B.(1), above.

The failure of procedural protections to be utilized has been a sufficient ground for the United States Supreme Court and other courts to find systemic problems. For example, in *Fuentes v. Shevin*[38] the United States Supreme Court cited to the fact that in none of the 442 cases of prejudgment replevin, did the defendant take advantage of the recovery provision in holding Florida's replevin procedures unconstitutional. In *Streicher v. Prescot,t*[39] involving the same type of interest as here, the United States District Court for the District of Columbia cited the fact that no patients had ever received any form of judicial review since they had been involuntary committed under constitutionally defective proceedings, in deciding to order judicial review for all such patients.

This Court should correct the pervasive failure of its court system to honor AS 47.30 involuntary commitment and forced drugging respondents' rights. Appellate Rule 508(e) allows complete discretion with respect to awarding attorney's fees on appeal, providing: "Attorney's fees may be allowed in an amount to be determined by the court." Full fees should be awarded here under Appellate Rule 508, or under this Court's inherent authority over the administration of justice (or both). In such case, neither prevailing

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[37] It may be that the Public Defender Agency believes it has no authority to file any such appeals, which increases the importance of granting full fees.
[38] 407 U.S. 67, 84, n.14, 92. S.Ct. 1983, 1996 (US 1971).
[39] 663 F.Supp. 335, 336 (D.D.C. 1987).

party or public interest status forms the basis of the award and Ch86/HB145 does not come into play.

(3) Infringing Access to the Courts

A closely related issue is that Appellate Rule 508 should be interpreted in a way that does not infringe upon AS 47.30 respondents' access to this Court. This Court has held that access to the courts is an important right deserving of close scrutiny.[40] Normally, the concept of not infringing access to the courts is invoked to limit, or prohibit attorney's fee awards *against* a party, but as can be seen from the previous section, here, it is necessary to award full fees to ensure access to this Court to vindicate AS 47.30 involuntary commitment and medication respondents constitutional appeal rights.

II. Apportionment

A. <u>Should Apportionment Be Required</u>?

In its Order, this Court asked whether Appellant's counsel should be required to apportion his fees . . . attributable to the successful constitutional claims." The relevant portions of AS 09.60.010 (c) & (d), which were added by Ch. 86/HB 145 are:

> (c) In a civil action or appeal concerning the establishment, protection, or enforcement of a right under the United States Constitution or the Constitution of the State of Alaska, the court
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> (1) shall award, subject to (d) and (e) of this section, full reasonable attorney fees and costs to a claimant, who, as plaintiff, counterclaimant,

[40] *Patrick v. Lynden Transp., Inc.*, 765 P.2d 1375, 1379 (Alaska 1988), cited a n. 76 of *Nunapitchuk.*

> cross claimant, or third-party plaintiff in the action or on appeal, has prevailed in asserting the right; . . .
>
> (d) In calculating an award of attorney fees and costs under (c)(1) of this section,
>
> (1) the court shall include in the award only that portion of the services of claimant's attorney fees and associated costs that were devoted to claims concerning rights under the United States Constitution or the Constitution of the State of Alaska upon which the claimant ultimately prevailed; and . . .

In her original motion, Ms. Wetherhorn addressed the issue of apportionment under AS 09.60.010, by citing to *Danserau v. Ulmer*, 955 P.2d 916, 920 (Alaska 1998), where this Court held that "attorney's fees for prevailing public interest litigants . . . may be apportioned only in exceptional circumstances." However, §1(b) of Ch86/HB145 expressly states it is the intent of the Legislature to overrule *Danserau*, among other decisions of this Court, so the question is whether or not it has constitutionally done so and if so, what the effect is on the pending fee motion.

It should be emphasized that apportionment is not required for an award of full attorney's fees not based on the prohibited AS 09.60.010(b) factors identified in §1.B above. More than that, because these are rooted in AS 47.30 involuntary commitment and forced drugging respondents' constitutional right to counsel on appeal, this court's supervisory power of its court system and their constitutional right to access to the courts, apportionment is not appropriate.

In determining whether AS 09.60.010(d)(1)'s direction that the court may award only that portion of attorney fees devoted to constitutional claims upon which the

claimant ultimately prevailed, it seems to Ms. Wetherhorn the key question is whether the apportionment "creates, defines and regulates rights" or is a "method of enforcing the rights."[41] If the former, it is in the province of the Legislature; if the latter, this Court's. Ms. Wetherhorn suggests it is the latter; the Legislature created, defined and regulated the right to full attorney's fees to prevailing constitutional claimants, but whether the fees should be apportioned by issue is a method of enforcing the right.

B. Portion of Full Fees Attributable to the Successful Constitutional Claims.

In its Order, this Court also asked for an accounting of the portion of full fees attributable to the successful constitutional claims. The successful constitutional claim is that involuntarily committing someone as "gravely disabled" under the definition contained in AS 47.30.915(7)(B) is constitutional only if construed to require a level of incapacity so substantial that the alleged mentally ill person could not survive safely in freedom (Gravely Disabled Issue). Frankly, the most important issue in the appeal to PsychRights was establishing standards for the effective assistance of counsel, which this Court declined to rule upon. The arguments pertaining to the Gravely Disabled Issue had been raised at the trial court in a number of cases, including *Myers*, but was not the basis for an appeal by PsychRights before this one. The result of this is the argument before this Court had been fairly well developed prior to taking this appeal. Thus, the largest amount of time on the issue was in working on the Reply Brief in developing the

[41] *Nunapitchuk*, 156 P.3d at 397.

responses to the State's arguments against it. Out of the almost $40,000 in attorney's fees requested, counsel estimates that one eighth or $5,000 is attributable to the Gravely Disabled Issue if one counts only the work done during this appeal. If one counts the work done prior to filing the notice of appeal here, it is probably one quarter or $10,000.[42]

III. Conclusion

For the foregoing reasons, Appellant respectfully requests the Court to grant her motion for full, reasonable attorney's fees.

Dated this 8th day of June, 2007, at Anchorage, Alaska.

LAW PROJECT FOR PSYCHIATRIC RIGHTS

By: _____
James B. Gottstein, Esq.
Alaska Bar No. 7811100

[42] In both *Cook Inlet Pipeline v. APUC*, 836 P.2d 343, 354 (Alaska 1992); and *Aloha Lumber Corp. v. Univ. of Alaska*, 994 P.2d 991, 1003 (Alaska 1999), this Court allowed an award of fees occurring before or outside of the specific appeal if closely related and necessary to the appeal. The Law Project for Psychiatric Rights' mission is to mount a strategic litigation campaign against unwarranted forced psychiatric drugging. Pursuing appeals is the primary legal mechanism for achieving this mission. As mentioned, the argument on the Gravely Disabled Issue was presented to the trial court in *Myers*, however, for strategic reasons, it was not appealed in *Myers*. In the end, however, this work became the core successful constitutional argument here. In this sense it was closely related to this appeal.

Factors Involved in Outcome and Recovery in Schizophrenia Patients Not on Antipsychotic Medications: A 15-Year Multifollow-Up Study

Martin Harrow, PhD, and Thomas H. Jobe, MD

Abstract: This prospective longitudinal 15-year multifollow-up research studied whether unmedicated patients with schizophrenia can function as well as schizophrenia patients on antipsychotic medications. If so, can differences in premorbid characteristics and personality factors account for this? One hundred and forty-five patients, including 64 with schizophrenia, were evaluated on premorbid variables, assessed prospectively at index hospitalization, and then followed up 5 times over 15 years. At each follow-up, patients were compared on symptoms and global outcome. A larger percent of schizophrenia patients not on antipsychotics showed periods of recovery and better global functioning ($p < .001$). The longitudinal data identify a subgroup of schizophrenia patients who do not immediately relapse while off antipsychotics and experience intervals of recovery. Their more favorable outcome is associated with internal characteristics of the patients, including better premorbid developmental achievements, favorable personality and attitudinal approaches, less vulnerability, greater resilience, and favorable prognostic factors. The current longitudinal data suggest not all schizophrenia patients need to use antipsychotic medications continuously throughout their lives.

Key Words: Antipsychotic medications, schizophrenia, outcome, recovery and psychosis, longitudinal 15-year follow-ups, unmedicated patients, prognostic factors.

(*J Nerv Ment Dis* 2007;195: 406–414)

The current longitudinal research studies (a) potential differences in functioning, assessed over a multiyear period between patients with schizophrenia who are not on antipsychotic medications versus those on antipsychotics, and (b) if schizophrenia patients not on medications are functioning adequately, which types function adequately without antipsychotics, and what factors influence their adequate functioning? Many investigators have emphasized the importance of determining which types of schizophrenia patients can function adequately when off antipsychotics for a prolonged multiyear period (Bola and Mosher, 2002; Bola et al., 2006; Fenton and McGlashan, 1987; Gilbert et al., 1995; Harrow et al., 2005b). The importance of determining characteristics which might allow some to go off antipsychotics with partly successful outcomes has been increased by research suggesting the potential side effects of long-term treatment with antipsychotics and data suggesting some similarity of the treatment response to both first and second generation antipsychotics (Hunter et al., 2003; Lewis et al., 2006; Lieberman et al., 2005; McEvoy et al., 2006; Stroup et al., 2006; Wahlbeck et al., 1999).

Multiple carefully controlled efficacy studies and other effectiveness studies of both first- and second-generation antipsychotic medications have assessed the value of antipsychotics (Davis et al., 2003; Gilbert et al., 1995; Hogarty et al., 1974; Janicak et al., 2001; Kane et al., 1982; Lieberman et al., 2005; Moncrieff, 2003; Schooler et al., 1980) On balance, the majority of these studies are positive for antipsychotics, although potential side effects for first-generation antipsychotics (tardive dyskinesia, apathy/sluggishness, depression, etc.) and second-generation antipsychotics (weight gain, diabetes) can present problems (American Diabetes Association, 2004; Carpenter, 1997; Haddad, 2004; Harrow et al., 1994; Lieberman et al., 2005; Marder et al., 1991; Seeman and Tallerico, 1999). To counter these problems, some major investigators have explored alternate approaches to facilitate treatment effectiveness, including withdrawing, tapering, or targeting the use of antipsychotics (Baldessarini and Viguera, 1995; Bola, 2006; Bola and Mosher, 2002; Carpenter, 1986; Herz et al., 2000; Marder et al., 1991). Associated with studies in this area, the issue of the relative safety of periods off medication have been addressed by Carpenter et al., (1997) and in an important article by Bola (2006) followed by commentaries. A problem which arises is that many positive studies on antipsychotics are based on an important population of patients, those involved in clinic treatment and clinic settings. However, after acute hospital treatment, when these patients leave the hospital, not all patients originally treated with antipsychotic medications continue on these medications (Lieberman et al., 2005). Studies of Fenton and McGlashan (1987) and previous studies of ours and others (Bola and Mosher, 2002; Carone et al., 1991; Harrow et al., 2005a; Harrow et al., 1997) suggest that

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Supported, in part, by USPHS Grants MH-26341 and MH-068688 from the National Institute of Mental Health, USA (Dr. Harrow).
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ISSN: 0022-3018/07/19505-0406
DOI: 10.1097/01.nmd.0000253783.32338.6e

when investigated on a longitudinal basis, over many years, within a naturalistic design, a number of schizophrenia patients not on medications may show adequate functioning or even recovery for a period of time. The following questions were addressed:

1. In a naturalistic research design, which includes patients in treatment and those not in treatment, can schizophrenia patients not on antipsychotics function better and show periods of recovery?
2. Which particular types of schizophrenia patients go off medications for a prolonged period, and do factors associated with this influence subsequent outcome and recovery?
3. Do schizophrenia patients who do not remain on medications differ in (a) premorbid developmental achievements and (b) prognostic potential or in personality and attitudinal factors?

METHOD

Patient Sample

The present investigation is derived from the Chicago follow-up study, a prospective multifollow-up research program studying course, outcome, psychosis, and potential recovery in schizophrenia and bipolar disorders longitudinally (Carone et al., 1991; Goldberg and Harrow, 2001; Goldberg et al., 1995; Harrow et al., 1997, 2000, 2005a; Jobe and Harrow, 2005). The sample of 145 DSM-III diagnosed patients included 64 schizophrenia patients and a control sample of 81 nonschizophrenia patients who were psychotic at index hospitalization. All of these DSM III schizophrenia patients met the 6 months duration of illness criteria (none were schizophreniform patients) and none were schizoaffective patients. The 81 nonschizophrenia patients who were psychotic at index included 31 bipolar manic patients, 28 psychotic unipolar depressives, 6 psychotic bipolar depressives, 5 paranoid disorders, and 11 patients with other psychotic disorders.

An initially young sample of patients from 2 Chicago area hospitals (a private hospital and a state hospital) was prospectively assessed at index hospitalization and then reassessed in 5 successive follow-up interviews over a 15-year period at a mean of 2-years, 4.5-years, 7.5-years, 10-years, and 15-years posthospital discharge. All 145 patients were studied at index hospitalization and at the 15-year follow-ups. One hundred ten of the 145 patients (75.9%) were studied at all 5 follow-ups over the 15 years, and another 23 patients (15.9%) were studied at 4 of the 5 follow-ups.

Diagnoses were based on at least one of 2 structured research interviews conducted at index hospitalization that have been used successfully in previous research: (1) the schedule for affective disorders and schizophrenia (SADS) and (2) the schizophrenic state inventory, with each interview tape recorded (Grinker and Harrow, 1987). Inter-rater reliability for diagnosis was obtained (Kappa for schizophrenia was $\hat{e} = 0.88$).

Informed written consent was obtained at index hospitalization and at each follow-up. The inpatients were given a series of structured interviews and questionnaires at index hospitalization. Trained interviewers who were not informed of diagnosis or results of previous follow-ups conducted later follow-ups.

At index hospitalization, the patients were consecutive admissions within the limitation of giving preference to younger (between 17- and 32-year-old at index) patients with fewer previous hospitalizations. The mean age of the sample at index hospitalization was 22.9 years. The mean education level at index was 13.01 years. Fifty-six percent of the sample was male and 44% were female. There were no significant differences between diagnostic groups in age. There were significant sex differences between the diagnostic groups. A larger percent of the schizophrenia patients was male (67%), and a larger percent of patients with other types of psychotic disorders was female (53%). The sex ratio difference is typical of those found in early young psychotic patients who have been hospitalized and is consonant with recent evidence suggesting a larger percent of patients with schizophrenia is male (McGrath, 2005). Over the 15 years, outcome data on posthospital status were obtained on slightly over 77% of the original sample. Forty-six percent of the sample was first admission patients at index, and another 21% had only one previous hospitalization.

Follow-Up Assessments

To assess global functioning and adjustment during the follow-up assessments, we used the Levenstein-Klein-Pollack (LKP) scale (Grinker and Harrow, 1987) and structured interviews (the SADS and a functioning interview) (Carone et al., 1991) approved by an IRB, to evaluate psychosis (delusions and/or hallucinations) during the follow-up year (Harrow et al., 2004; Harrow et al., 1995); other major symptoms (negative symptoms, anxiety, and affective symptoms), instrumental work performance and self-support, social functioning, family functioning, rehospitalization, and treatment.

The LKP, our major index of global functioning at each follow-up year, has been used successfully by our research team and others (Carone et al., 1991; Grinker and Harrow, 1987; Harrow et al., 2000). The 8-point LKP scale takes into account work and social functioning, life adjustment, level of self-support, major symptoms, relapses, and rehospitalization. In a recent assessment of inter-rater reliability, we obtained an intraclass correlation of 0.92. Ratings for global assessment in the year before follow-up on the 8-point LKP scale range from "1" (adequate functioning and recovery during the follow-up year) to "8" (very poor psychosocial functioning, considerable symptoms, and lengthy rehospitalization). We obtained a correlation of $r = 0.85$ ($p < .0001$) between the 8-point LKP scale and scores on the global assessment scale (Endicott et al., 1976), which is almost identical to the global assessment functioning scale (American Psychiatric Association, 2000).

Operational Definition of Recovery

Recovery was defined by outcome status during the entire follow-up year. Meeting the operational criteria for a period of recovery requires both (1) the absence of major symptoms throughout the follow-up year (absence of psycho-

sis and negative symptoms) and (2) adequate psychosocial functioning (e.g., instrumental work half-time or more and acceptable social functioning during the follow-up year) (Harrow et al., 2005a). The criteria are met by a score of "1" or "2" on the 8-point LKP scale. Recovery at any given follow-up does not automatically prejudge whether recovery will continue during future years, which may be a function of (a) the natural course of schizophrenia, (b) individual characteristics of the patient assessed, and (c) treatment.

Locus of Control and Self-Esteem

To assess attitudinal and personality characteristics that may relate to medication status, a scale to assess locus of control (LOC) (a concept and measure originally advanced by Rotter) (1966), and another to assess self-esteem were administered at the 4.5-year follow-ups. LOC refers to the extent to which an individual perceives events in his or her life as being a consequence of his or her actions. One may believe that events in peoples' lives result from their own efforts, skills, and internal dispositions (internal control) or that they stem from external forces such as luck, chance, fate, or powerful others (external control). The scale to assess self-esteem was a 7-item inventory derived from a widely used scale (Rosenberg, 1965). It included items such as "I feel I do not have much to be proud of" and "I take a positive attitude towards myself."

Early Prognostic Potential and Developmental Achievements

To assess earlier prognostic and developmental achievements, we analyzed data from 2 widely used measures collected prospectively, years earlier, at index hospitalization. One, the Zigler-Phillips scale, an index of earlier developmental achievements, is based on patients' work history, education, marital status, age at first break, and IQ (Zigler and Glick, 2001). The Zigler-Phillips scale has been linked to developmental formulations and theories concerning premorbid competence. It has been used in studies applying developmental theory to adult psychopathology and outcome, to self image, and to mental retardation (Glick and Zigler, 1985; Katz and Zigler, 1967; Westermeyer and Harrow, 1986; Zigler and Glick, 2001; Zigler and Levine, 1983; Zigler and Phillips, 1961). Scoring is reliable (Glick et al., 1985) and the many studies using the scale provide support for it's construct validity (Zigler and Glick, 2001). The other is a composite index of prognostic potential derived from factors outlined in the research of Vaillant (1978), of Stephens (1978), Stephens et al., (1997), and others (Westermeyer and Harrow, 1984). The poor prognostic factors assessed prospectively at index hospitalization included no acute onset, no precipitating stress at index, poor work and social adjustment before index, no preoccupation with death, the absence of depressive symptoms, no confusion, no guilt, being unmarried, and blunted affect.

Medications

Table 1 reports the data on the percent of patients with schizophrenia on medications at each of the 5 follow-ups over 15 years. As frequently found in the natural course of a large series of schizophrenia patients, there was no single, uniform treatment plan which applied to all patients. Rather, at the 15-year follow-ups, 69% of the patients with schizophrenia were on psychiatric medications; this included 61% on antipsychotic medications with or without other medications. Eighty percent of the schizophrenia patients on antipsychotics at the 15-year follow-ups had been on an antipsychotic at the 2-year follow-up, and another 7% had been on other medications, but not antipsychotics. Of the schizophrenia patients not on any medications at the 15-year follow-up, 29% were on antipsychotics at the 2-year follow-ups and another 7% were on other medications, but not antipsychotics. Because the 15-year follow-ups were conducted during the early years of FDA approval of second-generation antipsychotics, 33 of the 39 schizophrenia patients on antipsychotics at the 15-year follow-ups (85%) were still on first generation antipsychotics. At the 15-year follow-ups, 33% of the patients with other types of psychotic disorders also were on antipsychotics with or without other medications, and an additional 20% were on other psychiatric medications, but not on antipsychotics.

RESULTS

Table 2 reports the results on global adjustment and functioning and compares (a) patients with schizophrenia who were on antipsychotic medications with those not on any medications and (b) patients with other types of psychotic disorders on any medications with those not on medications at each of the 5 assessments over 15 years.

Figure 1 presents data on the percent of schizophrenia patients with psychotic activity, comparing patients on antipsychotic medications with those not on any medications at both the 10- and 15-year follow-ups.

TABLE 1. Percent of Schizophrenia Patients on Antipsychotic Medications and Percent Not in Treatment

	Antipsychotics (%)	Other Psychiatric Medications (No Antipsychotics) (%)	In Treatment (No Medications) (%)	No Mental Health Treatment (%)
2 Year FU	64	6	11	19
4.5 Year FU	63	12	5	19
7.5 Year FU	59	16	2	24
10 Year FU	59	16	3	22
15 Year FU	61	8	6	25

TABLE 2. Global Adjustment Over 15 Years for Medicated and Nonmedicated Schizophrenia and Other Psychotic Patients

	Global Adjustment*			
	Schizophrenia Patients		Other Psychotic Patients	
	On Antipsychotic Medications, *M* (*SD*)	Not On Any Psychiatric Medications, *M* (*SD*)	On Psychiatric Medications, *M* (*SD*)	Not on any Psychiatric Medications, *M* (*SD*)
2 Year FU	6.17 (2.05)	5.36 (2.56)	5.70 (1.90)	4.00 (2.28)*
4.5 Year FU	6.39 (1.78)	3.43 (2.53)**	5.12 (2.07)	2.64 (1.44)**
7.5 Year FU	5.94 (2.04)	3.47 (1.96)**	5.04 (2.16)	2.84 (1.98)**
10 Year FU	6.62 (1.52)	3.00 (2.45)**	5.31 (1.98)	2.84 (1.91)**
15 Year FU	5.67 (1.94)	3.55 (2.24)**	4.88 (1.99)	2.08 (1.34)**

*Global functioning and adjustment scale (1–8). Low scores represent good functioning.
*$p < .01$, **$p < .001$.

Although the focus of this report is on the 15-year follow-ups, there were large, significant differences in global functioning between patients on medications and patients not on medications at 4 of the 5 follow-ups ($p < .001$) (Table 2). Patients with schizophrenia who had removed themselves or been removed from antipsychotic medications showed significantly better global functioning and outcome than those still being treated with antipsychotics.

Detailed analyses of those patients with schizophrenia on antipsychotic medications versus those not on medications at the 15-year follow-ups also were conducted. These analyses indicated that in addition to the significant differences in global functioning between these groups, 19 of the 23 schizophrenia patients (83%) with uniformly poor outcome at the 15-year follow-ups were on antipsychotic medications.

The data on psychosis in Figure 1 show that at the 10-year follow-ups, 79% of the patients with schizophrenia on antipsychotics had psychotic activity, whereas 23% of those not on any medications had psychotic activity ($\chi^2 = 12.04$, 1 *df*, $p = .001$). Sixty-four percent of the schizophrenia patients treated with antipsychotic medications at the 15-year follow-ups had psychotic activity, whereas 28% of those not on any medications had signs of psychotic activity ($\chi^2 = 6.27$, 1 *df*, $p < .01$).

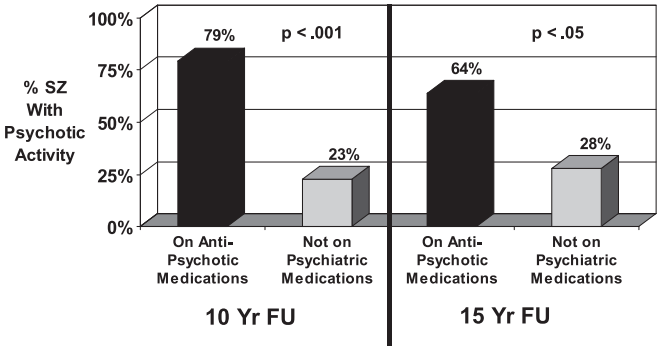

FIGURE 1. Psychosis at 10-year and 15-year follow-ups in medicated and unmedicated schizophrenia patients.

Medication Status of Schizophrenia Patients in a Period of Recovery

Only a minority of patients with schizophrenia were in a period of recovery at the 15-year follow-ups. However, the data show the majority of these schizophrenia patients in recovery were not on antipsychotic medications. Thus, at the 15-year follow-up, 12 of the 64 schizophrenia patients (19%) were in a period of recovery. This includes 8 of the 20 schizophrenia patients (40%) not on any psychiatric medications. It includes significantly fewer (2 of the 39) patients with schizophrenia (5%) on antipsychotic medications ($\chi^2 = 11.42$, 1 *df*, $p < .001$). Two of the other 5 schizophrenia patients on other medications but not on antipsychotics also were in recovery at the 15-year period.

Medication Status and Outcome of Patients With Other Types of Psychotic Disorders

The results for the nonschizophrenia patients who had psychotic disorders at index hospitalization also showed very large significant differences; patients with other types of psychotic disorders not on any medications at the 15-year follow-ups showed better outcome than those on medications ($t = 6.00$, 77 *df*, $p < .0001$). Some of the differences could be because of the patients with major symptoms being more likely to be placed on antipsychotic medications, and as a result, in naturalistic samples, patients on these medications are more likely to be more symptomatic and functioning poorly.

Long-Term Characteristics of Unmedicated Patients

We analyzed data providing clues on whether the better functioning of the subgroup of unmedicated patients with schizophrenia versus those on antipsychotics at the 15-year follow-up was a function of their current medication status. An alternative is that other long-term characteristics marked them off as different types of patients. For this analysis, we compared the 2 groups on earlier prognostic and premorbid factors, earlier attitudinal and personality features, and previous periods of recovery.

Figure 2 reports the data on earlier periods of recovery for these 2 groups of schizophrenia patients at each of the previous 4 follow-ups. Those who were unmedicated at the 15-year follow-ups had previously experienced (5, 7.5, and 10.5 years earlier) significantly more periods of recovery ($p < .001$) than those on antipsychotic medications at the 15-year follow-ups.

In addition, we analyzed the earlier personality data on LOC and self-esteem at the 4.5-year follow-ups to determine whether patients with schizophrenia who were not on any medications at the 15-year follow-ups were different in terms of showing earlier signs of having more internal LOC and having more positive self-esteem. Figure 3 presents the data on LOC. The data indicate that the schizophrenia patients on antipsychotics at the 15-year follow-ups had been significantly more external (using the LOC scores from the 4.5-year follow-ups) over 10 years earlier than those on not on medications at the 15-year follow-ups ($t = 2.27$, 30 *df*, $p < .05$). There also was a trend for schizophrenia patients who were on antipsychotics at the 15-year follow-ups, when compared with those not on medications at the 15-year follow-ups, to have had more negative self-esteem or self-images when they were compared over 10 years earlier ($t = 2.18$, 31 *df*, $p < .05$).

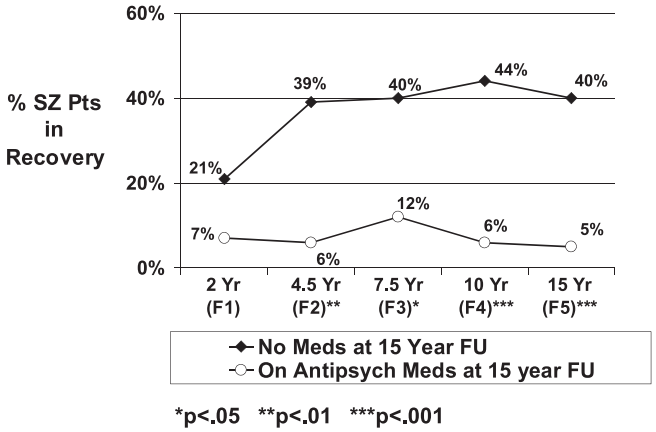

FIGURE 2. Schizophrenia patients who at the 15-year follow-up are on antipsychotic medications: Previous functioning of these patients.

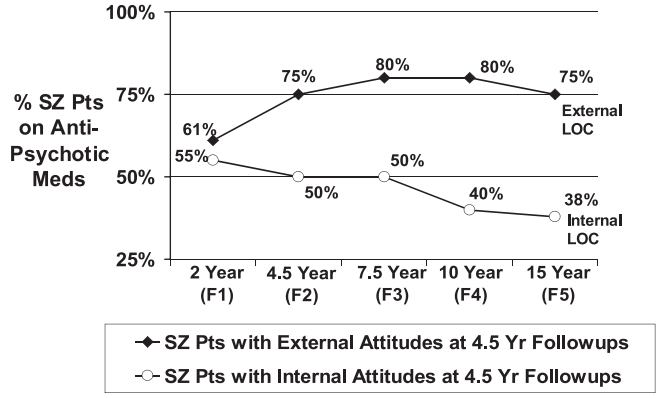

FIGURE 3. Schizophrenia patients with internal and external locus of control (LOC) at 4.5-year follow-ups: Percent patients later on antipsychotic medications.

Earlier Prognostic Potential and Early Developmental Achievements of Schizophrenia Patients Not on Medications

Figure 4 compares the percent of schizophrenia patients with good prognostic features at index hospitalization (Vaillant-Stephens scale) on antipsychotics with those not on any medications, comparing these 2 medication groups at both the 4.5-year follow-ups and the 15-year follow-ups. Figure 5 reports the percent of these 2 medication groups with good versus poor premorbid developmental achievements (Zigler-Phillips scale). The results from Figure 4 indicate significantly more favorable prognostic scores (Vaillant-Stephens) at index hospitalization for schizophrenia patients later not on medications (versus those on antipsychotics) at both the 4.5-year follow-ups ($\chi^2 = 5.57$,1 *df*, $p < .02$) and the 15-year follow-ups ($\chi^2 = 6.83$,1 *df*, $p < .01$). The results from Figure 5 indicate more favorable premorbid developmental achievements for schizophrenia patients not on medications (versus those on antipsychotics) at the 4.5-year follow-ups ($\chi^2 = 3.18$,1 *df*, $p < .10$) and the 15-year follow-ups ($\chi^2 = 3.97$,1 *df*, $p < .05$).

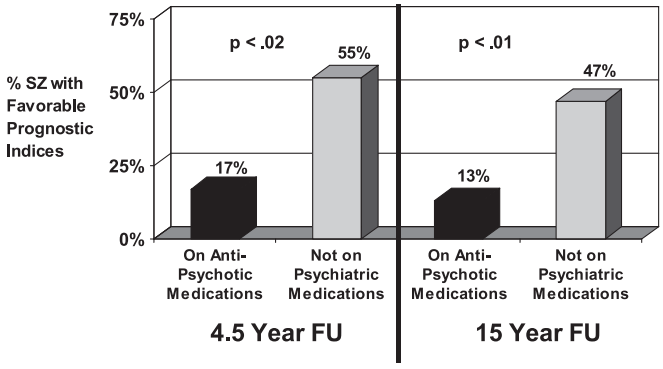

FIGURE 4. Prognostic indices (Vaillant–Stephens) as a later influence on medication treatment among schizophrenia patients (sz).

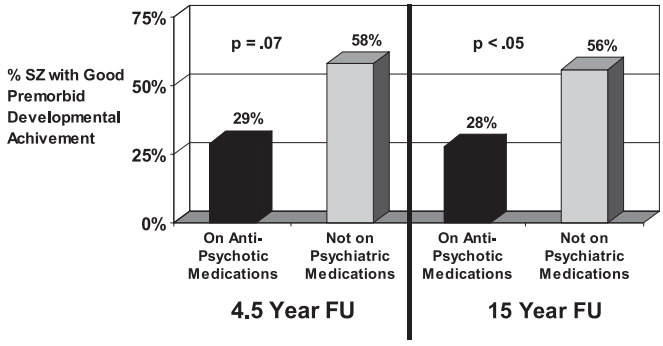

FIGURE 5. Premorbid developmental achievements as a later influence on medication treatment among schizophrenia patients (sz).

The results suggest that the subgroup of schizophrenia patients not on medications was different in terms of being a self-selected group having better earlier prognostic and developmental potential.

In addition, global outcome for the group of patients with schizophrenia who were on antipsychotics was compared with that for the off-medication schizophrenia patients with similar prognostic status. Starting with the 4.5-year follow-ups and extending to the 15-year follow-ups the off-medication subgroup tended to show better global outcomes at each follow-up.

Time Course and Outcome for Patients With Favorable Prognostic Indices

We conducted additional analysis of the medication course over time of the subsample of 10 schizophrenia patients who, at the 15-year follow-ups, were not on antipsychotics and also were in a period of recovery. At the 15-year follow-ups, 8 of these 10 schizophrenia patients were not on any psychiatric medications and the other 2 were on other medications, but not on antipsychotics. These 10 patients had removed themselves or been removed from antipsychotics at a relatively early period in their posthospital course. Thus, by the 2-year follow-ups 6 of these schizophrenia patients were not on antipsychotics, and remained off of them at all subsequent follow-ups. Another 2 were not on antipsychotics by the 4.5-year follow-ups, and the other 2 were not on antipsychotic medications by the 7.5-year follow-ups.

The current focus is on whether some or a subgroup of schizophrenia patients can show favorable outcomes after stopping their antipsychotics, and on characteristics of those who stay off antipsychotics for a sustained period. However, we also analyzed whether 2 of the main characteristics of the unmedicated patients are, in general, associated with more favorable global outcomes. The data indicate that both the Vaillant–Stephens prognostic index ($F = 12.04$, $df = 1.37$, $p < .001$), and the Zigler measure of premorbid developmental achievements ($F = 31.53$, $df = 1.41$, $p < .0001$) were predictors of significantly more favorable outcomes for the schizophrenia patients.

DISCUSSION

An important issue is which types of patients with schizophrenia, when studied on a longitudinal basis, are most likely to function adequately without antipsychotic medications. In general, modern-day medications for the severely mentally ill are a positive factor for many of these patients, especially those who remain in clinical outpatient settings; this has been firmly established in a large number of efficacy and effectiveness studies with first-generation antipsychotics and, more recently, second-generation antipsychotics, with the studies involving patients in clinical settings. Most of the many positive studies are based on an important population of patients, those involved in clinic treatment and clinic settings. However, after acute hospital treatment, when these patients leave the hospital, not all patients originally treated with antipsychotic medications continue on these medications. Thus, although the majority of patients with schizophrenia were on antipsychotic medications, at each of the 5 follow-ups, over a third were not on antipsychotic medications. Although the focus of the current report is on the medication status of the patients at the 15-year follow-ups, the data indicate significantly better functioning for the patients not on antipsychotic medications at the 15-year follow-ups and also at earlier follow-ups for these patients extending back over the previous 10 years. It seems likely that some of these schizophrenia patients chose to leave the mental health caretaking system because their symptom level and functioning had improved.

A certain number of schizophrenia patients who go off antipsychotic medications and relapse are quickly brought to the attention of psychiatrists and other mental health workers when they return for treatment and/or rehospitalization; these relapsing patients are the ones from whom opinions by some about the absolute necessity of continual antipsychotic medications for all patients with schizophrenia are formed. The possible biases involved in limiting one's study to only this type of sample is discussed by Cohen and Cohen (1984).

The current results are similar in principle to earlier results reported from an important, landmark, report by Fenton and McGlashan (1987), but also involve continuous multifollow-up study of these patients and assessment with personality scales and other instruments. Unlike the Fenton and McGlashan study, it also involves prognostic and personality comparisons of patients on antipsychotics versus the combination of all schizophrenia patients not on medications, regardless of whether the latter patients had favorable or unfavorable outcomes.

It is possible that a lack of compliance with antipsychotic medication treatment may have reduced its effectiveness and lowered functioning for some schizophrenia patients. However, lack of compliance does not account for the relatively favorable outcomes of the untreated patients, especially select schizophrenia patients with favorable prognostic features, who experienced periods of recovery. Some of these schizophrenia patients eventually encounter (5–12 years later) further psychopathology and/or further disabilities.

Part of the reason that the current results do not fit some casual clinical observations is that many professionals in the mental health caretaking system are more closely in contact with those patients with schizophrenia and other types of psychotic disorders who are in treatment, either consistently or sporadically; the good and bad periods for these patients make a greater impression on us. We have less contact with patients not in treatment for a prolonged period and they are not included in medication versus placebo studies, so their outcomes are less likely to shape our views. However, the current results suggest that a number of other patients who do not immediately relapse while off medications, and especially those who disappear from the mental health caretaking system for a prolonged period, are less likely to come to the attention of professionals. As in many other areas of medicine, when one comes into contact with patients years after initial acute treatment, "sicker" people are more likely to

have been in continual treatment, and those who had symptom-free periods are less likely to be in treatment.

Looked at from a different viewpoint, the data suggest that schizophrenia patients with good prognostic features, with better premorbid developmental achievements and with more favorable personality characteristics are the subgroup more likely to stay off antipsychotics for a prolonged period.

Viewed as a group the total sample of patients with schizophrenia showed poorer outcomes than the other psychotic patients (Table 2). As shown in Table 2, in general, schizophrenia is a relatively poor outcome disorder compared with the outcomes of other disorders involving psychosis. However, the subgroup of schizophrenia patients with good prognostic characteristics who showed adequate outcomes for a number of years even without antipsychotics underscores that there is some heterogeneity of outcome in schizophrenia (Ciompi, 1984; Harding et al., 1987; Harrow et al., 2005a; Liberman, 2002) The heterogeneity of outcome is not unique to schizophrenia, and is found in many other major disorders.

Changes Over Time of Medication Status of Patients With Better Functioning

In regard to changes over time, the data indicate the strongest effect and the greatest likelihood of a number of factors of importance to emerge occurred after the first 2 years. Thus, by the 4.5- and 7.5-year follow-ups and at each follow-up thereafter, this trend toward better functioning for the patients not on antipsychotics and with more positive personality characteristics was stronger and statistically significant for this subgroup with more internal resources and positive attitudes about themselves.

Schizophrenia Patients Not on Antipsychotic Medications: Two Factors of Importance

As with other disorders, all schizophrenia patients are not alike. The view of "one treatment fits all" is not consonant with the current data or with clinical experience (Jobe and Harrow, 2005). Some patients have better internal resources, and there are other potential differences in personality style and attitudinal approaches. A number of researchers have pointed out the value of exploring predictors to identify schizophrenia patients who might function adequately without antipsychotics. Our data indicate 2 different types of factors that facilitate the better functioning of the patients with schizophrenia who were not on antipsychotics at the 15-year follow-ups.

The first set of factors concerns a trend for schizophrenia patients with favorable scores on the prognostic indices assessed years earlier (at index hospitalization), indicating their potential for better prognoses and better clinical courses, to not be on any antipsychotics many years later.

Viewed with the outlook that these indices tap a certain type of inner strength or a tendency to be less vulnerable to major psychopathology, the data on premorbid functioning and the prognostic data indicate one prominent factor is that the unmedicated patients were more likely to be more resilient patients with better prognostic potential, better developmental achievements, and more internal resources. The prospectively collected data in Figures 4 and 5 support the view that the patients who were no longer medicated were different on these premorbid factors from those on antipsychotics. Although prognostic factors and premorbid developmental achievements are important influences on outcome, and were the strongest predictors, multiple other factors also are involved because the off-medication patients showed better global outcomes than the on-antipsychotic patients, even when subgroups with similar prognostic status were compared.

With regard to the other type of earlier influence we studied, the data indicate the value of constructive attitudinal and personality characteristics present years earlier before the 15-year follow-ups. Thus, the data indicate that patients with schizophrenia who were unmedicated at the 15-year follow-ups were more likely, over 10 years earlier, to have been patients who had (a) more internal attitudes on an LOC scale concerning the importance of their own efforts toward better functioning and (b) better self-esteem or better self-images. It is probable that for patients with a more internal attitude and better self-images at the 4.5-year follow-ups, some initial success in functioning contributed to their beliefs that their improved functioning was due to their own efforts and talents rather than to chance. This, in turn, could encourage and reinforce a more internal LOC, leading to increased personal efforts when faced with subsequent challenges, with the constructive attitudes and positive functioning exerting reciprocal positive influences on each other. Patients who are internally orientated and have better self-esteem are the types of patients who are more likely, if their functioning improves, to urge that they try functioning without medications and/or to choose to try functioning without any treatment at all. These data would fit with some reports and empirical studies on consumers who believe that schizophrenia patients who feel they have recovered are more likely to be those who have "taken responsibility for their lives" (Tooth et al., 2003, p 76).

Which Patients With Schizophrenia Can Profitably Stay Off Antipsychotic Medications?

Fenton and McGlashan (1987) note that it would be desirable to determine which patients with schizophrenia can profitably stay off antipsychotic medications. While identifying an important subgroup, they note that these factors could not be used to accurately predict which specific schizophrenia patients among those with favorable features would function well without medications. The premorbid factors they found seem to be effective predictors for many rather than all such schizophrenia patients. The difficulty of prediction can be seen when Vaillant (1978) and Stephens (1978) also noted that some, but not all, patients with favorable prognostic features function adequately (Jobe and Harrow, 2005).

Our data produced results that are similar in principle. Recommendations regarding the use of medications at various phases of illness are often based on a risk-benefit analysis involving, as in many other areas of modern medicine, the probability of success rather than certainty. The current data identify a clear subgroup of schizophrenia patients not being treated, a number of whom experienced periods of recovery, with the data indicating that on average, those patients not on any medications at the 15-year follow-ups had significantly better current and previous global adjustment than those on

antipsychotics (Fig. 2). There also has been some indication that as our patient sample is getting older, there may be some tendency for improvement among schizophrenia patients. Our overall analysis indicates that many schizophrenia patients not on antipsychotic medications played some role themselves in the decision for them to stop taking medication and leave treatment at a relatively early phase of their posthospital course. Thus, most of the subgroup of schizophrenia patients not on any medications who were in a period of recovery at the 15-year follow-ups had been taken off or removed themselves from antipsychotic medications over 10 years earlier by the 2-year or 4.5-year follow-ups.

After the acute phase, many schizophrenia patients are less symptomatic and function better, partly as a result of antipsychotics. We, as professionals, are closest to our treatments and are influenced by the positive effects on many patients of these treatments. However, other factors also influence our patients' subsequent symptom levels and outcomes. These include the extent or strength of their diathesis or constitutional predispositions toward schizophrenia, internal resources and cognitive skills, attitudes and personalities, and the not-totally-predictable external environmental events they will encounter in the future. Some tend to overlook the potential importance of these latter factors in influencing subsequent outcomes.

CONCLUSIONS

The data indicate that after the acute phase certain specific subgroups of patients with schizophrenia have an increased probability of going off antipsychotics for prolonged periods and opting out of the mental health caregiving system and indicate the characteristics of this particular subgroup are. Posthospital treatment is important for most patients with schizophrenia. The controlled trials data on clinic populations of patients suggest that among the patients with schizophrenia who stay in clinic treatment settings for years after the acute phase there is increased risk of relapse when going off antipsychotics. However, the current data suggest that for the select subgroup of patients with schizophrenia who are not in clinic settings, who have gone off antipsychotics and did not immediately relapse, and stayed off them for a period of time, a surprising number experienced periods of recovery and continued to function well for a considerable period without antipsychotics. Clearly, the present longitudinal data suggest that not all patients with schizophrenia need to use antipsychotic medications continuously throughout their lives.

It is not known how the off-medication schizophrenia patients experiencing periods of recovery, and those experiencing difficulties in functioning, would have been functioning had they been receiving medications, and from the present study one is not able to make definitive causal inferences about the treatment factors affecting outcome. However, knowledge by clinical workers of which factors are associated with greater chances of success can be helpful in treatment decisions for patients with schizophrenia who express an interest in going off antipsychotics.

The data, collected over a 15-year period, reveal factors that are protective and indicate which patients are more likely (but not certain) to function adequately if they choose to leave treatment. These factors, which were identified prospectively (e.g., the prognostic and developmental data were collected and scored many years earlier, at index hospitalization), and increase the probability of success when off antipsychotics, include 2 different prognostic indices and 2 different personality scales. For those schizophrenia patients who are functioning better for a period who, by themselves, show an interest in coming off antipsychotic medications and also show evidence of inner resources (or earlier favorable prognostic features and good developmental achievements), the data suggest that some or many will succeed for a period. Periods or intervals of recovery are dependent on multiple internal characteristics of the patient, and on external factors and treatment, rather than only one factor, and prediction can be made with moderate rather than perfect probability, as in most other areas of medicine and many areas of biology.

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Ethical Human Psychology and Psychiatry, Volume 7, Number 1, Spring 2005

Anatomy of an Epidemic: Psychiatric Drugs and the Astonishing Rise of Mental Illness in America

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Over the past 50 years, there has been an astonishing increase in severe mental illness in the United States. The percentage of Americans disabled by mental illness has increased fivefold since 1955, when Thorazine—remembered today as psychiatry's first "wonder" drug—was introduced into the market. The number of Americans disabled by mental illness has nearly doubled since 1987, when Prozac—the first in a second generation of wonder drugs for mental illness—was introduced. There are now nearly 6 million Americans disabled by mental illness, and this number increases by more than 400 people each day. A review of the scientific literature reveals that it is our drug-based paradigm of care that is fueling this epidemic. The drugs increase the likelihood that a person will become chronically ill, and induce new and more severe psychiatric symptoms in a significant percentage of patients.

Keywords: antipsychotics; antidepressants; mental illness; epidemic; schizophrenia

The modern era of psychiatry is typically said to date back to 1955, when chlorpromazine, marketed as Thorazine, was introduced into asylum medicine. In 1955, the number of patients in public mental hospitals reached a high-water mark of 558,922 and then began to gradually decline, and historians typically credit this emptying of the state hospitals to chlorpromazine. As Edward Shorter wrote in his 1997 book, *A History of Psychiatry*, "Chlorpromazine initiated a revolution in psychiatry, comparable to the introduction of penicillin in general medicine" (Shorter, 1997, p. 255). Haldol and other antipsychotic medications were soon brought to market, and then antidepressants and antianxiety drugs. Psychiatry now had drugs said to target specific illnesses, much like insulin for diabetes.

However, since 1955, when this modern era of psychopharmacology was born, there has been an astonishing rise in the incidence of severe mental illness in this country. Although the number of hospitalized mentally ill may have gone down, every other metric used to measure disabling mental illness in the United States has risen dramatically, so much so that E. Fuller Torrey, in his 2001 book *The Invisible Plague*, concluded that insanity had risen to the level of an "epidemic" (Torrey, 2001). Since this epidemic has unfolded in lockstep with the ever-increasing use of psychiatric drugs, an obvious question arises: Is our drug-based paradigm of care fueling this modern-day plague?

THE EPIDEMIC

The U.S. Department of Health and Human Services uses "patient care episodes" to estimate the number of people treated each year for mental illness. This metric tracks the number of people treated at psychiatric hospitals, residential facilities for the mentally ill, and ambulatory care facilities. In 1955, the government reported 1,675,352 patient care episodes, or 1,028 episodes per 100,000 population. In 2000, patient-care episodes totaled 10,741,243, or 3,806 per 100,000 population. That is nearly a fourfold per capita increase in 50 years (Table 1).

A second way to assess this epidemic is to look at the number of disabled mentally ill in the country. Up until the 1950s, the number of hospitalized mentally ill provided a rough estimate of this group. Today, the disabled mentally ill typically receive a disability payment either from the Social Security Disability Insurance (SSDI) program or the Supplemental Security Income (SSI) program, and many live in residential shelters or other subsidized living arrangements. Thus, the hospitalized patient of 50 years ago receives either SSDI or SSI today, and this line of evidence reveals that the number of disabled mentally ill has increased nearly sixfold since Thorazine was introduced.

In 1955, there were 559,000 people in public mental hospitals, or 3.38 people per 1,000 population. In 2003, there were 5.726 million people who received either an SSI or SSDI payment (or from both programs), and were either disabled by mental illness (SSDI statistics) or diagnosed as mentally ill (SSI statistics).[1] That is a disability rate of 19.69 people per 1,000 population, which is nearly six times what it was in 1955 (Table 2).

It is also noteworthy that the number of disabled mentally ill has increased dramatically since 1987, the year Prozac was introduced. Prozac was touted as the first of a second generation of psychiatric medications said to be so much better than the old. Prozac and the other SSRIs replaced the tricyclics, while the atypical antipsychotics (Risperidone, Zyprexa, etc.) replaced Thorazine and the other standard neuroleptics. The combined sales of antidepressants and antipsychotics jumped from around $500 million in 1986 to nearly $20 billion in 2004 (from September 2003 to August 2004), a 40-fold

TABLE 1. Patient-Care Episodes

Year	Total Episodes	Per 100,000 Population
1955	1,675,352	1,028
1965	2,636,525	1,376
1969	3,682,454	1,853
1971	4,190,913	2,026
1975	6,857,597	3,182
1983	7,194,038	3,084
1986	7,885,618	3,295
1990	8,620,628	3,491
1992	8,824,701	3,580
1994	9,584,216	3,680
1998	10,549,951	3,903
2000	10,741,243	3,806

Data Source: U.S. Department of Health and Human Services, SAMHSA. *Mental Health, United States, 2002.* Per 100,000 numbers calculated according to U.S. Census.

TABLE 2. The Disabled Mentally Ill in the United States

Year	Rate of Disabled Mentally Ill per 1,000 Population
1850	.2
1903	1.86
1955	3.38
1987	13.75
2003	19.69

Source: The disability rates for 1850 through 1955 are based on the number of hospitalized mentally ill, as cited by E. Fuller Torrey in *The Invisible Plague* (2001). The disability rates for 1987 and 2003 are based on the number of mentally ill receiving SSI or SSDI payments, as was reported in 2004 by the Social Security Administration.

increase.[2] During this period, the number of disabled mentally ill in the United States, as calculated by the SSI and SSDI figures, increased from 3.331 million people to 5.726 million.[3] That is an increase of 149,739 people per year, or 410 people newly disabled by mental illness *every day* (Table 3).

A BIOLOGICAL CAUSE FOR THE EPIDEMIC

The notion that psychiatric drugs work by balancing brain chemistry was first raised in the early 1960s. Once Thorazine and the standard neuroleptics were shown to block dopamine activity in the brain, researchers hypothesized that schizophrenia was caused by too much of this neurotransmitter. Thus, the neuroleptics—by blocking the dopamine receptors—helped normalize the brain's dopamine system. Since the tricyclics raised norephinephrine and serotonin levels in the brain, researchers reasoned that depression was caused by low levels of these brain chemicals. Merck, meanwhile, marketed its antianxiety drug Suavitil as a "mood normalizer." These normalizing claims suggested that the drugs were indeed curative of biological ailments.

However, this hypothesis—that the drugs balanced abnormal brain chemistry—never panned out. Although the public may still be told that the drugs normalize brain chemistry, the truth is that researchers did not find that people with schizophrenia had overactive dopamine systems (prior to being medicated), or that those diagnosed with depression suffered from abnormally low levels of serotonin or norephinephrine. As U.S. Surgeon General David Satcher acknowledged in his 1999 report on mental health, the causes of mental disorders "remain unknown" (Satcher, 1999, p. 102).

Yet, scientists have come to understand how the drugs affect the human brain, at least in terms of their immediate mechanisms of action. In 1996, the director of the National Institute of Mental Health (NIMH), neuroscientist Steven Hyman, set forth a paradigm for understanding how all psychiatric drugs work. Antipsychotics, antidepressants, and antianxiety drugs, he wrote, "create perturbations in neurotransmitter functions" (Hyman & Nestler, 1996, p. 153). In response, the brain goes through a series of

TABLE 3. Disability in the Prozac Era

Year	SSDI Recipients Disabled by Mental Illness	SSI Recipients With Diagnosis of Mental Illness	Total Number of SSI and SSDI Payments to Disabled Mentally Ill	Number of SSDI Recipients Who Also Received an SSI Payment	Total Disabled Mentally Ill
1987	800,139	2,630,999	3,431,138	100,017	3,331,121
2003	1,812,021	4,141,418	5,953,439	226,502	5,726,937
Increase from 1987-2003	1,011,882	1,510,419	2,522,301		2,395,816

Data Source: Annual Statistical Report on the Social Security Disability Insurance Program, 2003; and SSI Annual Statistical Report, 2003.

compensatory adaptations. For instance, Prozac and other SSRI antidepressants block the reuptake of serotonin. In order to cope with this hindrance of normal function, the brain tones down its whole serotonergic system. Neurons both release less serotonin and down-regulate (or decrease) their number of serotonin receptors. The density of serotonin receptors in the brain may decrease by 50% or more. As part of this adaptation process, Hyman noted, there are also changes in intracellular signaling pathways and gene expression. After a few weeks, Hyman concluded, the patient's brain is functioning in a manner that is "qualitatively as well as quantitatively different from the normal state" (Hyman & Nestler, 1996, p. 161).

In short, psychiatric drugs induce a *pathology*. Princeton neuroscientist Barry Jacobs has explicitly made this point about SSRIs. These drugs, he said,

> alter the level of synaptic transmission beyond the physiologic range achieved under (normal) environmental/biological conditions. Thus, any behavioral or physiologic change produced under these conditions might more appropriately be considered pathologic, rather than reflective of the normal biological role of serotonin. (Jacobs, 1991, p. 22)

Once psychiatric drugs are viewed in this way, it is easy to understand why their widespread use would precipitate an epidemic of mental illness. As E. Fuller Torrey wrote in *The Invisible Plague*, conditions that "disrupt brain chemistry may cause delusions, hallucinations, disordered thinking, and mood swings—the symptoms of insanity" (Torrey, 2001, p. 315). He noted that infectious agents, tumors, metabolic and toxic disorders, and various diseases could all affect the brain in this manner. What Torrey failed to mention is that psychiatric medications also "disrupt brain chemistry." As a result, their long-term use is bound to be problematic, and that is precisely what the research literature reveals: Their use increases the likelihood that a person will become chronically ill, and they cause a significant percentage of patients to become ill in new and more severe ways.

TURNING PATIENTS CHRONICALLY ILL

Neuroleptics

The study that is still cited today as proving the efficacy of neuroleptics for curbing acute episodes of schizophrenia was a nine-hospital trial of 344 patients conducted by the NIMH in the early 1960s. At the end of 6 weeks, 75% of the drug-treated patients were "much improved" or "very much improved" compared to 23% of the placebo patients. (National Institute of Mental Health Psychopharmacology Services Center Collaborative Study Group, 1964).

However, 3 years later, the NIMH reported on 1-year outcomes for the patients. Much to their surprise, they found that "patients who received placebo treatment were less likely to be rehospitalized than those who received any of the three active phenothiazines" (Schooler, Goldberg, Boothe, & Cole, 1967, p. 991). This result raised an unsettling possibility: While the drugs were effective over the short term, perhaps they made people more biologically vulnerable to psychosis over the long run, and thus the higher rehospitalization rates at the end of 1 year.

In the wake of that disturbing report, the NIMH conducted two medication-withdrawal studies. In each one, relapse rates *rose* in correlation with neuroleptic dosage before withdrawal. In the two trials, only 7% of patients who were on placebo relapsed

during the following 6 months. Twenty-three percent of the patients on less than 300 mg of chlorpromazine daily relapsed following drug withdrawal; this rate climbed to 54% for those receiving 300-500 mg and to 65% for patients taking more than 500 mg. The researchers concluded: "Relapse was found to be significantly related to the dose of the tranquilizing medication the patient was receiving before he was put on placebo—the higher the dose, the greater the probability of relapse" (Prien, Levine, & Switalski, 1971, p. 22).

Once again, the results suggested that neuroleptics increased the patients' biological vulnerability to psychosis. Other reports soon deepened this suspicion. Even when patients reliably took their medications, relapse was common, and researchers reported in 1976 that it appeared that relapse during drug administration was greater in severity than when no drugs were given (Gardos & Cole, 1977). A retrospective study by Bockoven also indicated that the drugs were making patients chronically ill. He reported that 45% of patients treated at Boston Psychopathic Hospital in 1947 with a progressive model of care did not relapse in the 5 years following discharge, and that 76% were successfully living in the community at the end of that follow-up period. In contrast, only 31% of patients treated in 1967 with neuroleptics at a community health center remained relapse-free over the next 5 years, and as a group they were much more "socially dependent"—on welfare and needing other forms of support—than those in the 1947 cohort (Bockoven & Solomon, 1975).

With debate over the merits of neuroleptics rising, the NIMH revisited the question of whether newly admitted schizophrenia patients could be successfully treated without drugs. There were three NIMH-funded studies conducted during the 1970s that examined this possibility, and in each instance, the newly admitted patients treated without drugs did better than those treated in a conventional manner. In 1977, Carpenter reported that only 35% of the non-medicated patients in his study relapsed within a year after discharge, compared to 45% of those treated with neuroleptics (Carpenter, McGlashan, & Strauss, 1977). A year later, Rappaport reported that in a trial of 80 young male schizophrenics admitted to a state hospital, only 27% of patients treated without neuroleptics relapsed in the 3 years following discharge, compared to 62% of the medicated group (Rappaport, Hopkins, Hall, Belleza, & Silverman, 1978). The final study came from Mosher, head of schizophrenia research at the NIMH. In 1979, he reported that patients who were treated without neuroleptics in an experimental home staffed by nonprofessionals had lower relapse rates over a 2-year period than a control group treated with drugs in a hospital. As in the other studies, Mosher reported that the patients treated without drugs were the better functioning group as well (Bola & Mosher, 2003; Mathews, Roper, Mosher, & Mann, 2003).

The three studies all pointed to the same conclusion: Exposure to neuroleptics increased the long-term incidence of relapse. Carpenter's group defined the conundrum:

> There is no question that, once patients are placed on medication, they are less vulnerable to relapse if maintained on neuroleptics. But what if these patients had never been treated with drugs to begin with? We raise the possibility that antipsychotic medication may make some schizophrenic patients more vulnerable to future relapse than would be the case in the natural course of the illness. (Carpenter & McGlashan, 1977, p. 19)

In the late 1970s, two physicians at McGill University in Montreal offered a biological explanation for why this was so (one that fits with the paradigm later outlined by Hyman). The brain responds to neuroleptics—which block 70% to 90% of all D_2 dopamine receptors in the brain—as though they are a pathological insult. To compensate, dopaminergic brain cells increase the density of their D_2 receptors by 30% or more. The

brain is now "supersensitive" to dopamine, and this neurotransmitter is thought to be a mediator of psychosis. The person has become more biologically vulnerable to psychosis and is at particularly high risk of severe relapse should he or she abruptly quit taking the drugs (Chouinard, Jones, & Annable, 1978; Chouinard & Jones, 1980). The two Canadian researchers concluded:

> Neuroleptics can produce a dopamine supersensitivity that leads to both dyskinetic and psychotic symptoms. An implication is that the tendency toward psychotic relapse in a patient who had developed such a supersensitivity is determined by more than just the normal course of the illness. (Chouniard, Jones, & Annable, 1978, p. 1410)

Together, the various studies painted a compelling picture of how neuroleptics shifted outcomes away from recovery. Bockoven's retrospective and the other experiments all suggested that with minimal or no exposure to neuroleptics, at least 40% of people who suffered a psychotic break and were diagnosed with schizophrenia would not relapse after leaving the hospital, and perhaps as many as 65% would function fairly well over the long term. However, once first-episode patients were treated with neuroleptics, a different fate awaited them. Their brains would undergo drug-induced changes that would increase their biological vulnerability to psychosis, and this would increase the likelihood that they would become chronically ill (and thus permanently disabled).

That understanding of neuroleptics had been fleshed out by the early 1980s, and since then, other studies have provided additional confirming evidence. Most notably, the World Health Organization twice compared schizophrenia outcomes in the rich countries of the world with outcomes in poor countries, and each time the patients in the poor countries—where drug usage was much less—were doing dramatically better at 2-year and 5-year follow-ups. In India, Nigeria and Colombia, where only 16% of patients were maintained continuously on neuroleptics, roughly two-thirds were doing fairly well at the end of the follow-up period and only one third had become chronically ill. In the US and other rich countries, where 61% of the patients were kept on antipsychotic drugs, the ratio of good-to-bad outcomes was almost precisely the reverse. Only about one third had good outcomes, and the remaining two thirds became chronically ill (Jablensky et al., 1992; Leff, Sartorius, Jablensky, Korten, & Ernberg, 1992).

More recently, MRI studies have shown the same link between drug usage and chronic illness. In the mid 1990s, several research teams reported that the drugs cause atrophy of the cerebral cortex and an enlargement of the basal ganglia (Chakos et al., 1994; Gur et al., 1998; Madsen, Keiding, Karle, Esbjerg, & Hemmingsen, 1998). These were disquieting findings, as they clearly showed that the drugs were causing structural changes in the brain. Then, in 1998, researchers at the University of Pennsylvania reported that the drug-induced enlargement of the basal ganglia was "associated with greater severity of both negative and positive symptoms" (Gur, Maany et al., 1998, p. 1711). In other words, they found that over the long term the drugs cause changes in the brain associated with a *worsening* of the very symptoms the drugs are supposed to alleviate. The MRI research, in fact, had painted a very convincing picture of a disease process: An outside agent causes an observable change in the size of brain structures, and as this occurs, the patient deteriorates.

Antidepressants

The story of antidepressants is a bit subtler, and yet it leads to the same conclusion that these drugs increase chronic illness over time. Even their short-term efficacy, in terms of a benefit greater than placebo, is of a questionable sort.

In the early 1960s, there were two types of antidepressants, monoamine oxidase inhibitors (MAOIs) and tricyclics. However, MAOIs soon fell out of favor because of dangerous side effects and a 1965 finding by the Medical Research Council in the United Kingdom that they were no more effective than placebo (Medical Research Council, 1965). Four years later, the NIMH concluded that there was also reason to doubt the merits of tricyclics. After reviewing the medical literature, NIMH investigators determined that in "well-designed studies, the differences between the effectiveness of antidepressant drugs and placebo are not impressive" (Smith, 1969, p. 19). About 61% of the drug-treated patients improved, versus 46% of the placebo patients, producing a net drug benefit of only 15% (Smith, 1969).

This finding led some investigators to wonder whether the placebo response was the mechanism that was helping people feel better. What the drugs did, several speculated, was amplify the placebo response, and they did so because they produced physical side effects that helped convince patients that they were getting a "magic pill" for depression. To test this hypothesis, investigators conducted at least eight studies in which they compared a tricyclic to an "active" placebo, rather than an inert one. (An active placebo is a chemical that produces an unpleasant side effect of some kind, like dry mouth.) In seven of the eight, there was no difference in outcomes, leading investigators at New York Medical College to conclude "there is practical value in viewing [psychotropics] as mere amplifiers or inhibitors of the placebo effects" (Dinnerstein, Lowenthal, & Blitz, 1966; Thompson, 1982).

With such confusion over the efficacy of tricyclics hanging in the air, the NIMH launched an ambitious long-term study of depression treatments in the early 1980s. Two hundred thirty-nine patients were randomized into four treatment groups—cognitive behavior therapy, interpersonal therapy, the tricyclic imipramine, and placebo. The results were startling. At the end of 16 weeks, "there were no significant differences among treatments, including placebo plus clinical management, for the less severely depressed and functionally impaired patients." Only the severely depressed patients fared better on a tricyclic than on placebo. However, at the end of 18 months, even this minimal benefit disappeared. Stay-well rates were best for the cognitive behavior group (30%) and poorest for the imipramine group (19%) (Elkin, 1990). Moreover, two pharmacology researchers at the State University of New York, Seymour Fisher and Roger Greenberg, concluded that if study dropouts were included in the analysis, then the "results look even worse" (Greenberg & Fisher, 1997, p. 147). Patients treated with an antidepressant were the most likely group to seek treatment following termination of the initial treatment period, they had the highest incidence of relapse, and they "exhibited the fewest weeks of reduced or minimal symptoms during the follow-up period" (Greenberg & Fisher, 1997, p. 147).

Once again, the results led to an unnerving conclusion. Antidepressants were making people chronically ill, just like the antipsychotics were. Other studies deepened this suspicion. In 1985, a U.K. group reported that in a 2-year study comparing drug therapy to cognitive therapy, relapse "was significantly higher in the pharmacotherapy group" (Blackburn, Eunson, & Bishop, 1986, p. 67). In 1994, Italian researcher Giovanni Fava reviewed the outcomes literature and concluded that "long-term use of antidepressants may increase the (patient's) biochemical vulnerability to depression," and thus "worsen the course of affective disorders" (Fava, 1994, p. 127). Fava revisited the issue in 2003. An analysis of 27 studies, he wrote, showed that "whether one treats a depressed patient for 3 months or 3 years, it does not matter when one stops the drugs.

A statistical trend suggested that the longer the drug treatment, the higher the likelihood of relapse" (Fava, 2003, p. 124).

Benzodiazepines

This same basic paradox—that a psychiatric drug may curb symptoms over the short term but worsen the long-term course of the disorder—has been found to hold true for benzodiazepines, at least when used to treat panic attacks. In 1988, researchers who led the large Cross-National Collaborative Panic Study, which involved 1,700 patients in 14 countries, reported that at the end of 4 weeks, 82% of the patients treated with Xanax (alprazolam) were "moderately improved" or "better," versus 42% of the placebo patients. However, by the end of 8 weeks, there was no difference between the groups, at least among those who remained in the study (Ballenger et al., 1988). Any benefit with Xanax seemed to last for only a short period. As a followup to that study, researchers in Canada and the UK studied benzodiazepine-treated patients over a period of 6 months. They reported that the Xanax patients got better during the first four weeks of treatment, that they did not improve any more in weeks 4 to 8, and that their symptoms began to worsen after that. As patients were weaned from the drugs, a high percentage relapsed, and by the end of 23 weeks, they were worse off than patients treated without drugs on five different outcomes measures (Marks et al., 1993). More bad news of this sort was reported by Pecknold in 1988. He found that as patients were tapered off Xanax they suffered nearly four times as many panic attacks as the nondrug patients, and that 25% of the Xanax patients suffered from rebound anxiety more severe than when they began the study. The Xanax patients were also significantly worse off than nondrug patients on a global assessment scale by the end of the study (Pecknold, Swinson, Kuch, & Lewis, 1988).

Then and Now

Research by David Healy, a prominent U.K. psychiatrist who has written several books on the history of psychopharmacology, shows how this problem of drug-induced chronicity plays out in society as a whole. Healy determined that outcomes for psychiatric patients in North Wales were much better a century ago than they are today, even though patients back then, at their moment of initial treatment, were much sicker. He concluded that today's drug-treated patients spend much more time in hospital beds and are "far more likely to die from their mental illness than they were in 1896." "Modern treatments," he said, "have set up a revolving door" and appear to be a "leading cause of injury and death" (Healy et al., 2001).

MANUFACTURING MENTAL ILLNESS

It is well known that all of the major classes of psychiatric drugs—antipsychotics, antidepressants, benzodiazepines, and stimulants for ADHD—can trigger new and more severe psychiatric symptoms in a significant percentage of patients. This is the second factor causing a rapid rise in the number of disabled mentally ill in the United States. Moreover, it is easy to see this epidemic-creating factor at work with Prozac and the other SSRIs.

Although serotonin has been publicly touted as the brain's mood molecule, in truth it is a very common chemical in the body, found in the walls of the blood vessels, the gut, blood platelets, and the brain. The serotonin system is also one that could be said to be primitive in kind. Serotonergic neurons are found in the nervous systems of all vertebrates and most invertebrates, and in humans their cell bodies are localized along the midline of the brain stem. From there, their axons spread up into the brain and down into the spinal cord. The first purpose of this neuronal network is thought to be control of respiratory, cardiac, and repetitive motor activity, as opposed to higher cognitive functions.

As one would expect, perturbing this system—and to a degree that could be considered pathologic, as Jacobs said—causes a wide range of problems. In Prozac's first 2 years on the market, the FDA's Medwatch program received more adverse-event reports about this new "wonder drug" than it had received for the leading tricyclic in the previous 20 years. Prozac quickly took up the top position as America's most complained about drug, and by 1997, 39,000 adverse-event reports about it had been sent to Medwatch. These reports are thought to represent only 1% of the actual number of such events, suggesting that nearly 4 million people in the US had suffered such problems, which included mania, psychotic depression, nervousness, anxiety, agitation, hostility, hallucinations, memory loss, tremors, impotence, convulsions, insomnia, and nausea. The other SSRIs brought to market caused a similar range of problems, and by 1994, four SSRIs were among the top 20 most complained-about drugs on the FDA's Medwatch list (Moore, 1997).

In terms of helping fuel a rapid rise in the number of disabled mentally ill, the propensity of Prozac and other SSRIs to trigger mania or psychosis is undoubtedly the biggest problem with these drugs. In clinical trials, slightly more than 1% of the Prozac patients developed mania, which was three times higher than the rate for patients given a tricyclic (Breggin, 2003). Other studies have found much higher rates of SSRI-induced mania. In 1996, Howland reported that 6% of 184 depressed patients treated with an SSRI suffered manic episodes that were "generally quite severe." A year later, Ebert reported that 8.5% of patients had a severe psychological reaction to Luvox (fluvoxamine) (Breggin). Robert Bourguignon, after surveying doctors in Belgium, estimated that Prozac induced psychotic episodes in 5% to 7% of patients (Bourguignon, 1997). All of this led the American Psychiatric Association to warn that manic or hypomanic episodes are "estimated to occur in 5% to 20% of patients treated with antidepressants" (Breggin).

As Fava has noted, "Antidepressant-induced mania is not simply a temporary and reversible phenomenon, but a complex biochemical mechanism of illness deterioration" (Fava, 2003, p. 126). The best available evidence suggests that this is now happening to well more than 500,000 Americans a year. In 2001, Preda and other Yale researchers reported that 8.1% of all admissions to a psychiatric hospital they studied were due to SSRI-induced mania or psychosis (Preda, MacLean, Mazure, & Bowers, 2001). The federal government reported that there were 10.741 million "patient care episodes" in 2000; if 8% were SSRI-induced manic or psychotic episodes, that would mean that 860,000 people suffered this type of adverse reaction in 2000.

Thus, the SSRI path to a disabling mental illness can be easily seen. A depressed patient treated with an antidepressant suffers a manic or psychotic episode, at which time his or her diagnosis is changed to bipolar disorder. At that point, the person is prescribed an antipsychotic to go along with the antidepressant, and once on a drug cocktail, the person is well along on the road to permanent disability. Since Prozac was

introduced in 1987, the number of disabled mentally ill in the US has risen by 2.4 million people, and given the risk of mania and psychosis with the SSRIs, that increase was to be expected.

CONCLUSION

A century ago, fewer than two people per 1,000 were considered to be "disabled" by mental illness and in need of hospitalization. By 1955, that number had jumped to 3.38 people per 1,000, and during the past 50 years, a period when psychiatric drugs have been the cornerstone of care, the disability rate has climbed steadily, and has now reached around 20 people per 1,000. (Table 2). As with any epidemic, one would suspect that an outside agent of some type—a virus, a bacterial infection, or an environmental toxin—was causing this rise in illness. That is indeed the case here. There is an outside agent fueling this epidemic of mental illness, only it is to be found in the medicine cabinet. Psychiatric drugs perturb normal neurotransmitter function, and while that perturbation may curb symptoms over a short term, over the long run it increases the likelihood that a person will become chronically ill, or ill with new and more severe symptoms. A review of the scientific literature shows quite clearly that it is our drug-based paradigm of care that is fueling this modern-day plague.

NOTES

1. These data come from the 2003 annual Social Security reports for the SSI and SSDI programs. The figure of 5,726,937 disabled mentally ill is calculated as follows: There were 1,812,021 SSDI recipients who were disabled because of mental illness. There were 4,141,418 SSI recipients diagnosed as mentally ill. However, one out of every eight recipients of SSDI, or 226,502 people, also received an SSI payment. Thus, the number of disabled mentally ill is: 1,812,021 + 4,141,418 - 226,502 = 5,726,937.

2. In 1985, U.S. sales of antidepressants totaled $240 million, and U.S. sales of antipsychotics were $263 million. From September 1, 2003 to August 30, 2004, U.S. sales of antidepressants were $11.2 billion, and U.S. sales of antipsychotics were $8.6 billion. The source for the 1985 figures is Zore, Larson, Lyons, and Beardsley (1991). The 2004 sales figures are from IMS Retail Drug Monitor: 12 months to August 2004.

3. The calculation for the number of disabled mentally ill in 1987 is as follows: There were 800,139 SSDI recipients who were disabled because of mental illness. There were 2,630,999 SSI recipients diagnosed as mentally ill. One out of every eight recipients of SSDI, or 100,017 people, also received an SSI payment. Thus, the number of disabled mentally ill is: 800,139 + 2,630,999 - 100,017 = 3,331,120.

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