Draft

WHITE PAPER

on

Improving Patient Outcomes, Addressing Treatment Caused Trauma & Injuries, Enhancing Patient Rights

and

Grievance Procedures

for the

Report Required by § 36 of CH 41 SLA 2022 (HB172)

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I. EXECUTIVE SUMMARY

On July 15, 2022, Governor Dunleavy signed HB172 into law as Chapter 41 Session Laws of Alaska 2022 (Legislation), which at Section 36 requires the Department of Health, Department of Family and Community Services, and the Alaska Mental Health Trust Authority to report on, among other things, improving psychiatric patient outcomes, institutional trauma, enhancing patient rights, the grievance process, and patient injuries (Report). This White Paper provides input for the Report.

If the fundamental purpose of the mental health system is to improve the lives of psychiatric patients it is failing miserably. That the State does not keep track of institutional trauma and patient complaints, and has no legitimate grievance process are illustrations of the lack of commitment to improving patients' lives.

The mental health system's standard treatments are counterproductive and harmful, and often forced on unwilling patients. The overreliance on psychiatric drugs is reducing the recovery rate of people diagnosed with serious mental illness from a possible 80% to 5% and reducing their life spans by 20 years or so. Psychiatric incarceration, euphemistically called "involuntary commitment," is similarly counterproductive and harmful, adding to patients' trauma and massively associated with suicides. Harmful psychiatric interventions are being imposed on people by judges in proceedings where facts about treatments and their harms are not being presented by appointed counsel, rendering the proceedings shams.

Court proceedings to psychiatrically incarcerate people on the grounds it is necessary to protect other people from harm should be eliminated; predictions of violence are not accurate and no one else besides someone who receives a psychiatric diagnosis is incarcerated for something they might do in the future. Court proceedings to psychiatrically drug people against their will on the grounds it is in their best interest should be eliminated. They are not in people's best interest. "If it is not voluntary it is not treatment." If such proceedings are nonetheless held, they should be conducted in a legitimate manner.

The most important elements for improving patients' lives are People, Place and Purpose. People—even psychiatric patients—need to have a safe place to live (Place), relationships (People), and to have activity that is meaningful to them, usually school or work (Purpose). People need to be given hope these are possible. Voluntary approaches that improve people's lives should be made available instead of the counterproductive and harmful psychiatric drugs for everyone, forever regime often forced on people currently prevailing. These approaches include Non-Police Community Response Teams, Peer Respites, Soteria Houses, Drug-Free Hospitals, Healing Homes, Warm Lines, Hearing Voices Network, and emotional CPR (eCPR).

By implementing these approaches, Alaska's mental health system can move towards the 80% possible recovery rate.

As bad as it is for adults, the psychiatric incarceration and psychiatric drugging of children and youth is more tragic and should be stopped. Instead, children and youth should be helped to manage their emotions and become successful, and their parents should be given support and assistance to achieve this.

II. TABLE OF CONTENTS

Table of Contents

III. INTRODUCTION

HB172 was passed by the 32nd Alaska Legislature on May 17, 2022, and signed by the Governor on July 15, 2022, becoming Chapter 41 Session Laws of Alaska 2022 (Legislation). The Legislation was enacted to comply with a settlement over a successful lawsuit brought against the State of Alaska for illegally confining people for extended periods of time in correctional facilities and emergency rooms awaiting admission to the Alaska Psychiatric Institute (API) for court ordered psychiatric evaluations (Settlement). The Settlement required, among other things, that the State to seek legislative approval to implement a program called "Crisis Now," whose three core elements are (1) a high tech crisis call center, (2) Twenty-four hour a day, seven days a week mobile crisis teams, and (3) crisis stabilization facilities.

Section 36 of the Legislation requires the Department of Health, the Department of Family and Community Services (State), and the Alaska Mental Health Trust Authority (Trust) to submit a joint report to the legislature one year after the effective date of the Legislation (Report), that must:

> (1) include an assessment of the current state, federal, and accrediting body requirements for psychiatric patient rights, including patient grievance and appeal policies and procedures; the assessment must address the adequacy of these policies and procedures and the practical challenges patients face in availing themselves of these rights;
>
> (2) identify and recommend any additional changes to state statutes, regulations, or other requirements that could improve patient outcomes and enhance patient rights, including items that could be added to AS 47.30.825, particularly involving involuntary admissions, involuntary medications, and the practical ability of patients to avail themselves of their rights;
>
> (3) assess and recommend any needed changes to current processes for data collection and reporting of patient grievances and appeals, patient reports of harm and restraint, and the resolution of these matters and provide recommendations for making this information available to the public; and
>
> (4) identify methods for collecting and making available to the legislature and the general public statistics recording
>
> (A) the number, type, and cause of patient and staff injuries;
>
> (B) the number, type, and resolution of patient and staff complaints; and
>
> (C) the number, type, and cause of traumatic events experienced by a patient; in this subparagraph, "traumatic event" means being administered medication involuntarily or being placed in isolation or physical restraint of any kind.

(emphases added).

The State and the Trust published Crisis Stabilization in Alaska: Understanding HB172 to explain the Legislation.

This White Paper[1] provides input for the required Report to the Legislature, focusing on improving patient outcomes, enhancing patient rights, having an effective and legitimate grievance process, and addressing patient injuries and treatment-caused trauma. These are all interrelated. For example, providing proven, effective alternatives to incarceration and psychiatric drugs, such as Peer Respites, Soteria Houses, and Open Dialogue, will enhance patients' rights to these less restrictive and intrusive alternatives to psychiatric incarceration[2] and forced drugging. Eliminating force against patients will improve patient outcomes by dramatically reducing treatment caused trauma and psychiatric incarceration associated suicide.

In his 1872 book, *A Mad World and Its Inhabitants*, Julius Chambers had himself committed to a psychiatric hospital to expose abuses and made these recommendations.:

- Do not mix violent patients with regular patients.
- Do not let psychiatric facilities operate in secret.
- Put the attendants under such supervision as to render the perpetration of cruelty impossible.

One hundred and fifty years later all these steps still need to be taken. Let's do better. Now.

IV. IMPROVING PATIENT OUTCOMES

The Ubiquitous Use of Psychiatric Drugs

It is fairly universally accepted that America's mental health system is a failure, especially regarding what has been accomplished with the most noteworthy feature of psychiatric treatment since the 1950s and exponentially so since the early 1980s, psychiatric drugs. Alaska's mental health system is no exception. At great public expense, our system's ubiquitous deployment of psychiatric drugs, including through court orders against unwilling patients, often by holding them down and injecting them against their will, or threatening to do so to obtain "compliance," dramatically worsens outcomes and suffering.

Since the introduction of the so-called miracle drug Thorazine (chlorpromazine) in the mid-1950's the disability rate of people diagnosed with serious mental illness has increased more than seven-fold.[3]

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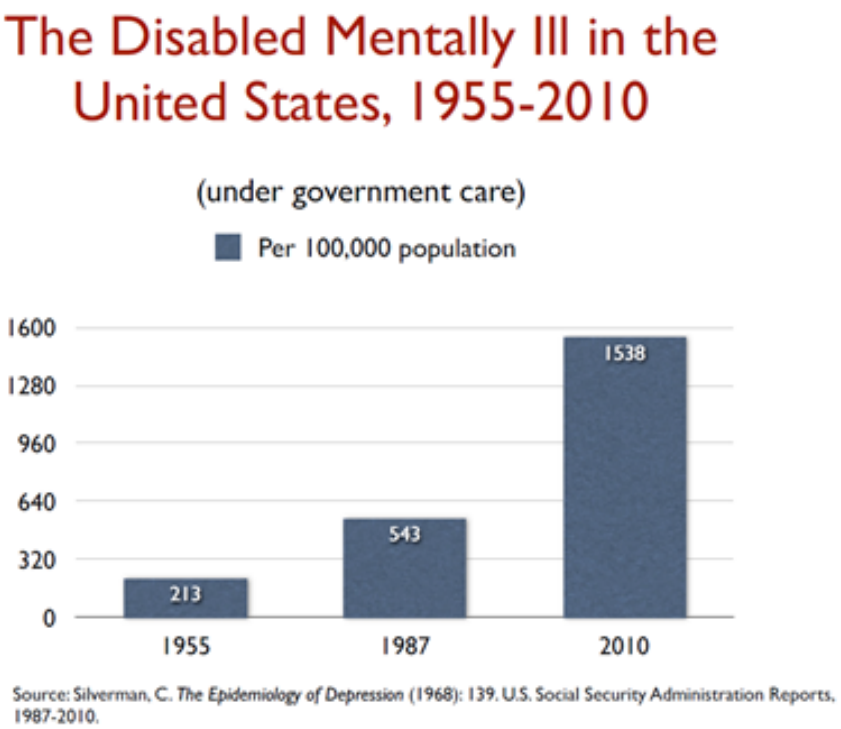
[1] "White Paper is defined by Oxford Languages as "a government or other authoritative report giving information or proposals on an issue."

[2] The term "psychiatric incarceration," is used because it is an honest description. In fact the definition of "inmate" is, "A resident of a dwelling that houses a number of occupants, especially a person confined to an institution, such as a prison or hospital." (The American Heritage Dictionary, 4th Ed., emphasis added). Euphemisms such as "involuntary commitment" obscure the true nature of what is being done to people in the name of their mental health.

[3] The charts in this letter are from talks given by award winning journalist, Robert Whitaker, author of *Anatomy of an Epidemic* and *Mad in America*, including his July 16, 2021, talk to the Soteria Network in



We now see a recovery rate of only 5% for people diagnosed with schizophrenia who are maintained on neuroleptics, the family of chlorpromazine-like drugs.[4] No less an authority than Thomas Insel, who for 12 years was Director of the National Institute of Mental Health (NIMH), frankly stated in 2009 and repeatedly thereafter, "despite five decades of antipsychotic medication and deinstitutionalization, there is little evidence that the prospects for recovery have changed substantially in the past century."[5]

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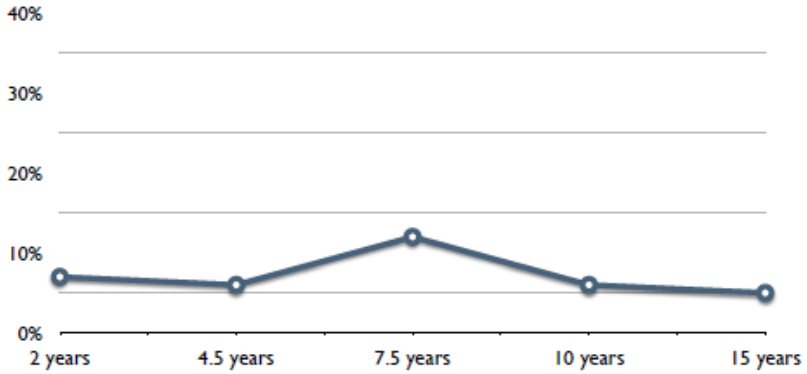
the UK, "Soteria Past, Present, and Future: The Evidence For This Model of Care." This one hour talk is highly recommended.

[4] Marketed as "antipsychotics" even though they don't have specific anti-psychotic effects.

[5] Insel, TR. Translating scientific opportunity into public health impact. *Archives of General Psychiatry*. 2009; *66*(2): 128-133.

Long-term Recovery Rates for Schizophrenia Patients on Antipsychotics

(Martin Harrow's study)



Source: Harrow M. "Factors involved in outcome and recovery in schizophrenia patients not on antipsychotic medications." *Journal of Nervous and Mental Disease* 195 (2007):406-14.

This is far worse than anything seen before the advent of the neuroleptics in the mid-1950's.

Outcomes in Select Studies from Pre-Antipsychotic Era

(Patients diagnosed as insane, schizophrenic or psychotic)

Study	Time	Good Outcome*
York Retreat	1796-1811	70%
Worcester Asylum	1833-1846	65%
Pennsylvania Hospital	1841-1882	45% to 70%
Warren State Hospital	1946-1950	73%
Delaware Hospital	1948-1950	70%
Boston Psychopathic Hospital	1947-1952	76%
Norway	1948-1952	63%
California FEP study	1956 (no neuroleptics)	88%

* Good outcome = discharge from hospital, or living in community at end of study period

Yet if we try to avoid the use of neuroleptics when people experience their first psychotic break a nearly 80% recovery rate can be achieved. The following chart shows results from the "Open Dialogue" program in Northern Finland in which the use of neuroleptics is avoided if possible.

Open Dialogue in Northern Finland

(Results for First-Episode Patients at Five Years)

Patients (N = 75)	
Schizophrenia (N = 30)	
Other psychotic disorders (N = 45)	
Antipsychotic Use	
Never exposed to antipsychotics	67%
Occasional use during five years	33%
Ongoing use at end of five years	20%
Psychotic Symptoms	
Never relapsed during five years	67%
Asymptomatic at five-year followup	79%
Functional Outcomes at Five Years	
Working or in school	73%
Unemployed	7%
On disability	20%

Source: J. Seikkula. "Five-year experiences of first-episode nonaffective psychosis in open-dialogue approach." Psychotherapy Research 16 (2006): 214-28.

Similar results were achieved during the Soteria-House study in the 1970s conducted by Loren Mosher, MD, then Chief of Schizophrenia Research at the NIMH. Soteria House was staffed by non-professionals and involved no immediate use of antipsychotics.

Soteria-House Study

At six weeks, psychopathology reduced comparably in both groups.

At two years:

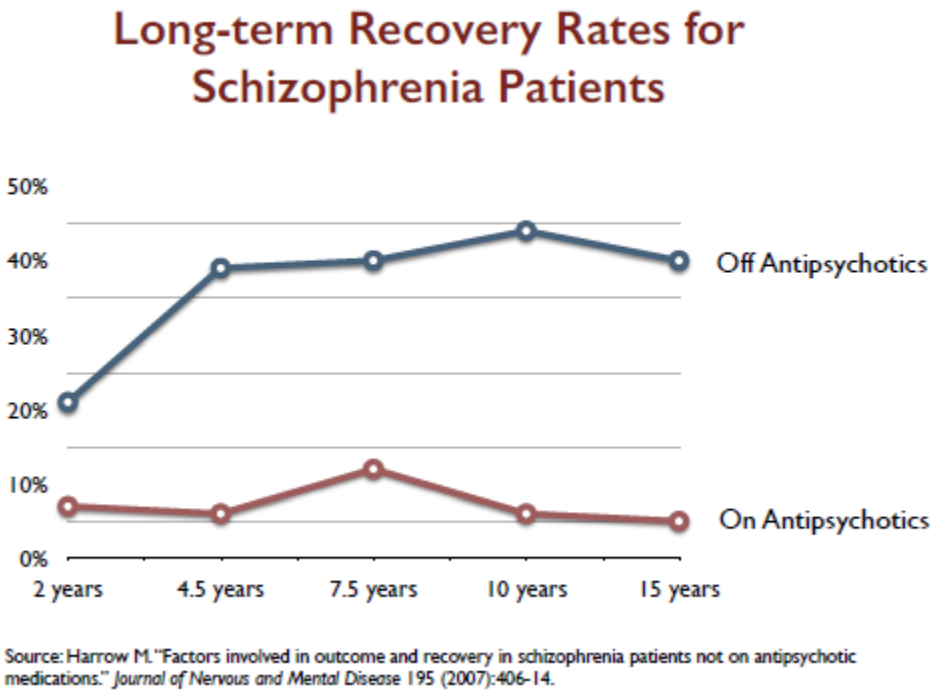
- Soteria patients had better psychopathology scores
- Soteria patients had fewer hospital readmissions
- Soteria patients had higher occupational levels
- Soteria patients were more often living independently or with peers

Antipsychotic Use in Soteria Patients:

- 76% did not use antipsychotic drugs during first six weeks
- 42% did not use any antipsychotic during two-year study
- Only 19 % regularly maintained on drugs during follow-up period

J Nerv Ment Dis 1999; 187:142-149,
J Nerv Ment Dis 2003; 191: 219-229

Moreover, the recovery rate of people who get off of neuroleptics after they have been on them goes from 5% to 40%.



Source: Harrow M. "Factors involved in outcome and recovery in schizophrenia patients not on antipsychotic medications." *Journal of Nervous and Mental Disease* 195 (2007):406-14.

While this is 8 times better than staying on them (40% vs. 5%), it is half of what can be achieved by avoiding the use of neuroleptics in the first place as established by the Open Dialogue and Soteria House studies, both of which achieved close to an 80% recovery rate.[6] **This demonstrates the importance of avoiding the use of neuroleptics.** In addition to their lives being so much better, allowing 16 times more people to recover not only saves a tremendous amount of treatment expense, it converts people who would otherwise be receiving life-long publicly paid services and transfer payments into productive, taxpaying citizens. [7]

In this 15-year longitudinal study, as shown, Harrow and Jobe reported the recovery rate for schizophrenia patients off medication was eight times higher than for those who stayed on the

[6] While there might not be a 100% overlap between the 80% who recovered and the 80% who were not taking the neuroleptics long term, clearly minimizing the use of the neuroleptics produces dramatically better outcomes.

[7] The best book to understand the impact of psychiatric drugs in general, not just the neuroleptics, is *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America*, by Robert Whitaker, from whose work the foregoing is largely drawn.

drugs.[8] However, they speculated that the less severely disturbed schizophrenia patients were more likely to stop taking neuroleptcs, and this was the reason for the much higher recovery rate for those off neuroleptics, not necessarily that they worsened outcome. Still, they continued to analyze their data over the next years and followed it to a far different conclusion. Five years later, they reported that these schizophrenia patients not on neuroleptics for prolonged periods were significantly less likely to be anxious or psychotic, more likely to have higher levels of cognitive functioning, and more likely to have periods of recovery.[9]

A year later they emphasized the potential harm of antipsychotics by noting poor outcomes as a result of stopping neuroleptics are likely to be temporary chemical withdrawal effects, not a resumption of schizophrenia.[10] They further highlighted that while many patients with less severe symptoms who got off neuroleptics had favorable outcomes, there were also patients with less severe symptoms who stayed on neuroleptics for prolonged periods with no favorable outcomes.

In 2014, they focused on a comparison of patients who remained on antipsychotics permanently and those who stopped taking them. They found 70% of those remaining on the drug were actively psychotic while those who stopped taking them experienced less psychosis, concluding "After the first few years, antipsychotic medications do not eliminate or reduce the frequency of psychosis in schizophrenia, or reduce the severity of post-acute psychosis."[11]

In 2017, they addressed the effect of neuroleptics on patients' ability to work. They found, similarly to the previous study, that patients who stayed on neuroleptics had worse work history than those who stopped taking them. This was even true, regardless of severity of symptoms at baseline. In fact, the work history in the bad prognosis group who stopped taking antipsychotics was superior to the work history in the good prognosis group who continually took antipsychotics.[12]

In 2018 and 2022, they reiterated their previous findings in response to the continued claim by the orthodoxy that less symptom severity was the cause of better outcomes for those off drugs.[13] They again showed that when comparing outcomes for medicated and unmedicated patients in both the "good prognosis" and "bad prognosis" cohorts, those patients not on antipsychotics for 15-20 years had fewer symptoms and better outcomes in the long term.

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[8] Harrow, M. & Jobe, T. (2007). 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, 195(5)*:406-14

[9] Harrow, M., Jobe T., & Faull R. (2012). Do all schizophrenia patients need antipsychotic treatment continuously throughout their lifetime? A 20-year longitudinal study. *Psychological Medicine, 42(10)*:2145-55.

[10] Harrow, M. & Jobe, T. (2013). Does long-term treatment of schizophrenia with antipsychotic medications facilitate recovery? *Schizophrenia Bulletin, 39(5)*: 962–965.

[11] Harrow, M., Jobe T., & Faull, R. (2014). Does treatment of schizophrenia with antipsychotic medications eliminate or reduce psychosis? A 20-year multi-follow-up study. *Psychological Medicine,44(14)*:3007-16.

[12] Harrow, M., Jobe, T., Faull, R., & Yang, J. (2017). A 20-year multi-followup longitudinal study assessing whether antipsychotic medications contribute to work functioning in schizophrenia. *Psychiatry Research, 256*: 267–274.

[13] Harrow, M. & Jobe, T. (2018). Long-term antipsychotic treatment of schizophrenia: does it help or hurt over a 20-year period? *World Psychiatry, 17(2),* 162; Harrow, M., Jobe, T., Tong, L. (2022). Twenty-year effects of antipsychotics in schizophrenia and affective psychotic disorders. *Psychological Medicine, 52(13)*:2681-2691.

Further, they emphasized how the initial poor results of coming of the drugs were likely due to drug withdrawal effects, not schizophrenia returning.

In addition to dramatically reducing the recovery rate, the ubiquitous use of psychiatric drugs reduces the lifespan of people diagnosed with serious mental illness in the public mental illness system by 20 years or so.[14]

In addition to the Open Dialogue and Soteria-House models, proven effective approaches that eschew psychiatric force and avoid the drugs, or at least allow choice, include Community Response Teams, Peer Respites, Warm Lines, Healing Homes, Emotional CPR (eCPR), the Hearing Voices Network. These should be the cornerstones of Alaska's mental health program.

Treatment Should Be Voluntary

More important than eliminating the over-reliance on counterproductive and harmful drugs is eliminating forced psychiatric interventions altogether. These are human rights violations prohibited by international law.

Under Articles 12 and 14 of the United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD) governments are prohibited from denying people decision-making authority, from confining people, or administering any other psychiatric intervention on the basis of a disability, including being diagnosed with a mental illness.[15] The UN has repeatedly stated such unwanted psychiatric interventions can amount to torture.[16] The CRPD was signed by President Obama in 2009, but has not been ratified by the United States Senate. Nonetheless, Alaska's mental health system should stop violating international law.

Alaska's mental health system should stop violating international law.

Many effective and non-coercive services exist for the treatment of mental health patients. Unfortunately, even backed by scientific evidence such programs have not been brought to scale and therefore not widely available. They are psychosocially focused; not medically focused, and not coercive. While they differ because they have been developed within different geographical and cultural contexts, they share the following values:

1. Voluntariness and **informed** choice.
2. Relationships as the first line of treatment.

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[14] See, various studies at Neuroleptics at PsychRights.org.

[15] Because there was a general misunderstanding of the scope of Article 12 of the CRPD, the United Nations Committee on the Rights of persons with Disabilities issued General Comment No. 1 (2014) to clarify that taking away someone's decision making rights and forced psychiatric treatment are prohibited. See, also, Guidelines on the right to liberty and security of persons with disabilities (The practice of detaining people on the grounds of actual or perceived impairment provided there are other reasons including that they are deemed dangerous to themselves or others is incompatible with article 14).

[16] United Nations Human Rights Council, Resolution 43/13, June 19, 2020; Torture and other cruel, inhuman or degrading treatment or punishment Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, March 20, 2020; Statement by Mr. Juan E Méndez, Special Rapporteur On Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 22nd session of the Human Rights Council of the United Nations.

3. Respect for the individual and their life experience.
4. Emphasizing community inclusion (continuing to participate as student, worker, family member).

While the Legislation was ultimately supported by Gottstein and not opposed by Myers because it was a potential improvement over the current system of calling police and bringing people to the psychiatric emergency room or hospital in handcuffs, that part of the Crisis Now approach consisting of psychiatric incarceration is harmful and counterproductive.

A tenet of the C/S/X[17] or Consumer/Survivor movement is, "If it is not voluntary it is not treatment." Dr. Loren Mosher testified at the trial in *Myers v. Alaska Psychiatric Institute*[18] that involuntary treatment should be difficult to implement and should be used only in the direst of circumstances. He continued:

> [I]n the field of psychiatry, it is the therapeutic relationship which is the single most important thing. . . . Now, if because of some altered state of consciousness, somebody is about to do themselves grievous harm or someone else grievous harm, well then, I would stop them in whatever way I needed to. . . . In my career I have never committed anyone. . . . I make it my business to form the kind of relationship [through which the mentally ill person and I] can establish a[n] ongoing treatment plan that is acceptable to both of us.[19]

Unwanted psychiatric interventions are violence perpetrated against the patient. Restraining psychiatric patients, pulling down their pants and injecting them with psychiatric drugs they do not want is violence, justified on the grounds patients don't know what is good for them. Patients protesting what is true—that the drugs hurt them and do not help—are said to be delusional and the statements cited to prove they "lack insight" and should be drugged against their will.[20] That this occurs every day does not make it right.

Forced psychiatric interventions are not for the benefit of patients; they are to manage troublesome people.

> [The] coercive function is what society and most people actually appreciate most about psychiatry. That families and other people in crisis can call upon the police to restrain someone acting in a seemingly incomprehensible or dangerous way

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[17] "C/S/X" stands for Mental Health **C**onsumers, Psychiatric **S**urvivors, and e**X**-patients, and are together "people with lived experience."

[18] 138 P3d 238 (Alaska 2006).

[19] Transcript, *In the Matter of F.M.*, Anchorage Superior Court, Case No. 3AN-02-00277 CI, page 177.

[20] Tasch, Gail & Gøtzsche, Peter C (2023): Systematic violations of patients' rights and safety: forced medication of a cohort of 30 patients in Alaska, *Psychosis*, DOI: 10.1080/17522439.2023.2183428: https://doi.org/10.1080/17522439.2023.2183428; Gøtzsche PC, Sørensen A. Systematic violations of patients' rights and safety: Forced 529 medication of a cohort of 30 patients. Ind J Med Ethics. 2020;Oct-Dec;5(4) NS: 312-8.

and have that person taken by force to a place run by psychiatrists is truly where psychiatry as a profession distinguishes itself.[21]

Inpatient Hospitalizations Associated with Astronomically Higher Suicide Rates

Similarly, the idea people need to be psychiatrically incarcerated to keep them from harming themselves is directly challenged by suicides dramatically increasing following hospitalization. For example, a 2019 study concluded: "Among patients recently discharged from psychiatric hospitalization, rates of suicide deaths and attempts were far higher than . . . in unselected clinical samples of comparable patients."[22]

Another study of all suicides in Denmark between 1981 and 1997, found the risk of suicide 102 times higher for men and 246 times higher for women in the first week after discharge (compared to hundreds of thousands of control subjects matched for age, sex, and calendar time of suicide).[23] These rates decline the longer someone is hospitalized and after discharge, but still greatly exceed what would be expected.[24]

Gøtzsche describes another Danish study in his 2015 book, *Deadly Psychiatry and Organized Denial*:

> The fact that forced treatment can be fatal was recently underlined in a Danish register study of 2,429 suicides.[25] It showed that the closer the contact with psychiatric staff – which often involves forced treatment – the worse the outcome. Compared to people who had not received any psychiatric treatment in the preceding year, the adjusted rate ratio for suicide was six for people receiving only psychiatric medication, eight for people with psychiatric outpatient contact, 28 for people with psychiatric emergency room contacts, and 44 for people who had been admitted to a psychiatric hospital. Patients admitted to hospital would of course be expected to be at greatest risk of suicide because they were more ill than the others (confounding by indication), but the findings were robust and most of the potential biases in the study were actually conservative, i.e. favoured the null hypothesis of there being no relationship. An accompanying editorial noted that there is little doubt that suicide is related to both stigma and trauma and that it is entirely plausible that the stigma and trauma inherent in psychiatric treatment –

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[21] It's the Coercion Stupid, by author David Cohn, *Mad in America*. See, also, Mad Science: Psychiatric Coercion, Diagnosis, and Drugs, by Stuart A. Kirk, Tomi Gomory, and author David Cohen, Routledge 2015.

[22] Forte A, Buscajoni A, Fiorillo A, Pompili M, Baldessarini RJ., Suicidal Risk Following Hospital Discharge: A Review Suicidal Risk Following Hospital Discharge: A Review, Harvard Review of Psychiatry, 2019 -27(4) p 209-216.

[23] Qin P, Nordentoft, Suicide Risk in Relation to Psychiatric Hospitalization: Evidence Based on Longitudinal Registers, Arch Gen Psychiatry. 2005;62(4):427-432.

[24] Id.

[25] Hjorthøj CR, Madsen T, Agerbo E, et al. Risk of suicide according to level of psychiatric treatment: a nationwide nested case-control study. Soc Psychiatry Psychiatr Epidemiol 2014;49:1357–65.

> particularly if involuntary – might cause suicide.[26] The editorialists believed that a proportion of people who commit suicide during or after an admission to hospital do so because of conditions inherent in that hospitalisation.

Thus, the notion someone should be incarcerated to prevent suicide is fallacious, even ridiculous.[27] If the best society has to offer someone grappling with a life-and-death decision is to remove their agency and lock them up until they say what others want to hear, then it is easy to imagine why people would lose faith in society's ability to help them, and be more likely to commit suicide as soon as they are released.

The Trauma of Forced Drugging

In addition to the other state-sanctioned violence inflicted on psychiatric inmates, forcing unwanted psychiatric drugs into a patient (forced drugging), especially when the patient is knowledgeable about their counterproductive and harmful effects, is traumatic, often extremely so. The Legislation explicitly recognizes this in §36(a)(4)(C), by defining "traumatic event" to include "being administered medication involuntarily."

Even when a patient agrees to take the drug(s), they are not giving informed consent because they are not informed about the likely or common outcomes of taking the drugs. While some states have changed this, at common law, failure to obtain informed consent constitutes a battery.[28] Again, this recognizes forced drugging is violence perpetrated against the patient.

The Legislation prohibits the Crisis Stabilization and Crisis Residential Centers from administering psychiatric drugs except in an emergency under AS 47.30.838. That statute has very strict requirements, including it can only be used when immediate use of the drug(s) is required "to preserve the life of, or prevent significant physical harm to, the patient or another person." It can be safely assumed that without a vigorous enforcement mechanism, preferably through effective representation of patients, these strict requirements will be ignored. In Chapter 11 of Gottstein's book, *The Zyprexa Papers*, there is an example of just that by a psychiatrist at API who invoked the emergency drugging statute without having any idea of the law's requirements. In 2003, when Myers was incarcerated at API and it was prohibited from drugging her under the nonemergency provisions of AS 47.20.839 pending consideration of her appeal to the Alaska Supreme Court, API illegally invoked emergency drugging under AS 47.30.838 when Ms. Myers got frustrated and dumped some crayons on a staff members head. Forced drugging was hardly necessary to preserve the life or prevent significant harm to anyone as required by law.

In short, unwanted psychiatric drugging is traumatic, counterproductive and harmful, and should be eliminated.

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[26] Large, MM, Ryan CJ. Disturbing findings about the risk of suicide and psychiatric hospitals. Soc Psychiatry Psychiatr Epidemiol 2014;49:1353–5.

[27] See, e.g., Harris, Leah. (2023). You Can't Coerce Someone Into Wanting to Be Alive: The Carceral Heart of the 988 Lifeline, by Leah Harris, *Mad in America*.

[28] Gottstein, James B. (2007). Psychiatrists' Failure to Inform: Is There Substantial Financial Exposure?, *Ethical Human Psychology and Psychiatry*, Volume 9, Number 2, 2007.

The Power of Peer Support

In stark contrast, Peer Support is a proven approach for fostering recovery, i.e., much better outcomes for people who experience what is sometimes called "extreme states" or "psychosis" and diagnosed as serious mental illness such as schizophrenia and bi-polar disorder.[29] Peer Support arose from the Consumer/Survivor Movement and is steeped in the use of relationship and support to help people get through a crisis or difficult time that is otherwise likely to result in hospitalization or some other form of hospital emergency services.[30]

> Peer-developed peer support is a non-hierarchical approach with origins in informal self-help and consciousness-raising groups organized in the 1970s by people in the ex-patients' movement. It arose in reaction to negative experiences with mental health treatment and dissatisfaction with the limits of the mental patient role. Peer support among people with psychiatric histories is closely intertwined with experiences of powerlessness within the mental health system and with activism promoting human rights and alternatives to the medical model.[31]

It is defined by the use of people who have lived experience of extreme states and/or the behavioral health system; "lived experience" for short. Most have experienced psychiatric incarceration and forced drugging and/or electroshock.

The magic of peers is (1) their ability to relate and connect to people currently ensnared in the mental health system through shared experience and (2) they belie the mental health system's message of hopelessness by their example of recovery. True Peer Support is egalitarian and based on respect, reciprocity, validation, self-help and mutual aid. Peer Support is always voluntary.

The dramatic success of peer support has led the Substance Abuse and Mental Health Services Administration (SAMHSA) to designate it as an evidence based practice[32] and it is now a Medicaid reimbursable service. This has also unfortunately led to the perversion of peer support, especially when incorporated into traditional mental health programs.[33] It is not just the lived experience that works its magic; it must be combined with true Peer Support Principles. SAMHSA articulates the following core competencies for behavioral health peer workers.[34]

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[29] See, Evidence for Peer-Run Crisis Alternatives at the National Empowerment Center, footnote omitted.

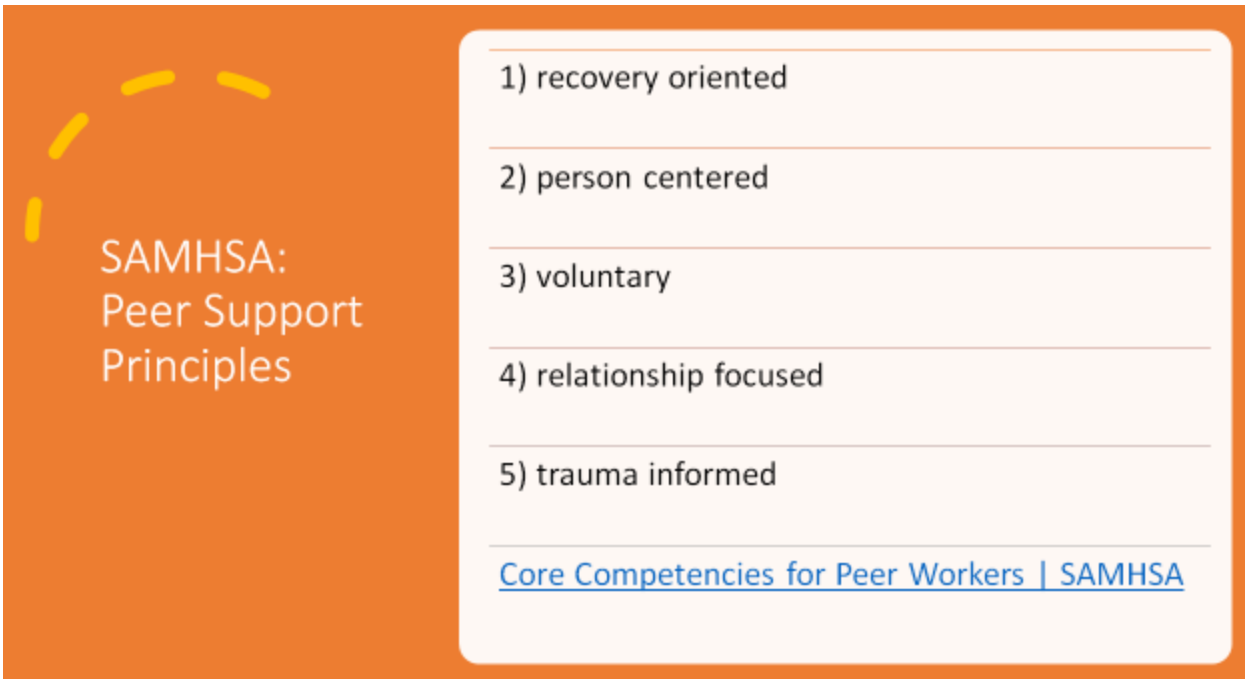
[30] Judi Chamberlin's 1978 *On Our: Patient-Controlled Alternatives to the Mental Health System*, National Empowerment Center, is considered to have started this approach in the modern era.

[31] Darby, Penney, Who Gets to Define Peer Support, *Mad in America*, February 10, 2018.

[32] See, e.g., SAMHSA Advisory, Peer Support Services in Crisis Care, June, 2022.

[33] Alberta and Ploski (2014). Cooptation of Peer Support Staff: Quantitative Evidence. *Rehabilitation Process and Outcome*:3 25–29 doi:10.4137/RPO.S12343.

[34] Core Competencies for Peer Workers in Behavioral Health Services.



A peer specialist who is tasked with medication compliance, for example, is not engaging in true peer support and is not likely to achieve any more success than traditional mental health services. Thus, it is especially important to maintain fidelity to Peer Support Principles.[35] It is pointless and counterproductive to deploy peers in violation of Peer Support Principles.

It is pointless and counterproductive to deploy peers in violation of Peer Support Principles.

Children and Youth Should Not be Given Psychiatric Drugs

The psychiatric drugging of children and youth, especially those on Medicaid and in foster care, is perhaps the most heartbreaking and tragic example of the misuse of psychiatric drugs. They are told there is something incurably wrong with their brain, their unacceptable behavior is the result of this defect and not their fault, they need to take debilitating psychiatric drugs for the rest of their lives, and the best they can hope for is to minimize psychiatric hospitalizations. These are exactly the wrong messages to give to children and youth.

One of the most important things children and youth should learn is how to cope with their emotions without engaging in unacceptable behavior. In other words, take responsibility for their behavior. We should not be telling children and youth they are defective. And parents should be helped to achieve this.

One of the terms of the multi-state settlement of consumer fraud claims regarding the illegal marketing of the prescription drug Neurontin® was funding a rigorous review of

[35] The International Peer Respite/Soteria Summit (Summit) has posted a 35 minute video of one of its Mentoring Circle's meetings discussing this, Navigating a Misguided System.

psychiatric drugs administered to children and youth. This resulted in the *CriticalThinkRx* curriculum as a series of eight modules.

- Module One: Why a Critical Skills Curriculum on Psychotropic Medications?
- Module Two: Increasing Use of Psychotropics: Public Health Concerns.
- Module Three: The Drug Approval Process.
- Module Four: Pharmaceutical Industry Influences on Prescribing.
- Module Five: Specific Drug Classes: Use, Efficacy, Safety.
- Module Six: Non-Medical Professionals and Psychotropic Medications: Legal, Ethical and Training Issues.
- Module Seven: Medication Management: Professional Roles and Best Practices.
- Module Eight: Alternatives to Medication: Evidence-Based Psychosocial Interventions

There are also eight videos of 10-20 minutes each on these modules.

Chapter Seven of *Drugging Our Children: How Profiteers Are Pushing Antipsychotics on Our Youngest, and What We Can Do to Stop It*,[36] by child psychiatrist Tony Stanton describes, Seneca, the extremely successful non-drug residential program where the most difficult youth were sent. It turned out whether the success achieved at Seneca was lasting depended upon the environment to which the youth was returned. This illustrates that rather than blaming parents, we should be helping them raise their children to be resilient and successful. While there are some parents who deliberately abuse their children, almost all want the best for them and do the best they know how. We should help them to successfully raise their children. We should invest in parents' and children and youths' success, not abusive kid-drugging prisons.[37]

Exit Interview/Survey

That there is no credible evaluation of patient views of their inpatient experience demonstrates the system's disdain for the people it purports to help. There should be a requirement for statewide independent exit polls asking every psychiatric inpatient questions such as:

- "Were you injured during treatment or transportation?"
- "Were you treated with dignity and respect?"
- "Were you traumatized?"
- "Did the patient advocate help you?"
- "Were you told you had a right by state law to bring your grievance to an impartial body?"

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[36] Praeger, 2012.

[37] The abuses by psychiatrically incarcerated children and youth by North Star Hospital and the over one hundred 2022 police calls have recently made the news. The very profitable abuse by what is called the Troubled Teen Industry, to whom Alaska regularly sends its children, has been the subject of recent exposés. See, e.g., Can You Punish A Child's Mental Health Problems Away?, *The New York Times*, October 11, 2022.

- "Did the grievance and appeal process work?"
- "Was your stay in the psychiatric facility beneficial?"
- "Were you treated fairly in the grievance and appeal process?"
- "Would you recommend this to someone in distress or crisis?"

Acute care psychiatric patients being treated in a facility often feel they cannot give honest answers to hospital staff in a patient survey because of the reasonable fear of retaliation. For the best results, patients must be able to trust who is asking questions. All surveys should be done by someone outside the Department of Health or hospital staff. To the extent they can be conducted after a person is discharged that would also help with fear of retaliation.

Number of Involuntary Commitments, Forced Drugging Proceedings and Outcomes

The State should keep track of the number of involuntary commitment and force drugging proceedings, the results of such proceedings and patient outcomes. Related counts and metrics should be kept, distributed to the Legislature annually with an accompanying report, and made available to the public in aggregate form. They should also be acted upon.

Both the number of proceedings and the number of unique individuals must be counted, to determine how many multiple proceedings occur to the same persons. The duration of detentions, whether short or longer-term, must be determined, as by definition these constitute a deprivation of liberty. The basic socio-demographic characteristics of people who are involuntarily committed should be recorded, in order to determine whether there exist disparities in the frequency of detentions among different socio-economic and racial groups.

Since the goals of any psychiatric intervention should be to improve people's lives, these must be evaluated independently at appropriate follow-ups. In other words, did the person recover? Finish school or gain employment? Have relationships? Stay out of the hospital or jail? Housed? The State should commission independent researchers to determine whether people subject to proceedings committed suicide following their discharge. Without such key metrics, a mental health system cannot meaningfully pursue any reform or even simply evaluate its performance, nor can it provide basic accountability to the public about what it does.

Peer Respites

Peer respites are voluntary, short-term, overnight programs that provide community-based, non-clinical crisis support to help people find new understanding and ways to move forward. They operate 24 hours per day in a homelike environment and were designed as psychiatric hospital diversion programs to support individuals experiencing or at-risk of a psychiatric crisis. Typically, people can stay for 7-10 days at Peer Respites.

The premise behind Peer Respites is that psychiatric emergency services can be avoided if non-coercive supports are available in the community. They are 100% staffed and operated by people who have lived experience of extreme states and/or the behavioral health system and are either operated by a peer-run organization, or has an advisory group with 51% or more members having lived experience.[38]

[38] This description of Peer Respites was pulled from the website of Live and Learn, Inc.

Since the first completely peer operated respite house was developed in 1997 in New Hampshire by Shery Mead (the originator of Intentional Peer Support—the approach implemented as a foundation of the house) —they have proliferated around the country because of their outstanding success.[39] Three prominent Consumer Operated Service Programs (COSPs), that operate peer respites are the People USA's Rose Houses in New York State, Wildflower Alliance in Massachusetts, formerly known as the Western Massachusetts Recovery Learning Community and the Promise Resource Network in Mecklenburg, North Carolina. All three have a lot of information about how these kinds of programs should be operated.

The International Peer Respite/Soteria Summit has posted a five minute video on YouTube, How Afiya House Helped Me, pulled from the December 5, 2021, follow-up day that provides a good picture of how a Peer Respite approaches people who would otherwise be locked up in a psychiatric hospital and the tremendously beneficial effects of such an approach.

To the extent the Crisis Stabilization and Crisis Residential Centers lock up people who are experiencing what characterized as an acute behavioral health crisis, just not in a hospital, it is a fundamentally misguided approach. Instead, Peer Respites or programs with a similar non-coercive approach should be utilized, such as Soteria Houses, Open Dialogue, and eCPR.

World Health Organization Recommendations

In 2021 the World Health Organization published *Guidance on Community Mental Health Services: Promoting Person-Centered and Rights-Based Approaches*, identifying these key points consistent with the recommendations found in this White Paper:

- Many people with mental health conditions and psychosocial disabilities face poor quality care and violations of their human rights, which demand profound changes in mental health systems and service delivery.
- In many parts of the world examples exist of good practice, community-based mental health services that are person-centered, recovery-oriented and adhere to human rights standards.
- In many cases these good practice, community-based mental health services show lower costs of service provision than comparable mainstream services.
- Significant changes in the social sector are required to support access to education, employment, housing and social benefits for people with mental health conditions and psychosocial disabilities.
- It is essential to scale up networks of integrated, community-based mental health services to accomplish the changes required by the CRPD.

Housing

In Dr. Loren Mosher's affidavit in the *Myers* case, he testifies, "Without adequate housing mental health 'treatment' is mostly a waste of time and money." The United Nations Convention on the Rights of Persons with Disabilities (CRPD) promotes the right to housing for persons with disabilities including the right to a secure home and community. Housing is an important

[39] There is a somewhat outdated list at the National Empowerment Center website.

determinant of mental health and an essential part of recovery. Addressing adequate housing is not only a human right, but also a public health priority.

The Housing First approach was pioneered in the 1990s by two prominent organizations, Pathways to Housing in New York City and by what was then called the Downtown Emergency Service Center in Seattle, Washington (DESC).[40] Its underpinnings were person-centered—asking people on the street "what do you need or how can I help you?" They didn't say counselling. They didn't say medication—they said "a home" and to not have strings attached. There is evidence to support the beneficial effects of the Housing First approach on people's quality of life, including dimensions such as community adjustment and social integration, and some aspects of health. As the research base is growing in favor of this approach, the Housing First model is now expanding across European countries and has even become national policy in Finland. Alaska has a small Housing First program and should adopt the Housing First approach across the board, providing no strings attached adequate housing to all patients who do not have such housing. It will be money well spent, reducing other costs, likely by multiples.

Employment

Behind housing, employment is perhaps the most important therapeutic element for people diagnosed with serious mental illness. In a 30-year longitudinal research study conducted using more 269 subjects who were discharged from the back wards of public institutions, it was found the strongest link to successful recovery and integration into community roles was involvement in community based rehabilitation, particularly vocational rehabilitation leading to employment.[41]

In Employment is a Critical Mental Health Intervention, Robert E. Drake and Michael A. Wallach, state "[E]mployment improves the mental health and wellbeing of people with serious mental disorders, including improved self-esteem, symptom control, quality of life, social relationships and community integration, without harmful side effects."[42] Drake and Wallach do an excellent job of summarizing the data on employment, including the following:

> "The great majority of people with serious mental disorders desire employment as a primary treatment goal (Wescott et al., 2015)."
>
> "[P]eople with mental disorders view 'recovery' as a meaningful, active, functional life, not as a complete absence of symptoms (Deegan, 1988). People can learn to tolerate and cope with symptoms if they have a life that they consider valuable."

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[40] See, What is Housing First?

[41] DeSisto, Harding e.t al., The Maine and Vermont Three-Decade Studies of Serious Mental Illness: I. Matched Comparison of Cross-Sectional Outcome, originally published in the *British Journal of Psychiatry* 1995, 167, 331-342.

[42] Employment is a Critical Mental Health Intervention, by Robert E. Drake and Michael A. Wallach Epidemiology and Psychiatric Sciences 29, e178, 1–3 (2020), citing Drake RE, Frey W, Bond GR, Goldman HH, Salkever D, Miller A, Moore TD, Riley J, Milfort R and Hale T (2013) Can Social Security Disability Insurance beneficiaries with schizophrenia, bipolar disorder, or depression return to work? American Journal of Psychiatry 170, 1433–1441.

"They want a safe apartment; a part-time job; and the chance to meet people, have friends, contribute to society and participate in community life that comes with a job and a modest income. They also value the secondary benefits – a positive identity, structure to the day, enhanced self-esteem, friends at work, less interaction with the mental health system and reduced personal and social stigma – gains that do not usually follow hospitalisation, polypharmacy or involuntary treatment."

"[E]mployment is both a critical health intervention and a meaningful outcome for people with serious mental disorders such as schizophrenia, bipolar disorder and depression (Knapp and Wong, 2020). This recognition follows patients' own expressed goals as well as actual work outcomes. People with even the most serious mental disorders report a higher quality of life, greater self-esteem and fewer psychiatric symptoms when they are employed (Luciano et al., 2014)."

" [E]mployment improves the mental health and wellbeing of people with serious mental disorders, including improved self-esteem, symptom control, quality of life, social relationships and community integration, without harmful side effects (Drake et al., 2013)."

"Supported employment is a relatively inexpensive intervention (Latimer et al., 2004) and employment leads to steady reductions in mental healthcare costs over at least 10 years (Bush et al., 2009). "

"[H]elping people with employment should be a standard mental health intervention."

"Helping people with employment should be a standard mental health intervention."

Minimize Patient Injuries

It should go without saying that minimizing patient injuries should be a high priority, but sadly, it is not. Every organization or facility with the ability to detain an individual, either for transport or for psychiatric evaluation, should be required by state law or regulation to make a report to a state agency. Length of time the person is held, reasons. There should also be a requirement to report to a state agency the number and type and cause of patient and staff injuries; the number and type and resolution of patient and staff complaints; and the number, type and cause of traumatic events experienced by a patient; "traumatic event" is defined as being administered medication involuntarily or being placed in isolation or physical restraint of any kind. The statistics shall be made available annually in a report to the Alaska legislature and the general public.

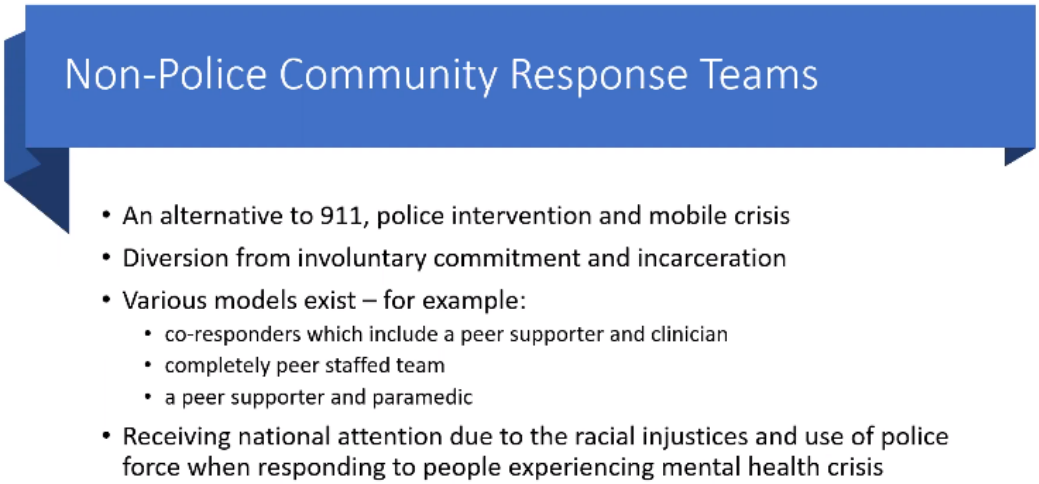
The state should be required to keep and share statistics of psychiatric patient complaints, injuries, and traumatic events

The state should be required to keep and share statistics of psychiatric patient complaints, injuries, and traumatic events.

Non-Police Community Response Teams

It is too early to evaluate the operation of the Crisis Now model in Alaska under the Settlement and Legislation, including Mobile Crisis Teams and there are good aspects of the Mobile Crisis Teams, but taking or referring people people to psychiatric incarceration is not one

of them. Mobile Crisis Teams should be converted to Non-Police Community Response Teams where people are diverted from psychiatric incarceration.



Soteria Houses

The Soteria House approach, whose outstanding outcomes are referenced above, is steeped in the use of relationships and supports to help people get through what is diagnosed as "psychosis." It is a home-like environment focusing on psychological and physical safety through compassionate relationships between staff and residents. The mantra of Soteria House is "be with, rather than do to." There is no pressure to get back on track too quickly which is often fueled by funding and insurance constraints. Residents can stay there until they have a plan to bridge into the community and are recovered from the experience.

Because it is community-based and provides safe housing, residents can maintain their role identities as family members, student workers, etc. The original Soteria House was established in San Jose, California by Loren Mosher, MD, a psychiatrist and schizophrenia expert who was at the time the Chief of Schizophrenia Studies for the National Institute of Mental Health. The original Soteria House was a research project for more than 10 years to answer the question: *Can people newly diagnosed with schizophrenia recover in the community without the conventional treatment of hospitalization and debilitating neuroleptic medications?*

The research demonstrated the typical Soteria resident became stabilized in about six weeks with an average stay of three months. After six weeks, when compared to hospitalized, medicated patients, persons served at Soteria House had similar outcomes. After one and two-year follow-ups the patients treated at Soteria House were doing significantly better than conventionally treated patients in terms of symptoms, rehospitalization, social functioning and employment, thus averting a trajectory of chronic mental illness. With respect to cost:

> In the first cohort, despite the large differences in lengths of stay during the initial admissions (about 1 month versus 5 months), the cost of the first 6 months of care for both groups was approximately $4000. Costs were similar despite 5-month

[43] Community Response Teams, by Cherene Caraco, June 16, 2021, from the CAFE TAC Peer-Run Crisis Alternatives Webinar Series. These are really worth watching.

> Soteria and 1-month hospital initial lengths of stay because of Soteria's low per diem cost and extensive use of day care, group, individual, and medication therapy by the discharged hospital control clients.[44]

Soteria Houses have subsequently been operated in the San Francisco Bay area, Berne, Switzerland, Anchorage AK, Burlington VT and Israel with similar success.

The Burlington, Vermont Soteria home is funded by the state of Vermont and operated by Pathways Vermont. This is a successful example of a partnership between the state, treatment providers and a housing provider. Funding for this good practice service was made possible by the closure of the ineffective coercive state hospital. Alaska is unique, but similar to Vermont in its ruralness, having only a few highly populated areas, and the existence of only one state operated facility. Despite its success, Soteria-Alaska closed due to a change in leadership, direction and vision by the organization, impacted by several factors including, but not limited to the fatigue of acquiring sufficient funding in the face of chronic inadequate financial support from the State and the Trust. A caution for future endeavors--sustainability is impacted, not just by funding but by commitment and fidelity to a vision and historical purpose.[45]

Drug Free Hospitals

Psychiatric inpatients should be given the option of no drugs. In 2010, at the urging of patient organizations, the Norwegian parliament mandated patients be allowed to choose a drug-free psychiatric hospital. As a result, the private Hurdalsjøen Recovery Center was opened and operated with extreme success.[46] Unfortunately, the Norwegian government decided not to continue financially supporting private hospitals, forcing its closure.[47] Alaska, however, should establish a drug-free psychiatric hospital for its citizens.

Cultural Competence

In the 1970s, Doctors at API wrote a 9-page report, titled "A 10-Year History of the Alaska Psychiatric Institute, that included the following:

> The Institute (API) is unique in its cultural-anthropological aspects. Because of the number of Eskimo, Indian and Aleut patients treated here, personnel cannot depend on traditional approaches for its psychiatric treatment plan but must

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[44] Mosher, Loren R. (1999) "Soteria and Other Alternatives to Acute Psychiatric Hospitalization," *The Journal of Nervous and Mental Disease*, 187:142-149, 1999.

[45] Gottstein, Jim. (2015) Lessons from Soteria Alaska, *Mad In America*.

[46] Whitaker, Robert. (2019) Medication Free Treatment in Norway: A Private Hospital Takes Center Stage, *Mad In America*, December 8, 2019.

[47] Whitaker, Robert (2023) A Revolution Wobbles: Will Norway's "Medication-Free" Hospital Survive?, by Robert Whitaker, Mad in America.

include consideration for the tremendous variations of human behavior due to cultural patterns.[48]

API has lost this orientation and should re-establish it.

Open Dialogue Approach

Open Dialogue, cited above, is an approach that focuses on families and individuals who are experiencing what is diagnosable as psychosis. The approach changes the focus from an individual as "the problem" to the whole community as "the solution." Like Soteria and Peer Respites, open communication and relationships are the foundation of the approach. This approach incorporates family therapy and conventional psychodynamic therapy to develop community connectedness leading to high rates of recovery. This approach was developed in Lappland, Finland which like Alaska is in a northern geographic locality with some city centers and many smaller rural and village communities. This approach has strong research behind it having been developed and researched by Jaakko Seikkula with up to 80 % recovery rates with people newly diagnosed with schizophrenia with no to minimal medication use and hospitalization. Open Dialogue or the dialogic approach as it is sometimes called has been replicated in the US and Europe, including New York, Massachusetts, Connecticut and New Mexico. The high rate of recovery demonstrates dramatic daily and lifetime cost savings as well as its social value of role recovery, family recovery, and community recovery.

Experiences from the Open Dialogue approach in Lappland confirm this. Follow-up data after 19 years showed that, compared to the standard approach in Finland, 19% vs 94% had more than 30 hospital days, and disability allowances at some point occurred for 42% vs 79%. Psychosis drugs at onset were used by 20% vs 70%, and at some point by 55% vs 97%. These differences were highly significant ($P < 0.00001$) and so large that they cannot be dismissed with on the grounds it was not a randomized comparison.

Similar to Soteria in Israel, Western Finland has brought this approach to scale meaning that it is the first and preferred treatment.

Hearing Voices Network

The World Health Organization's Report *Guidance on Community Mental Health Services: Promoting Person Centered and Rights based Approaches* endorses the Hearing Voices Network. Hearing Voices Groups bring together people who hear voices, in peer-supported group meetings that seek to help those with similar experiences explore the nature of their voices, meanings and ultimately, acceptance. Hearing Voices Groups have grown in popularity as suppressing voices using medication and other interventions are often ineffective.

The Hearing Voices Movement began in the Netherlands in the late 1980s. It now has national networks in 30 countries. Some groups are co-founded by professionals and closely aligned with mental health services while others are initiated independently by voice hearers. A

[48] Quoted in "Going Crazy in Alaska: A History of Alaska's Treatment of Psychiatric Patients," by Faith J. Myers, BookBaby, 2020. Original available at the University of Alaska Anchorage Consortium Library, Reference Section.

large number of hearing voices groups exist around the world including in the US, Australia, Hong Kong and Uganda. Due to the independent nature of these groups, it is challenging to research outcomes. In spite of limited research, some reported outcomes include: decrease in hospital admissions, voice frequency and use of medication, increase in support that is often otherwise unavailable and better understanding of voice experiences.

> The very low cost Hearing Voices Network approach should be encouraged and facilitated.

This is a low-cost option due to its often grass roots underpinnings. Funding for hearing voices groups comes from different sources depending on the group, including donor funding, some small amounts of out-of-pocket funding, and funding from health services. Minimal costs are involved beyond rent for a weekly meeting space and a possible fee for the facilitator. Groups can be supported by mental health services. Since Alaska has a preponderance of services in the more highly populated locations (and at that a dearth of non-coercive good practice services) with little supports other than community and family in rural areas, this is a good and culturally appropriate option to infuse into Alaska's mental health system.

Warm Lines

Warm lines are different than crisis/suicide lines which often betray callers by having the police dispatched and callers hauled off to the psychiatric hospital in handcuffs even though they advertise themselves as confidential and/or anonymous.[49] This betrayal went national with the rollout of the 988 line, which is an integral part of the Crisis Now Approach implemented by the Legislation. The rationale for the betrayal is they only call for the apprehension of people who are at risk of suicide so they can be incarcerated safely in a psych ward. Not only does this make people unwilling to call the hotline, but as shown above, increases the risk of suicide.

A fundamental principle of warm lines is to only do something the person wants. If they want to go to the hospital—fine. If they don't, that must be respected. Confidentiality is never breached. In order to achieve this, people staffing the warm lines cannot be mandatory reporters. The purpose of a warm line is connection to combat isolation, support through distress, troubleshoot life challenges, and provide information on resources if desired by the caller. They focus on crisis prevention and diversion from hospitals, 911, and mobile crisis.

> Alaska Should Join Those States with Warm Lines

"Standalone peer-run warm lines are garnering national attention as a part of states' responses as they are cost effective, highly utilized and are the most accessible way for people, regardless of age, gender, sexual orientation, race, ethnicity, geography, insurance/no insurance and financial circumstances to get support and prevent emergency

[49] Chapter 10 of the comprehensive and authoritative book on forced psychiatric Interventions, *Your Consent is Not Required*, by investigative reporter, Rob Wipond, documents the tracing of promised confidential and/or anonymous calls and dispatching of police to take people into custody.

department, 911 and involuntary hospital stays."[50] Forty states have Warm Lines, Alaska is not one of them, but should be.

Emotional CPR (eCPR)

Emotional CPR (eCPR) is an educational program designed to teach people to assist others through an emotional crisis[51] by three simple steps:

C = Connecting
P = emPowering, and
R = Revitalizing.

eCPR Training should be made widely available in Alaska.

The Connecting process of eCPR involves deepening listening skills, practicing presence, and creating a sense of safety for the person experiencing a crisis. The emPowering process helps people better understand how to feel empowered themselves as well as to assist others to feel more hopeful and engaged in life. In the Revitalizating process, people re-engage in relationships with their loved ones or their support system, and they resume or begin routines that support health and wellness which reinforces the person's sense of mastery and accomplishment, further energizing the healing process. eCPR is based on the principles found to be shared by a number of support approaches: trauma-informed, counseling after disasters, peer support to avoid continuing emotional despair, emotional intelligence, suicide prevention, and cultural attunement. It was developed with input from a diverse cadre of recognized leaders from across the U.S., who themselves have learned how to recover and grow from emotional crises. eCPR Training should be made widely available in Alaska.

eCPR is to be contrasted with Mental Health First Aid, which funnels people to the traditional mental health system with its message of hopelessness and psychiatric drugging.

Other Innovative Programs, Ionia, Healing Homes, WarFighter Advance

In addition to these programs there should be the opportunity for innovative approaches people and communities develop for themselves. When a community comes up with a solution they want to pursue, there is "buy-in" which succeeds because the community makes it succeed. Such programs are not necessarily susceptible to being replicated because the buy-in is such a critical component.

Ionia in Kasilof is a classic example of this. Five refugee couples from the psychiatric system on the East Coast settled in Kasilof after trying out a number of other locales. They pooled their individually meager assets to purchase land. Stating out in yurts the first winter, they then built cabins with wood stoves. They have a macrobiotic diet, growing as much of their own food as they can, and gathering other food such as seaweed. They have a community

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[50] From presentation b Cherene Caraco, Warm Lines, part of her series of webinars on Peer Run Crisis Alternatives, presented by the Café TA Center.

[51] The terrific book, *Heartbeats of Hope: the Empowerment Way to Recover*, by psychiatric survivor psychiatrist Daniel Fisher includes a description eCPR and its development.

meeting every day to work out conflicts and they consider their simple but hard, close to the earth work therapy. These couples, at least one of which in each were written off as hopelessly mentally ill have created a life that works for them. A whole generation of their children grew up there and there is a blossoming third generation. This is what they say about Ionia:

> Common problems and hopes for a common solution brought five families together in 1987. They purchased five acres of spruce forest on the Kenai Peninsula in South-Central Alaska and Ionia had its beginning. The founders came from different geographic, cultural and socio-economic backgrounds, as well as different kinds of internal hardships and behavioral dysfunction. Through a process of trial and error, the families realized that individuals, families and communities are truly interdependent; that in order to sustainably change one thing, they had to change almost everything; and, that it is impossible to create change without embodying it, together. This kind of thinking has led to Ionia's endurance.
>
> The founding families were in the cold, poor of spirit and hungry for an optimistic direction. Separately, we found our way to simple macrobiotic food and common sense. By gathering, we were able to add the time necessary for real change and recovery.
>
> Growing up at Ionia, the second generation has taken our tools of simple whole food and open explorative thought into renewable energy, natural building, outreach and a huge reservoir of social capital. Ionia's future is the same as everyone else's, except that two decades ago Ionians were under enough pressure to catch a wave of change – and now, Ionia has the shared multi-generational experience to demonstrate and inspire others who also need practical tools and hope.

The point is not that Ionia is a model program that should be replicated, but an example of people finding their own solutions.

Healing Homes operated by the Family Care Foundation in Gothenburg, Sweden, backed by over twenty years of experience, places people who have been failed by traditional psychiatry with host families — predominately farm families in the Swedish countryside — as a start for a whole new life journey without psychiatric drugs. Host families are chosen not for any psychiatric expertise, rather, for their compassion, stability, and desire to give back. People live with these families for upwards of a year or two and become an integral part of a functioning family system. Staff members offer clients intensive psychotherapy and provide host families with intensive supervision. The Family Care Foundation eschews the use of diagnosis, works within a framework of striving to help people come safely off psychiatric drugs, and provides their services, which operate within the context of the Swedish national health service, for free. There is a now-free movie, *Healing Homes*, by Daniel Mackler about this program that has been translated into 20 languages and viewed over 63,000 times. Like Soteria Houses and Peer Respites, Healing Homes provide a home or home-like environment with the expectation people can get through their experiences and come out the other side able to have meaning, purpose and connection in their lives.

Since there are so few family farms in Alaska, it is not directly applicable in Alaska, but the basic approach might be utilized. For example, a homeless Alaskan Native in the big city might be placed with a family in a village and re-connect with their roots. This would be a reversal of the trend of moving people experiencing problems in villages to the cities. A less dramatic reconnecting with roots could be sweat lodges.

Warfighter Advance is another example of a community fashioning a solution. In this case, the community are people who have been deployed to wars overseas and come home with psychiatric diagnoses, put on psychiatric drugs and told there is something wrong with their brain and they essentially have no future. Warfighter Advance changes the trajectory of the warfighter's post-deployment life, so that rather than an existence characterized by an endless cycle of mental illness diagnoses, medications, medical appointments and disappointments, the warfighter has a life characterized by pride, productivity, healthy relationships, continued service, and advocacy for the same outcomes for their fellow service members. Warfighter Advance eschews psychiatric drugs and force, instead encouraging informed consent. It has outstanding results in helping traumatized veterans live fulfilling lives. This program and two of its participants are featured in the award winning documentary film, Medicating Normal.

Allow Medicaid to Reimburse Peer Respites, Soteria Houses, etc., While Maintaining Fidelity to Their Principles

It is not usually recommended to use Medicaid to reimburse good practice services that serve as alternatives to the more conventional system. This is for four reasons:

1. Medicaid is a disease driven reimbursement system and as such uses disease language that is inconsistent with the hopeful language of good practice recovery-driven services such as those described above.
2. Medicaid requires proof of medical necessity which is demonstrated though extensive assessments and documentation that are barriers to easy access to services which is inconsistent with open door approaches to least restrictive community supports.
3. Medicaid for behavioral health services is not just for poor people, but often has requirements and expectations that the person will be exhibiting severe and chronic symptoms that last a lifetime with a goal of stabilization, while good practice recovery services recognize that people experience episodes from which they can recover with the proper supports.
4. The use of a disease reimbursement stream such as Medicaid can affect the way the treatment is delivered because of the documentation and disease language that is required.

Alaska is a "fee for service" Medicaid state, not having gone the managed care route. Managed Care states have some flexibility that Alaska does not have because the managed care companies incur risk and can use reinvestment funding or profits for services that are effective, save money and increase profits in the future. That being said there are changes to the Alaska Medicaid system that would promote health and ensure easier access to some of the good practice services and alternatives to the conventional system, increase choice and ultimately change the trajectory of chronic patienthood to one of valued community member. Some of these proposed changes might require regulations change, but some might be as simple as revising some service definitions or adding services that are consistent with federal regulations and the State Plan. It is understood Medicaid is state and federally funded and as such is subject to federal CMS policies

and regulations. State Plan changes are subject to approval by CMS. However, there are internal documents including the Administrative Policy Manuals overseen by the state mental health authorities that can be revised if they are consistent with federal regulations and the State Plan.

The following recommendations regarding Medicaid are proposed:

1. Review the existing state plan to see if there is any provision for services such as those that are being proposed in the paper (Soteria, Peer Respites, Open Dialogue etc).
2. Review the 1115 Waiver Administrative Policy Manual to see if services can be added or if existing services can be revised to reflect the proposed effective services identified in this paper.
3. Review the payment structure of services. Many of the services proposed here would be most effective with a payment unit being a day or a bundled unit rather than a 15 minute unit.
4. Ensure the reimbursement rates are adequate to provide services as needed to help the individual achieve improved outcomes.
5. If these changes are unsuccessful consider applying for an appropriate waiver or changes to the 1115 Waiver that will allow implementation of the proposed alternatives to the current conventional care.

Finally, a simple fix is for the Behavioral Health Services Division to expand choices to include a full array of services available through state general/MH funds. These could be grant funded or included in provider agreements. This would require shifting current funding or expanding the budget.

V. ENHANCING PATIENT RIGHTS

The Report is required to assess the practical challenges patients face in availing themselves of their rights, and identify and recommend any changes to state statutes, regulations, or other requirements that could enhance patient rights and the practical ability of patients to avail themselves of their rights. Below are what have been identified as the most important changes that should be made.

Effective Legal Representation

The single most effective action needed to "enhance . . . the practical ability of patients to avail themselves of their rights," is for psychiatric respondents to be provided effective legal representation in involuntary commitment and forced drugging proceedings.[52]

Currently, the Alaska Public Defender Agency is automatically appointed in both involuntary commitment and forced drugging cases. Under AS 47.30.700(a), when the Superior

[52] *See*, Gottstein, J., Involuntary Commitment and Forced Psychiatric Drugging in the Trial Courts: Rights Violations as a Matter of Course, 25 *Alaska Law Review* 51 (2008).

Court issues an order for a psychiatric evaluation, it "shall . . . appoint an attorney to represent the respondent." This statute doesn't require it be the Public Defender Agency. With respect to forced drugging, under AS 47.30.839(c), "If the patient cannot afford an attorney, the court shall direct the Public Defender Agency to provide an attorney." This is ignored and the Public Defender Agency is appointed in all cases, at least in Anchorage.

The problem isn't so much that the Public Defender Agency is appointed, but that it is not allowed to provide effective representation because of (1) the large number of cases a single public defender is required to defend on short notice, and (2) the practical inability to bring in an expert witness to counter the testimony of the hospital's staff. As Prof. Michael Perlin has noted,

> [C]ourts accept . . . testimonial dishonesty, . . . specifically where witnesses, especially expert witnesses, show a "high propensity to purposely distort their testimony in order to achieve desired ends." . . .
>
> Experts frequently . . . and openly subvert statutory and case law criteria that impose rigorous behavioral standards as predicates for commitment . . .
>
> This combination . . . helps define a system in which (1) dishonest testimony is often regularly (and unthinkingly) accepted; (2) statutory and case law standards are frequently subverted; and (3) insurmountable barriers are raised to insure that the allegedly "therapeutically correct" 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.[53]

Without giving the lawyers assigned to represent people facing involuntary commitment and forced drugging sufficient time to investigate and prepare a defense and sufficient resources to employ an independent expert witness, the legal proceedings are a sham, amounting to a Kangaroo Court.

Gottstein has estimated that no more than 10% of people who are psychiatrically imprisoned actually meet commitment criteria.[54] This is because the basic criteria for psychiatric incarceration is the state has to prove by clear and convincing evidence that as a result of mental illness one is a danger of serious harm to self or others in the relatively near future, if not imminently. First, people diagnosed with mental illness are not significantly more violent than the general population.[55] Second, psychiatrists are notoriously bad at predicting violence,

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

[54] Gottstein, J. (2005) How the Legal System Can Help Create a Recovery Culture in Mental Health Systems, presented at Alternatives 2005: Leading the Transformation to Recovery, Phoenix, Arizona, October 28, 2005.

[55] The Criminality of the Mentally Ill: A Dangerous Misconception, Linda A. Teplin, Ph.D., *Am J Psychiatry*, 142:593-599, 1985; Fazel S, Gulati G, Linsell L, Geddes JR, Grann M (2009) Schizophrenia and Violence: Systematic Review and Meta-Analysis. *PLoS Med* 6(8): e1000120. doi:10.1371/journal.pmed.1000120; The Intricate Link Between Violence and Mental Disorder: Results From the National Epidemiologic Survey on Alcohol and Related Conditions Eric B. Elbogen, PhD; Sally C. Johnson, MD, *Arch Gen Psychiatry*. 2009;66(2):152-161; .

basically being no better than chance.[56] This has been known for a long time. In fact, in the 1983 United States Supreme Court case of *Barefoot v. Estelle*,[57] the American Psychiatric Association filed an *amicus* brief in which they stated psychiatrists cannot accurately predict violence. Also, see the now free download of the 1984 book by Lee Coleman, MD, *Reign of Error*. A related problem is the treatment patients universally get while psychiatrically incarcerated—psychiatric drugs—often against the person's wishes, are known to cause both violence and suicidality, including in people who have never exhibited these previously to being administered these drugs.[58]

> Before 1955, four studies found that patients discharged from mental hospitals committed crimes at either the same or a lower rate than the general population. However, eight studies conducted from 1965 to 1979 determined that discharged patients were being arrested at rates that exceeded those of the general population. And while there may have been many social causes for this change in relative arrest rates (homelessness among the mentally ill is an obvious cause), akathisia was also clearly a contributing factor.[59]

And, of course, as we have seen, psychiatric incarceration dramatically increases suicides so it cannot be a legitimate basis for locking someone up to prevent self-harm.

The other ground for psychiatric incarceration is they are so disabled they cannot survive safely in freedom with the help of willing family and friends. Psychiatrists are no more able to accurately predict that than serious harm to self or others.[60]

As demonstrated by the information presented above, it cannot be legitimately established that psychiatrically drugging someone against their will is in their best interest under AS 47.30.839. [61] There are no studies showing psychiatric drugs improve patient outcomes.[62]

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[56] See, Judging Risk, California Law Review, by Brandon L. Garrett and John Monahan, Vol. 108, No. 2 (April 2020).

[57] 463 U.S. 880 (1983).

[58] Treatment Emergent Violence To Self And Others; A Literature Review of Neuropsychiatric Adverse Reactions For Antidepressant And Neuroleptic Psychiatric Drugs And General Medications, Catherine Clarke, Jan Evans, Kelly Brogan, *Adv Mind Body Med*: 2019;33(1):4-21.

[59] Whitaker, Robert. (2020). *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill*. New York: Basic Books, citing Rabkin, Judith Godwin, Criminal Behavior of Discharged Mental Patients, *Psychological Bulletin* 86 (1979):1-27.

[60] Franklin, Joseph C., et al., Risk Factors for Suicidal Thoughts and Behaviors: A Meta-Analysis of 50 Years of Research, *Psychological Bulletin* 2017, Vol. 143, No. 2, 187–232.

[61] In challenging the assertion by the state against the patient that drugging them against their will is in their best interest, it is critical patients' attorneys have access to the clinical trial data used to support the state's case because the published reports of such data misrepresent it and are often even ghost-written by the drug company sponsors, with the named authors not even allowed access to the underlying data. *See*, Appendix, "The Science of" by David Healy, MD.

[62] Wipond, R. (2023) "Your Consent is Not Required," Ch. 22, BenBella Books, Dallas, Texas.

Jury Trials for 30-Day Commitment Hearings

Under AS 47.30.745(c) and AS 47.30.770(b), people accused of being mentally ill and as a result dangerous to self or others have the right to a jury trial in 90-day and 180 commitment hearings, respectively. However, they don't for 30-day commitment trials. In *The Zyprexa Papers* Gottstein recounts Bill Bigley having been involuntarily committed in all but one of seventy or so non-jury commitment trials, but found not to meet commitment criteria in the two jury trials he had and was freed. In Systematic Violations of Patients' Rights and Safety: Forced Medication of a Cohort of 30 Patients in Alaska, by Tasch and Gøtzsche, all 29 of the commitment petitions heard by the judge were granted, while in the sole jury trial the jury found the person accused of being mentally ill and dangerous as a result did not meet commitment criteria and was freed.[63]

People accused of being mentally ill and as a result dangerous should have the right to a jury trial to defend against psychiatric incarceration in 30-day commitment proceedings. Criminal defendants have such a right when they are faced with 30-days or less of incarceration and psychiatric respondents are not even being accused of any crime.

To accomplish this, the following could be inserted as subsubsection (1) in AS 47.30.735(b), and the other subsections renumbered:

> (1) The respondent is entitled to a jury trial upon request filed with the court if the request is made before the hearing. If the respondent requests a jury trial, the hearing may be continued for no more than 3 calendar days. The jury shall consist of six persons.

Legitimate, Functioning Grievance Process

Many states, including those with over 100 years more experience in caring for and protecting individuals with a disability than Alaska, have reached the following conclusion: The Federal government and hospital certification organization's patient grievance requirements do not sufficiently protect individuals with a disability in the grievance and appeal process.

AS 47.30.847 requires every evaluation facility or designated treatment facility have a formal grievance procedure, inform patients of its existence and contents, and have a designated staff member trained in mental health consumer advocacy who will serve as an advocate, upon a patient's request, to assist the patient in bringing grievances or pursuing other redress for complaints concerning care, treatment, and rights. AS 47.30.660(b)(12) requires the Department of Family and Community Services and the Department of Health to investigate complaints made by a patient or an interested party on behalf of a patient. None of this is implemented in practice, which has led to virtually no accountability. In 2008, the state Ombudsman in a report made the point that the Department of Health and Social Services had not investigated a psychiatric patient's complaint for 5 years.[64]

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[63] Tasch, Gail & Gøtzsche, Peter C (2023): Systematic violations of patients' rights and safety: forced medication of a cohort of 30 patients in Alaska, *Psychosis*, DOI: 10.1080/17522439.2023.2183428: https://doi.org/10.1080/17522439.2023.2183428.

[64] October 16, 2008, State of Alaska Ombudsman Response to Complaint No. A2015-1822.

Under AS47.30.847 psychiatric patients have a right to bring their grievance to an impartial body, but State agencies have said the CEO of psychiatric hospitals can be the impartial body. Psychiatric patients must be informed up front that they have a right by state law to bring their grievance to an impartial body and patients must be given reasonable access to a trained patient advocate. Reasonable is between the hours of 8 am and 5 pm every work day.

AS47.30.660(b)(12) requires the Department of Family and Community Services and the Department of Health, in fulfilling each department's duties under AS47.30.660 and through each department's divisions responsible for mental health, shall, as applicable[65] to investigate complaints made by a patient or an interested party on behalf of a patient, but AS 47.30.660(b)(13) allows them to delegate their responsibility. This has resulted in no accountability. The Departments of Health and Family and Community Services should not be allowed to shirk their responsibilities this way. AS 47.30.660(b)(13) should be repealed.

AS 47.30.660(b)(13) should be repealed

When Gottstein was on the Alaska Mental Health Board (AMHB) he and others advocated for regulations to be promulgated by the then Division of Mental Health and Developmental Disabilities (DMHDD) to make the grievance rights meaningful in practice. Instead of adopting regulations which are relatively hard to change, DMHDD just included Consumer Grievance Redress Standards for Fiscal Year 2005, which included that all grievances had to be treated as serious and any grievances unresolved to the consumer's satisfaction within 30 days had to be reported to the DMHDD Regional Coordinator pursuant to AS 47.30.660(b)(12). After Gottstein left the AMHB it ceased to be an advocate for an effective grievance process and DMHDD did not include the Consumer Redress Standards as a grant requirement in subsequent years.

There must be a new state law or regulations giving psychiatric patients a right to file a grievance at the time of their choosing. As of now, there is no state law that prevents psychiatric facilities from putting patients through a long, informal complaint process.

The state should improve the grievance and appeal process for all psychiatric patients in acute care psychiatric facilities or units. Independent assistance should be provided to patients who wish to file a grievance or appeal.

Establish in Alaska law or regulations a standardized, state-wide grievance and appeal process that would protect individuals with a developmental disability and individuals diagnosed with a mental illness in the grievance and appeal process. The grievance law or regulations would protect anybody in a locked psychiatric facility or unit or in supportive housing or care. The State should at least adopt the

AS 47.30.847 should be amended to (1) at least include the requirements of the Consumer Grievance Redress Standards for Fiscal Year 2005, and (2) exempt appellants from Civil Rule 82 Fees.

[65] This was a requirement of the Department of Health and Social Services until it was split into the departments of Health and Family and Community Services and Alaska Laws Executive Ord. 2022-121 made the change.

Consumer Grievance Redress Standards or something stronger as regulations.

The patient or client grievance and appeal process would have to have state or independent oversight. The time frame for answering a grievance or appeal would have to have meaning—some individuals are only locked in a psychiatric facility for 72 hours.

Independent assistance must be provided to individuals with a disability when filing a grievance or an appeal. Rights and the grievance and appeal process would have to be fully explained to individuals and/or their guardian, both in written form and verbal.

The State should enforce compliance with AS 47.30.837 by every evaluation facility and designated treatment facility, including private facilities.

There should be established in Alaska law or regulations a standardized, state-wide grievance and appeal process protecting individuals diagnosed with mental illness in the grievance and appeal process. The grievance law or regulations must protect anybody in a locked psychiatric facility or unit or in supportive housing or care. At a minimum, the Consumer Grievance Redress Standards for Fiscal Year 2005 should be promulgated as regulations.

Children and youth have the Constitutional right not to be harmed by psychiatric drugs while in State custody.

The patient or client grievance and appeal process would have to have state or independent oversight. The time frame for answering a grievance or appeal would have to have meaning—some individuals are only locked in a psychiatric facility for 72 hours.

Independent assistance must be provided to individuals with a psychiatric disability when filing a grievance or an appeal. Rights and the grievance and appeal process should have to be fully explained to individuals and/or their guardian, both in written form and verbally. People appealing a grievance to the Superior Court should be exempted from Civil Rule 82 if they are unsuccessful and awarded full, reasonable attorney's fees if they are successful.

Children and Youth Should Not Be Psychiatrically Incarcerated or Drugged

On December 15, 2022, the United States Department of Justice issued a Report on its Investigation of the State of Alaska's Behavioral Health System for Children, finding the State has been violating the Americans with Disabilities Act by psychiatrically incarcerating children and youth rather than provide accessible community-based services. The State has also been sending children and youth to facilities outside the state. These facilities have been exposed as abusive.[66] Children and youth should not be psychiatrically incarcerated or drugged. Kid drugging prisons in Alaska is no solution.

[66] See, e.g., The National Youth Rights Association on "The 'Troubled Teen' Industry," and The American Bar Association's Five Facts About the Troubled Teen Industry.

Children and Youth in State Custody Have the Right Not to be Harmed by Psychiatric Drugging.

Children and youth in state custody such as the juvenile justice system and foster care have the constitutional right not to be harmed by psychotropic drugs through government action or inaction. In 1989 the United States Supreme Court held in *DeShaney v. Winnebago County*[67] that a state did not violate the U.S. Constitution when it discharged a child into the custody of an abusive father, but, when the State takes a person into its custody and holds them there against their will, the Constitution imposes upon it a corresponding duty to assume responsibility for their safety and general well-being. The rationale for this principle is simple enough: when the State by the affirmative exercise of its power so restrains an individual's liberty that it renders them unable to care for themself, and at the same time fails to provide for their basic human needs – e.g., food, clothing, shelter, medical care, and reasonable safety – it transgresses the substantive limits on state action set by the Eighth Amendment and the Due Process Clause. Psychiatric drugs, especially the neuroleptics, are very harmful to children and children and youth have the right under the United States Constitution to be protected from these harms when in state custody.

Conform Definition of Gravely Disabled to Alaska Supreme Court's Wetherhorn Decision

In Section 29 of the Legislation, in order to conform the statute to the Alaska and United States constitution as held in *Wetherhorn v. Alaska Psychiatric Institute*,[68] the definition of "gravely disabled," in subsection (b) of AS 47.20.9915(9) was amended to read:

> (9) "gravely disabled" means a condition in which a person as a result of mental illness
>
> . . . (b) is so incapacitated that the person is incapable of surviving safely in freedom.

However, this only partially conformed AS 37.40.915(9) to the requirements of the United States and Alaska constitutions as held by the Supreme Court in *Wetherhorn*. In a couple of other places the Alaska Supreme Court held a person was only gravely disabled if they were "helpless to avoid the hazards of freedom through their own efforts or with the aid of willing family members or friends."[69] Therefore, "through their own efforts or with the aid of willing family members or friends" should be inserted at the end of AS 37.40.915(9)(b) so it reads, "(b) is so incapacitated that the person is incapable of surviving safely in freedom through their own efforts or with the aid of willing family members or friends."

'Through their own efforts or with the aid of willing family members or friends" should be added to the definition of gravely disabled in AS 47.30.915(9)

[67] 489 U.S. 189,199- 200 (1989).

[68] 156 P.3d 371, 373 (Alaska 2007).

[69] 156 P.3d 371, 376 & n. 27 (Alaska 2007).

Least Restrictive/Least Intrusive Alternatives

In the 1999 United States Supreme Court *Olmstead v. LC*[70] decision it held people with disabilities have a qualified right to receive state funded supports and services in the community when it is determined that the supports are appropriate, the person does not object and the provision of services in the community would be a reasonable accommodation. This decision established that it is the responsibility of the state to provide such service choices even when they are not currently available. This decision was based on the 1990 Americans with Disabilities Act (ADA).[71] The section of this paper on Non-Coercive Good Practices proposes a number of services and supports that are voluntary and are not currently available in Alaska which would be contrary to Olmstead and puts Alaska at risk.

Psychiatric patients are legally entitled to the least restrictive alternative with respect to psychiatric incarceration, and the least intrusive alternative with respect to forced drugging. Technically, if there is a less restrictive or intrusive alternative that could feasibly be provided the state cannot psychiatrically imprison or drug someone against their will.[72] However, as a practical matter there is no alternative if there is no alternative. In other words, judges are reluctant to deny the state's applications to psychiatrically imprison and drug someone because there is a less restrictive or intrusive alternative that could be provided but isn't available. Thus, the way to enhance the practical ability of patients to avail themselves of their right to the least restrictive/intrusive alternatives is to have such alternatives exist for people to use. Proven approaches and programs have already been discussed above.

Insert "Serious" in AS 47.30.730(a)(1), .735(c), & 745(b)

The word "serious" is omitted in some of the statutes allowing people to be confined for being mentally ill and dangerous to themselves or others. For example, under AS 47.30.700(a), the Court may grant an *ex parté* order to be picked up and confined for a psychiatric evaluation if "the respondent is mentally ill and that condition causes the respondent to be gravely disabled or to present a likelihood of serious harm to self or others." (emphasis added). However, in AS 47.30.730(a)(1), a petition for a 30-day commitment need only "allege that the respondent is mentally ill and as a result is likely to cause harm to self or others or is gravely disabled," and in AS 47.30.735(c), the court may grant the 30-day involuntary commitment petition, "if it finds, by clear and convincing evidence, that the respondent is mentally ill and as a result is likely to cause harm to the respondent or others or is gravely disabled." There is no degree of harm specified. AS 47.30.915(12) defines "likely to cause serious harm," but there is no definition of "likely to cause harm," i.e., without the word "serious."

The serious criterion is included in AS 47.30.700, .705, & .710, pertaining evaluations and *ex parté* proceedings, but not in AS 47.30.730(a)(1), & .735(c) pertaining to 30 day commitments. This makes absolutely no sense. Then in the 90 & 180 day commitments of AS 47.30.740 & .770, respectively, to continue the commitments, the petition has to allege the respondent has

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[70] 527 U.S. 581 (1999).

[71] P.L 101-336—July 26, 1990, 104 STAT. 327, codified at 42 U.S.C. § 12101 *et seq*.

[72] As discussed below, the Alaska Supreme Court has acknowledged this with respect to forced drugging, but not for psychiatric incarceration.

attempted to inflict or has inflicted serious bodily harm upon the respondent or another since the respondent's acceptance for evaluation, or that the respondent was committed initially as a result of conduct in which the respondent attempted or inflicted serious bodily harm upon the respondent or another, or that the respondent continues to be gravely disabled, or that the respondent demonstrates a current intent to carry out plans of serious harm to the respondent or another;" (emphasis added).

However, AS 47.30.745(b), applicable to both 90 and 180 day commitments, only requires the court to find "harm," not "serious harm." It also makes absolutely no sense to require the petitions to allege serious harm, but the judge not to have to find it.

In *E.P. v. Alaska Psychiatric Institute*,[73] the Alaska Supreme Court held the definition of "likely to cause serious harm," relevant to interpretation of "likely to cause harm," but this is still confusing to the judges, even if they know about the *E.P.* decision. *See*, March 29, 2022, Letter to Sen. David Wilson, chair of Senate Health & Social Services Committee.

In addition to having the statutes make sense, in order to be constitutional there needs to be a serious level of harm to justify locking someone up for being mentally ill. In *Wetherhorn v. Alaska Psychiatric Institute*,[74] the Alaska Supreme Court ruled the definition of "gravely disabled" unconstitutional in AS 47.30.915(7)(B) to the extent it didn't "require a level of incapacity so substantial that the respondent is incapable of surviving safely in freedom." The Legislation conforms the definition of "gravely disabled" to the *Wetherhorn* decision and there has to be a similar level of harm to self or others to justify locking someone up for being mentally ill. For example, someone couldn't constitutionally be committed for smoking cigarettes even though it is harmful to self (& others).

This fix that fell through the cracks when the Legislation was enacted[75] and is simple to correct. Just insert "serious" before "harm" in AS 47.30.730(a)(1), .735(c), & .745(b).

Define "Feasible"

Prior to the enactment of the Legislation, AS 47.30.839(g) provided in pertinent part, "If the court determines that the patient is not competent to provide informed consent . . . the court shall approve the facility's proposed use of psychotropic medication." This was challenged as unconstitutional by Faith Myers, and in *Myers v. Alaska Psychiatric Institute*,[76] the Alaska Supreme Court held that under the Alaska Constitution, in addition to the statutory requirements, the court must also find, "that the proposed treatment is in the patient's best interests and that no less intrusive alternative is available." In determining the patient's best interests, the Alaska Supreme Court held that at a minimum the Superior Court should consider the information AS

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[73] 205 P.3d 1101, 1110 (Alaska 2009).

[74] 156 P.3d 371, 384 (Alaska 2007).

[75] The places where "serious" was not included in the Legislation were fixed, but places where it was not included in existing statutes were not fixed even though Gottstein identified these in his May 12, 2022, letter to Sen. David Wilson. This was not picked up in the House version of the bill, which was the one ultimately passed.

[76] 138 P.3d 238, 254 (Alaska 2006).

47.30.837(d)(2) directs the treatment facility to give to its patients in order to ensure the patient's ability to make an informed treatment choice.[77] These are:

> (A) an explanation of the patient's diagnosis and prognosis, or their predominant symptoms, with and without the medication;
>
> (B) information about the proposed medication, its purpose, the method of its administration, the recommended ranges of dosages, possible side effects and benefits, ways to treat side effects, and risks of other conditions, such as tardive dyskinesia;
>
> (C) a review of the patient's history, including medication history and previous side effects from medication;
>
> (D) an explanation of interactions with other drugs, including over-the-counter drugs, street drugs, and alcohol; and
>
> (E) information about alternative treatments and their risks, side effects, and benefits, including the risks of nontreatment[.]

These are called "The *Myers Factors*" by the Alaska Supreme Court.[78]

In *Bigley v. Alaska Psychiatric Institute*,[79] the Alaska Supreme Court held that in order for a less intrusive alternative to be available it must be feasible.

Thus, in order to conform the statutes with the Alaska Constitution as held in *Myers* and *Bigley*,[80] Section 25 of the Legislation amended AS 47.30.839(g) at Gottstein's suggestion to read as follows:

> If the court determines by clear and convincing evidence that the patient is not competent to provide informed consent and was not competent to provide informed consent at the time of previously expressed wishes documented under (d)(2) of this section, that the proposed use of medication is in the best interests of the patient considering at a minimum the factors listed in AS 47.30.837(d)(2)(A) - (E), and that there is no feasible less intrusive alternative, the court shall approve the facility's proposed use of psychotropic medication. The court's approval under this subsection applies to the patient's initial period of commitment if the decision is made during that time period. If the decision is made during a period for which the initial commitment has been extended, the court's approval under this subsection applies to the period for which commitment is extended.

A definition of feasible is needed.

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[77] 138 P.3d at 252.

[78] *Bigley*, 208 P.3d at 180.

[79] 208 P.3d 168, 185 (Alaska 2009). Gottstein also represented Mr. Bigley.

[80] 208 P3d 168 (Alaska 2009).

In *Bigley*, the Supreme Court also held that in order to be available, the less intrusive alternative had to be feasible and

> [T]he best interests and least intrusive alternative inquiries under *Myers* are parts of a constitutional test of the validity of API's proposed treatment. If that *Myers* inquiry had lead us to conclude that API's proposed treatment was constitutionally barred, that would not give rise to a legal obligation on API's part to provide Bigley's less intrusive alternative. API could attempt to offer some other form of treatment that was not constitutionally invalid, or could simply release Bigley without treatment (which is what happened in this case).[81]

That the State has to provide a feasible less intrusive alternative or let the person go is correct. However, in *Linda M.* which was tacked onto *Naomi B.*,[82] with respect to involuntary commitment, the Alaska Supreme Court held the State could decide to defund a less restrictive alternative, Soteria-Alaska, and thereby make it infeasible. This is clearly wrongly decided, although, of course, the Alaska Supreme Court is the final authority on the Alaska Constitution.

To illustrate why it is wrong, the State could not constitutionally jail people in Fairbanks in the winter in a facility without heat. It is not a question of the State's obligation to provide a heated facility, but a restriction against jailing someone in an unheated facility when the temperature is 30º F below zero. It is simply not allowed to do so. Similarly, the State is not allowed to involuntarily commit someone if a less *restrictive* alternative could reasonably be used instead, or psychiatrically drug someone against their will if there is a less *intrusive* alternative that could be reasonably provided. This is what the Alaska Supreme Court held in *Bigley* with respect to forced drugging, but got wrong with respect to involuntary commitment in *Linda M.*

As mentioned, *Linda M.* was tacked onto the *Naomi B.* appeal. The reason was that both Linda M. and Naomi B. argued the Alaska Supreme Court should abandon its exception riddled rule announced in *Wetherhorn*[83] that appeals of involuntary commitments and forced drugging orders were moot and therefore should not be considered. In *Naomi B.* and *Linda M.* almost all of the Alaska Supreme Court's 19 page decision was devoted to why it was overruling the mootness decision it had announced in *Wetherhorn*, and barely over one page to the critical question of the State's right to defund a less restrictive alternative and thus be able to prevail on the that there be no less restrictive alternative.

This is not only a very important legal rights issue, but also critical in moving the State towards achieving the possible 80% recovery rate, rather than the 5% recovery rate enforced by the courts when the State is allowed to evade its responsibility to provide the least intrusive feasible alternative. It took twelve years for the Alaska Supreme Court to recognize it had wrongly held involuntary commitment and forced drugging appeals were moot and the Legislature should just go ahead and fix its wrongly decided holding that failure to fund a less restrictive alternative renders it infeasible.

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[81] 208 P3d at 187-188.

[82] 435 P.3d 918 (Alaska 2019).

[83] 156 P.3d 180, *et. seq*.

Therefore, a proper definition of feasible should be added to AS 47.30.915. It is suggested the Alaska Supreme Court's own definition of feasible in *State v. Alaska Laser Wash, Inc.* be used that "feasible" means "capable of being accomplished or brought about; possible."[84]

Referrals to Masters Should be Eliminated

Currently, although the Superior Court has jurisdiction, in Anchorage, for assembly-line efficiency, involuntary commitment and medication petitions are automatically referred to the Probate Master or magistrates (Masters). Masters only have authority to make recommendations for the Superior Court to consider, but under Probate Rule 2(b)(3)(C) &(D) the Master's decisions are effective prior to such approval. This makes the Masters' decision a *fait accompli*, eviscerating the requirement that the Superior Court Judge makes the decision, which the Alaska Supreme Court has held is critical.

In *Wayne B v. Alaska Psychiatric Institute*,[85] an appeal over the rule that transcripts of hearings had to accompany the Masters' recommendations being ignored, the Supreme Court held the Superior Court was required to review the transcript of the trial(s) or listen to a recording, writing:

> Given the nature of the liberty interest at stake, it was critical that the superior court have full knowledge of the evidence that was said to justify committing Wayne B. to a mental institution.

It is believed transcripts are not prepared because of limited resources and the short time frames involved. This leaves the Superior Court Judges being required to listen to the hearings, which if followed, would defeat much of the purpose of referring the cases to Masters. In addition to the Master spending the time to conduct the hearing, the Superior Court Judge is required to spend the same amount of time listening to it. In one of Gottstein's cases, the Superior Court Judge indicated he had not listened to the hearing as required by the Alaska Supreme Court. It is likely this is typical. The time frames involved simply do not allow proper handling of these cases with masters in the middle, resulting in patients' right to a legitimate Superior Court determination being illusory.[86]

Referrals to Masters Should be Eliminated

VI. ACKNOWLEDGMENT

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[84] 382 P.3d 1143, 1152 (Alaska 2016).

[85] 192 P.3d 989 (Alaska 2008),

[86] Gottstein has written about this in his law review article, Involuntary Commitment and Forced Psychiatric Drugging in the Trial Courts: Rights Violations as a Matter of Course (p 86 [36]), and in Minority Report: Probate Rules Subcommittee on Involuntary Commitments and the Involuntary Administration of Psychotropic Medication.

VII. AUTHORS

James B. (Jim) Gottstein, Esq.

James B. (Jim) Gottstein, Esq., author of *The Zyprexa Papers*, is an Alaskan lawyer who in 1982, at the age twenty-nine, experienced a manic episode as a result of sleep deprivation and was held at the Alaska Psychiatric Institute (API) for 30 days. He was told he would never practice law again and the best he could hope for was to minimize his hospitalizations by taking one or more neuroleptics for the rest of his life. Instead, with one other brief hospitalization in 1985, Mr. Gottstein learned how to manage his life to avoid getting into trouble again.

Mr. Gottstein was one of the plaintiffs' lawyers in the Mental Health Trust Lands Litigation over the State of Alaska's illegal 1978 redesignation (theft) of Mental Health Trust Lands as General Grant, resulting in a 1994 settlement, reconstituting the Trust and creating the Alaska Mental Health Trust Authority. From 1998 to 2004, Mr. Gottstein was a member of the Alaska Mental Health Board, the state agency charged with planning and coordinating mental health services in the State of Alaska.

In 2002, Mr. Gottstein founded the Law Project for Psychiatric Rights (PsychRights) to mount a strategic litigation campaign against forced psychiatric drugging and electroshock, winning five Alaska Supreme Court Cases, three on constitutional grounds[87] and one in the Seventh Circuit Court of Appeals.

- *Myers v. Alaska Psychiatric Institute*, 138 P3d. 238 (Alaska 2006)
- *Wetherhorn v. Alaska Psychiatric Institute*, 156 P.3d 371 (Alaska 2007)
- *Wayne B. v. Alaska Psychiatric Institute*, 192 P.3d 989 (Alaska 2008)
- *Bigley v. Alaska Psychiatric Institute*, 208 P.3d 168 (Alaska 2009)
- *United States v. King-Vassel*, 728 F.3d 707 (7th Cir. 2013)
- *In the Matter of Heather R.*, 366 P.3d 530 (Alaska 2016)

PsychRights' Mission also includes informing the public about the counterproductive and harmful nature of the drugs and shock.

In addition, Mr. Gottstein co-founded a number of organizations to help psychiatric patients, all but one of which were peer-run:

- Mental Health Consumers of Alaska
- Alaska Mental Health Consumer Web
- Peer Properties
- CHOICES, Inc.
- Soteria-Alaska

See, Multifaceted Grassroots Efforts To Bring About Meaningful Change To Alaska's Mental Health Program.

[87] At Mr. Gottstein's suggestion the Legislation included amending the Alaska Statutes to conform to constitutional requirements established in these cases

Faith Myers

Faith J. Myers is the author of the book, *'Going Crazy in Alaska; a history of Alaska's treatment of psychiatric patients."* For approximately 5 years, from 1999 to 2003, Faith was in and out of acute care psychiatric facilities or units and at times, homeless. She is the Myers in *Myers v. Alaska Psychiatric Institute,* declaring Alaska's forced drugging regime unconstitutional.

On seven occasions, Faith ended up in a psychiatric facility, four times in a psychiatric evaluation unit and six times she was escorted to those facilities by the police in handcuffs. She was in crisis treatment centers three times. Faith stated, "It was the indifference of my treatment and mistreatment that led me to become a mental health psychiatric patient rights activist."

Susan Musante, LPCC

Susan Musante was the founding director of Soteria-Alaska, a model proven to be a highly effective alternative to hospitalization for newly diagnosed people, and of CHOICES, an alternative to conventional community mental health services directed and provided primarily by people who themselves have a "lived experience" with recovery. She is a leader, educator and advocate for the development of voluntary, compassionate supports and services that work. She has worked in universities, community-based centers and consumer-run services. She has educated peer practitioners and masters-level practitioners. Currently she is involved in advocacy and development projects as a contracted consultant. Her commitment is to respect the "lived experience" and support recovery

David Cohen, PhD

David Cohen is a Professor and Associate Dean for Research and Faculty Development at UCLA's Luskin School of Public Affairs. His looks at psychoactive drugs (prescribed, licit, and illicit) and their desirable and undesirable effects as socio-cultural phenomena "constructed" through language, policy, attitudes, and social interactions. He also documents treatment-induced harms (iatrogenesis), and pursues international comparative research on mental health trends, especially involving alternatives to coercion. Public and private institutions in the U.S., Canada, and France have funded him to conduct clinical-neuropsychological studies, qualitative investigations, and epidemiological surveys of patients, professionals, and the general population.

In his clinical work for over two decades, Cohen has developed person-centered methods to withdraw from psychiatric drugs and given workshops on this topic around the world. He designed and launched the CriticalThinkRx web-based Critical Curriculum on Psychotropic Medication for child welfare professionals in 2009, since taken by thousands of practitioners and updated in 2018. Tested in a 16-month longitudinal controlled study, CriticalThinkRx was shown to reduce psychiatric prescribing to children in foster care.

He has authored or co-authored over 120 articles and book chapters. His edited books include Challenging the Therapeutic State (1990), Médicalisation et contrôle social (1996), and Critical New Perspectives on ADHD (2006). His co-authored books include Guide critique des médicaments de l'âme (1995), Your Drug May Be Your Problem (1999/2007), and Mad Science (2013)

Dr. Cohen previously taught at Université de Montréal and Florida International University. In Montreal, he directed the Health & Prevention Social Research Group, and at Florida International University where he was PhD Program Director and Interim Director of the School of Social Work. He held the Fulbright-Tocqueville Chair to France in 2012.

Peter C. Gøtzsche, MD

Peter C. Gøtzsche is a specialist in internal medicine but has a special interest in psychiatry; has published numerous scientific articles and several books about psychiatric drugs and the harms of forced treatment; and has had five PhD students who worked with psychiatric drugs.

Gøtzsche is considered an internationally recognized expert in research methodology, which resulted in a professorship at the University of Copenhagen in Clinical Research Design and Analysis in 2010. Co-founded the Cochrane Collaboration and established the Nordic Cochrane Centre in 1993. Co-founded Council for Evidence-based Psychiatry in the UK in 2014 and International Institute for Psychiatric Drug Withdrawal in Sweden in 2016. Founded the Institute for Scientific Freedom in 2019.

Gøtzsche's greatest contribution to public health was when he, in 2010, opened the archives of clinical study reports in the European Medicines Agency after a 3-year long battle that involved a complaint to the European Ombudsman. EMA was solely concerned with protecting the drug industry's interests while ignoring those of the patients. The Ombudsman ruled there was no commercially confident information in the study reports.

Gøtzsche has published more than 75 papers in "the big five" (*BMJ*, *Lancet*, *JAMA*, *Annals of Internal Medicine* and *New England Journal of Medicine*) and his scientific works have been cited over 150,000 times (his H-index is 82 according to Web of Science, June 2022, which means that 82 papers have been cited at least 82 times). Gøtzsche is author of several books. The ones most relevant for psychiatry are:

- Critical psychiatry textbook (2022).
- Mental health survival kit and withdrawal from psychiatric drugs: a user's guide (2022, exists in 8 languages).
- Deadly psychiatry and organised denial (2015, in 9 languages).
- Deadly medicines and organised crime: How big pharma has corrupted health care (2013, in 16 languages). Winner, British Medical Association's Annual Book Award, Basis of Medicine in 2014.

Gøtzsche has given numerous interviews, one of which - about organised crime in the drug industry - has been seen over 430,000 times on YouTube. Gøtzsche was in The Daily Show in New York on 16 Sept 2014 where he played the role of Deep Throat revealing secrets about big pharma. A documentary film about Peter's reform work, Diagnosing Psychiatry, appeared in 2017, and another one is in the making.

Peter has an interest in statistics and research methodology. He has co-authored guidelines for good reporting: CONSORT for randomised trials, STROBE for observational studies, PRISMA for systematic reviews and meta-analyses, and SPIRIT for trial protocols. Peter was an editor in the Cochrane Methodology Review Group 1997-2014.

David Healy, MD

Dr. Healy is a psychiatrist, scientist, psychopharmacologist, and author.

Before becoming a professor of Psychiatry in Wales, and more recently in the Department of Family Medicine at McMaster University in Canada, he studied medicine in Dublin, and at Cambridge University. He is a former Secretary of the British Association for Psychopharmacology, and has authored more than 220 peer-reviewed articles, 300 other pieces, and 25 books, including The Antidepressant Era and The Creation of Psychopharmacology from Harvard University Press, The Psychopharmacologists Volumes 1-3 and Let Them Eat Prozac from New York University Press, and Mania from Johns Hopkins University Press and Pharmageddon.

His latest and most important book is *Shipwreck of the Singular. Healthcare's Castaways*. This documents how improvements in medicine which contributed to increasing our life expectancies have now turned inside out and are leading to shortened life spans. At the same time the climate of healthcare has turned toxic with increasingly fraught encounters between staff and management and between patients and services who are more concerned to manage risks to them rather than to their patients.

Dr. Healy's main areas of research are clinical trials in psychopharmacology, the history of psychopharmacology, and the impact of both trials and psychotropic drugs on our culture.

He has been involved as an expert witness in homicide and suicide trials involving psychotropic drugs, and in bringing problems with these drugs to the attention of American and European regulators, as well raising awareness of how pharmaceutical companies sell drugs by marketing diseases and co-opting academic opinion-leaders, ghost-writing their articles.

Dr. Healy is a founder and CEO of Data Based Medicine Limited, which operates through its website RxISK.org, dedicated to making medicines safer through online direct patient reporting of drug side effects. He and his colleagues recently established RxISK eConsult, an online medication consultation service to answer the question "Could it be my meds?

International Society for Ethical Psychology & Psychiatry (ISEPP)

The International Society for Ethical Psychology and Psychiatry, Inc. (ISEPP) is a 501(c)(3) non-profit volunteer organization of mental health professionals, physicians, educators, ex-patients and survivors of the mental health system, and their families, not affiliated with any political or religious group. ISEPP's purpose has always been to educate and recruit practitioners and academicians of the mental health professions who use scientific methods, both quantitative and qualitative, to critique the medical model of human distress.

ISEPP's questions of the Mental Health System's orthodoxy are simple:

- Where is the evidence that the problems diagnosed as mental disorder are due to dysfunctions in the individual, whether chemical, structural, or genetic?
- What internal dysfunction is the target of medical assessment and care for those diagnosed with mental disorder?
- How do chemicals, electricity, and surgery correct or alleviate that alleged internal dysfunction?

- Why are those diagnosed as mentally disordered the only "patients" of all the medical professions who are not given the right of full informed consent and, instead, are frequently coerced and conned into confinement and treatment in violation of basic human rights?

ISEPP publishes the scientific, educational, and professional focus, peer-reviewed journal, *Ethical Human Psychology and Psychiatry: An International Journal of Critical Inquiry* (EHPP).

VIII. APPENDIX

The Science Of, by David Healy, MD

This is written by a doctor who supports the medical model within the mental health domain and who primarily uses psychotropic drugs to treat nervous problems. Believing psychotropic drugs to have the potential to help, however, means knowing that they also have a potential to harm and being concerned to have these harms noticed and reversed where they happen.

In legal settings, parties for the government or services typically contrast the science that they supposedly depend on in respect of drug benefits and lack of harms with an apparent lack of science, or anecdotal quality to the evidence on a plaintiff's or claimant's side.

This position is rarely questioned. However, as a matter of fact, in so far as there is an appeal to company trials, there is no science on the government or services side.

With rare exceptions, the entirety of the clinical trial literature in the very best journals, and reviews of clinical trials, are ghostwritten. Without exception, there is no access to the data from these trials. Neither notional authors, nor regulators, nor anyone else has seen the data.

We know from FDA reviews of these trials, that FDA based on company study reports reviewed many of these trials as negative. These trials were then published by companies as positive.

We know from Study 329, a study of paroxetine in depressed teenagers, that the publication of this trial was fraudulent. The results were negative, but GlaxoSmithKline knowingly published them as positive. The Attorney General of New York took a fraud action against GSK in respect of this trial in 2004 and the company later resolved a Department of Justice action for $3 Billion.

Study 329 was a trial run in the very best University Hospitals in North America, with a distinguished authorship line and was published by the most highly regarded journal in child psychiatry. If this trial was fraudulent, fraud can be assumed to be the standard industry mode of operation. In many other trials, the claimed patients have not existed.

The greatest mismatch in all of 'science' can be found in psychotropic drug trials – with the published literature claiming benefits but the actual data when accessed indicating just the opposite – the treatment is not effective and is not safe.

Quite aside from the above points, the lack of access to any of the subjects in these trials and the fact the authors on the authorship line of these papers will never have met any of the patients or seen any of the problems that treatment can cause, means that these trials offer hearsay rather than material that meets scientific or legal rules of evidence.

No-one can be brought into a hearing and be cross-examined as to what exactly happened in any of these trials. Have the harms a plaintiff complains of happened to others? In cases where this has been investigated, patient complaints invariably feature in the clinical trials whose

publications claim that these events do not happen on the company drug. Companies regularly claim their drugs have no known side effects.

There is a further problem with company trials, which is that they generate average effects. They do not tell us what happened to David Healy or David Cohen, which might be completely different. The published average will likely appear as a minor benefit but this minor benefit will be touted as evidence the drug works and is sold as a major benefit to everyone who receives this drug.

The minor benefit in psychotropic drug trials typically involves a minor change in a rating scale score, while at the same time more people die from the active treatment than die on placebo. They typically die from suicide in psychotropic drug trials, with olanzapine having the highest rate of suicide in recorded clinical trial history.

More to the point, there may be people who do quite well and have significant rating scale changes; this may be of the order of 15-20% of trial participants. But an equal or larger number do much worse on treatment. The averaging of effects make the patients who do not suit the treatment disappear from view. These are the patients who end up on compulsory detention and treatment orders. The mental health system seems unable to comprehend that it might be generating the problems it then seeks to treat by pouring oil on the flames.

The system claims the science supports its point of view but in fact the only science in detention and treatment hearings comes from the patients subject to these hearings, whose views are discredited because they are mad. They are also discredited in favor of adherence to what has been relentlessly called science by companies standing to profit from making this designation stick. Legal systems, at present, have a comprehensive inability to see how this company maneuver sabotages patients' rights within the mental health domain.

In company trials, there are a greater number of suicides and suicidal events on active treatment, especially antipsychotics than on placebo.

In company trials, there are a greater number of homicidal events on active treatment on antipsychotics, anticonvulsants, and antidepressants than on placebo.

In general, drug regulators have refused to issue appropriate warnings to this effect.

There is also a growing body of evidence that while psychotropic drugs may be useful for some patients with substance misuse problems, that a significant number of people exposed to antipsychotics, anticonvulsants and antidepressants will develop substance misuse problems, involving alcohol, methamphetamine, cocaine and cannabis that they would not otherwise have had (Refs 1-2).

Stopping their psychotropic drugs can lead to a complete remission of their problems but mental health systems do not know this and instead compound the problems with further psychotropic drugs, often given in depot form.

In summary, primarily where patients who end up in mental health units are concerned, and especially those to end up on compulsory detention orders, there is a strong case to be made that the treatment they have been will for many have been the main trigger to a deterioration leading to hospitalization. Our current systems rarely recognize the problems they are causing,

because few doctors have any training in recognizing adverse events and few realize that the published medical literature on these drugs is not reliable. This leads in many cases (not all) to an inappropriate, medically dangerous, and legally indefensible over-riding of patient rights.

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