

Soteria-Alaska Development Proposal

January 2006

Development plan for the implementation of Soteria Alaska

The General plan for the development of a Soteria Alaska facility was presented to the Trust in a proposal dated September 14, 2004. That proposal is appended to this document.

The Soteria project would be residential facility housing up to 8 clients at any one time who would otherwise be hospitalized. It is anticipated that the average length of stay will be 3-5 months. The Vision of the program would be to "effectively use a community and milieu recovery model as the basis of a program to meet the needs of those Alaskans' who elect such an approach." The program would be a clear alternative to traditional hospitalization for this population.

The current proposal involves a three-stage process developed in conjunction with the Trust's Executive Director and Finance Committee Chair. The initial step in the development and implementation process involves acceptance by the Trust of the concept which involves preparation of a proposal for full funding at the September 2006 meeting of the Trust. If there were then acceptance of the full proposal in September, the program would commence and implement the necessary steps to open for full implementation in Fiscal Year 2008. The initial acceptance would entail the funding for the recruitment and placement of a contracted Project Manager. An announcement of the possibility of such a position has already been distributed on a nationwide basis. Applications and letters of interest from very qualified candidates have already been received by Soteria-Alaska, Inc. The Board and Dr. Wolf are developing the criteria for the engagement of such an individual. It is envisioned that if this present proposal is accepted that the qualified individuals will be interviewed by the middle of March 2006 and that the Project Manager will be in place by June 1, 2006.

The key Soteria-Alaska personnel who will be involved are the Project Manager, Dr. Wolf, and Alma Menn, of San Francisco, who was the administrator of the original Soteria House. In addition, it is anticipated the Alaska Division of Behavioral Health, Anchorage Community Mental Health Services, and other key providers, such as the Alaska Psychiatric Institute and Providence Hospital, as well as the national and international team of experts that has been assembled to help, will all be involved. Contractual Consultant/Advisors will also be a vital component for this early stage. They would deal with the fiscal, programmatic, outcomes management and operational issues of setting up the facility. It is anticipated there will be other consultants with specific areas of expertise who will also need to be accessed. There will also need to be funds for administrative backup for the Project manager and the Consultants. It is anticipated that office space, telephones, office equipment etc will be contracted with an existing office or agency. Anchorage Community Mental Health Inc will be approached first to establish whether they have such availability. If they do not, another established agency will be sought for this. Although administrative space and backup will be contracted, it is

anticipated that an administrative assistant will be engaged if the Trust gives a go-ahead to the project in September, 2006. This administrative assistant will support both the Project Manager and the consultants. There may also be a need for additional monies as well for possible fees for research, software, or initial accumulation of prior research data. A small amount of necessary travel will also be required both for the Project Manager recruitment and the evaluation of programs with a similar focus.

The time period between April and September 2006 will be utilized by the Project Manager and the consultants to develop the actual program, market the concept to the community, and begin the detailed process of establishing an actual facility with a program. The Project Manager will become the face of the Program to the community relative to funding, political and consumer acceptance and the details of establishing an operational entity. The Project Manager with the help of the Consultants will focus on acquiring a facility, developing the program, developing a budget, developing job descriptions for the personnel to be hired, and “selling” the concept to various stakeholders within the community.

A facility for opening in the Fall/Winter of 2007 will need to be acquired or built within the Municipality of Anchorage that could be adapted or designed to meet the needs of the anticipated population. Such a facility, because it would require a building permit for changes or initial construction would need to meet current Municipal zoning requirements. The establishment of such a facility would thus need to proceed through the Municipal Zoning Commission and be subject to the Public hearing process. In addition, there will likely be licensing requirements. Ideally the facility would exist in an area that is accessible to existing People Mover routes, both for the benefit of the staff and residents. The choice of a facility should encompass the needs of the residents, the staff and the surrounding community.

We appreciate the opportunity to present this program development proposal for consideration by the Trust.

January, 2006

Soteria-Alaska
Program Development Budget
FY 2006/2007

Budget 2/15/2006-6/30/2006

Recruitment of Project Manager 2/15—6/1		
a. Advertising of position in anchorage and Fairbanks newspapers	\$	600
b. Telephone Costs of candidate interviews by board and consultants	\$	100
c. Travel and hotel costs to Anchorage for top 3 candidates 2 days each	\$	3,000
d. consultation time for Dr. Wolf and Alma Menn (review of applications and interviews) 20 hours at 150/hr	\$	3,000
Contract for project director 6/1-6/30 at 6000/ month	\$	6,000
Executive Office Cost	\$	1,000
Administrative Assistant half time	\$	1,500
Moving Allowance for Project Manager	\$	2,000
Auto rental for Project Manager 200/wk times 4 weeks	\$	800
Cell phone rental for project director to cover local and long distance calls 6/1-6/30	\$	100
Consultating from Dr. Wolf and Alma Menn to aid in program development, business plan development, staff acquisition, site acquisition and other support. 50 hours -- 30 for Dr. Wolf and 30 for Ms. Menn at 150/ hr	\$	7,500
Travel	\$	1,500
Supplies	\$	150
Fees taxes etc.	\$	500
	Total to 6/30/06	\$ 27,750

Budget 7/1 2006—9/30 2006

Finalization of plan and preparation for implementation of the project

Contract for Project Manager 6,000/ month	\$	18,000
Administrative Assistant. Half time	\$	4,500
Executive Office at \$1,000/ month	\$	3,000
Auto rental for project director 200/wk	\$	2,400
Cell phone	\$	300
Consultants		
a. Dr. Wolf 15 hrs / month times 150	\$	6,750
b. Ms. Menn 15 hrs / month times 150	\$	6,750
c. specialist consultants 10 hrs/ month times 150	\$	4,500
Consultation with architects/engineers/contractors/lawyers etc., relative to facility	\$	2,000
Travel	\$	2,000
Fees/taxes misc	\$	250
Supplies	\$	250
	Total 7/1/06-9/30/06	\$ 50,700
	Total through September Trust Meeting	\$ 78,450

January, 2006

Soteria-Alaska
Program Development Budget
FY 2006/2007

Budget 10/1/2006 — 6/30/2007

Contract for Project Manager 6,000/ month	\$ 54,000
Administrative Assistant half time 10/1-12/31 full time 1/1/066/30/06	\$ 21,000
Rent	\$ 9,000
cell phone	\$ 900
Consultants	
a. Dr. Wolf 12 hrs / month times 150	\$ 16,200
b. Ms. Menn 8 hrs / month times 150	\$ 10,800
c. Specialist consultants	\$ 2,500
d. Consultation with architects/engineers/contractors/lawyers etc., relative to facility	\$ 7,500
Travel	\$ 4,500
Fees/taxes misc	\$ 700
Supplies	\$ 500
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Total 10/1/2006-5/30/2007	\$ 127,600
Total Development Budget if approved at September Trust Meeting	\$ 206,050

SOTERIA-ALASKA, INC.

406 G Street, Suite 206, Anchorage, Alaska 99501
(907) 274-7686 Phone (907) 274-9493 Fax

Key Information

(12/31/2005)

Purpose: To develop a non-coercive alternative to psychiatric hospitalization in Alaska employing the "Soteria Critical Elements" developed by Loren Mosher, MD., and Luc Ciompi, MD.

Formation: Incorporated as Alaska not for profit corporation on January 23, 2003.

Tax Status: Internal Revenue Service Advance Determination Letter granting 501(c)(3) status issued March 15, 2005.

Board of Directors:

- Jim Gottstein
- Eliza Eller
- Michele Turner

Key Consultants and Advisors:

- Aron Wolf, MMM, MD (Wolf Health Care Consulting)
- Alma Menn, MSW (Original Soteria Administrator)
- Jerry Jenkins, M.Ed., MAC (Anchorage Community Mental Health Services)
- Luc Ciompi, MD (Founder & Director, Soteria-Berne)
- Ann Silver, MD (Former Chestnut Lodge psychiatrist)
- Dan Dorman, MD (UCLA & Private Practice)
- John Bola, MSW, Ph.D. (USC)

SOTERIA CRITICAL ELEMENTS

Luc Ciompi, Loren Mosher

1. FACILITY:

- a. Small, community based
- b. Open, voluntary home-like
- c. sleeping no more than 10 persons including two staff (1 man & 1 woman) on duty
- d. preferably 24 – 48 hour shifts to allow prolonged intensive 1:1 contact as needed

2. SOCIAL ENVIRONMENT:

- a. respectful, consistent, clear and predictable with the ability to provide asylum, safety, protection, containment, control of stimulation, support and socialization as determined by individual needs
- b. over time it will come to be experienced as a surrogate family

3. SOCIAL STRUCTURE:

- a. preservation of personal power to maintain autonomy, diminish the hierarchy, prevent the development of unnecessary dependency and encourage reciprocal relationships
- b. minimal role differentiation (between staff and clients) to encourage flexibility of roles, relationships and responses
- c. daily running of house shared to the extent possible; “usual” activities carried out too maintain attachments to ordinary life – e.g. cooking, cleaning, shopping, art, excursions etc.

4. STAFF:

- a. may be mental health trained professionals, specifically trained and selected non-professionals, former clients, especially those who were treated in the program or a combination of the three types
- b. on the job training via supervision of work with clients, including family interventions, should be available to all staff as needed

5. RELATIONSHIPS: these are central to the program’s work

- a. facilitated by staff being ideologically uncommitted (i.e. to approach psychosis with an open mind)
- b. convey positive expectations of recovery

- c. validate the psychotic person's **subjective** experience of psychosis as real by developing an understanding of it by "being with" and "doing with" the clients
- d. no psychiatric jargon is used in interactions with these clients

6. THERAPY:

- a. all activities viewed as potentially "therapeutic" but without formal therapy sessions with the exception of work with families of those in residence
- b. in-house problems dealt with immediately by convening those involved in problem solving sessions

7. MEDICATIONS:

- a. no or low dose neuroleptic drug use to avoid their acute "dumbing down" effects and their suppression of affective expression, also avoids risk of long term toxicities
- b. benzodiazepines may be used short term to restore the sleep/wake cycles

8. LENGTH OF STAY:

- a. sufficient time spent in program for relationships to develop that allow precipitating events to be acknowledged, usually disavowed painful emotions to be experienced and expressed and put into perspective by fitting them into the continuity of a person's life

9. AFTER CARE:

- a. post discharge relationships encouraged (with staff and peers) to allow easy return (if necessary) and foster development of peer based problem solving community based social networks
- b. the availability of these networks is critical to long term outcome as they promote community integration of former clients and the program itself

SOTERIA-ALASKA PILOT PROGRAM
INITIAL DRAFT BUSINESS PLAN

September 15, 2004

Aron S. Wolf M.D. MMM

Soteria-Alaska Program

This paper is an implementation plan for the proposal submitted to the Alaska Mental Health Board by Mr. Jim Gottstein on August 8, 2004 and recommended by it for funding on August 11, 2004. I am including that proposal and its' attachments as an attachment to this paper.

Soteria-Alaska Inc. an Alaskan non-profit organization (Soteria-Alaska has applied for status as a 501C3 tax-exempt entity on April 15, 2004, and expects to receive such status without undue difficulty. Soteria-Alaska Inc is choosing to put forward this program which will be administered under its auspices. This program is called The Soteria-Alaska Pilot Project and shall be administered by the Board of Soteria-Alaska Inc which is a consumer directed organization.

MISSION

The mission of the Soteria-Alaska Pilot Program would be to effectively and efficiently treat mentally ill individuals within the Alaska community with a quality and cost effective program that demonstrates the effectiveness of an alternative to acute hospitalization and which allows them more choice and flexibility in the initial stages of their illness than a traditional hospital program.

VISION

To effectively use a community and milieu recovery model as the basis of a program to meet the needs of those Alaskan who would respond to such an individualized approach to the treatment of their mental illness, that if proven as a model will provide an additional choice/option for effective treatment.

DESCRIPTION OF PROGRAM

Soteria-Alaska would be a new addition to the array of services to those Alaskans experiencing acute mental illness. As the name of the non-profit-Choices- implies, this program of Choices is an alternative to fill a niche for those individuals who are symptomatic and need a supportive environment and who would otherwise be in a hospitalized setting. The care concept of the Soteria-Alaska pilot project is that the client has a choice and a significant input into their own provision of care. It will still be the responsibility of the professional staff of the program to inform and educate the clients about what treatments could be scientifically and medically efficacious for them. For those individuals who meet the admission and retention criteria of The Soteria-Alaska program, and thus can participate in the milieu, an individualized treatment plan will be developed by the Client and the Staff. All of the plans will include participation in the

Community and the milieu. The plans may or may not include the use of medication, but because of the pre-selection process, the working paradigm will be to utilize the community as the treatment rather than relying on neuroleptics. Other classifications of medications may indeed be used in this initial period. . The model and the protocols for the use of medication will be those of the original Soteria program as developed by Dr. Loren Mosher. It may or may not also include alternative therapies including massage, physical therapy, diet or other modalities. Even if medications are “elected” by the client to be a part of their treatment plan, the Community Program itself will always be the primary treatment modality with the medication only being an adjunct to that program and with a clear goal that such medications will be used in as minimal a way as is necessary and effective.

The basic conception of the program will be modeled after the original Soteria and several second generation projects as described by Dr. Loren Mosher in an article in the Journal of Nervous and Mental disease in 1999 entitled “Soteria and Other Alternatives to Acute Hospitalization.”

The Soteria-Alaska pilot program would be housed in a “home-like” facility. This could either be a large house or a 4 or 6 plex that is adapted for the program. Each Client would have their own room and privacy. There would be spaces for congregating both informally and for groups. There would also be one kitchen and dining facility as food preparation and “family” eating will be a part of the program. If the program is housed in a multiplex, the other kitchen areas shall be used for alternative activities. There will be activity areas both inside and out, and there will be a small living area for at least one staff member who is on duty during the night hours. The facility would have a maximum capacity of 10 clients. It is estimated that the average length of full live-in stay will be 3-5 months. The principal treatment focus will be the community and the milieu itself. There will be both daily groups and daily activities within the house as well as activities away from the facility itself. The groups will be free form in that the subjects will arise from either needs of the community or needs of individual clients within the community. These activities will include planning for and preparing the food as well as the activities of keeping a home such as cleaning and personal laundry. Although these activities, including the dietary activities will be client led, albeit within health department guidelines, the philosophy of the program would be for the diet to be kept to those foods that are “simple” in nature and have been found to enhance mental health. i.e.: sugars and caffeine should be kept to a minimum.

As much as is practicable, daily decisions and the flow of daily life within the community will be determined by the residents. The role of the professional and paraprofessional staff will be to enhance the program, but not to set the direction or mandate the program. Clients will be encouraged to be supportive to one another either on a 1:1 basis or within smaller groups. Both professional and paraprofessional staff will be available for 1:1 or small group meetings with clients as the need arises on a day by day basis. Because the House will be licensed by the State of Alaska and it is hoped that aspects of the treatment program will be reimbursable, staff shall keep such requisite notes of the clients on a daily basis as required by these programs and to insure the ongoing quality of the

program. Appropriate intake evaluations including an evaluation by the program psychiatrist shall be accomplished within 1 working day of admission. All admissions shall occur between Monday and Friday. Discharge summaries shall also be prepared. Confidentiality shall be adhered to and all HIPAA regulations shall also be observed. Medication administration, either psychiatric or non-psychiatric medications shall be administered within the guidelines for such activities within such a setting.

CLIENT ELIGIBILITY

The clients of the Soteria-Alaska program will be those individuals with a diagnosis of an Axis I DSM IV TR mental illness. Individuals with symptoms of these conditions can either be in a new and acute stage or they may be those having an exacerbation of a previously diagnosed illness.

The psychotic diagnostic categories will all be included. These include the schizophrenias, bipolar disorder and the severe depressive disorders. In addition, those individuals with severe forms of anxiety, panic disorder and OCD will also be eligible.

Because the the Soteria-Alaska program is one that is based on community and milieu and an interaction between the client and the community that fosters a diminution of the individual's psychiatric symptomatology, the program will be unable to accept or maintain as clients those who are violent. It will also not be able to accept those clients who cognitively cannot participate in the milieu either because of a Developmental Disability, a severe Traumatic Brain Injury or Dementia. Clients in the program who become too disorganized to participate in the program may be referred, for at least a short period, for traditional crisis-respite or hospitalization.

Soteria-Alaska will plan to be a direct alternative to hospitalization either at API, one of the "designated" units Statewide or one of the several voluntary mental health units in the state. Clients needing the services of Soteria-Alaska may be referred from the Providence Psychiatric Emergency Department, Alaska Psychiatric Institute, Community Mental Health Screening clinics, General Hospitals with mental health screeners, private mental health clinics or private psychologists or therapists within South-Central Alaska. All clients, irrespective of their referral source must be "medically cleared" prior to their admission to the program.

Due to the limited size of the program, an initial phone interview will be conducted by the Soteria-Alaska Director or their designee. This phone interview will determine both the individual's applicability and their interest in a community and milieu oriented therapeutic program. The program will focus on admitting those individuals who wish to engage in such a program with a minimal amount of pharmacologic intervention. If the program is full then the "program eligible" clients will be placed on a waiting list and the patient will be encouraged to get other immediate appropriate treatment.

STAFFING

Soteria-Alaska will indeed function as a community with a milieu based program where there is a great deal of self help and peer help. The program will, however, meet the professional criteria set forth by the State of Alaska Medicaid program.

All staff for the program shall need to be comfortable with the philosophy of the program for client choices. Additionally, to the extent possible, staff shall be selected (and deselected) under the criteria set forth in Chapter 10 of “community Mental Health: a Practical Guide” by Loren Mosher and Lorenzo Burti.

The program will have a full time Executive Director. The director is envisioned to be a master’s level trained mental health professional that also has administrative training and background. The director will be responsible to the Board and will hire and supervise all other staff. They will be responsible for “The Program” and ensure the quality and safety of the clients through all the program components. The Director will ensure that all applicable local, state and federal requirements that apply to the program are met. The Director will be responsible for the financial aspects of the program including payroll, accounts receivable and contract compliance. The director will be responsible for either doing or having an initial intake done on each client, and will also be responsible for doing or having a discharge summary done on each client. The director will also ensure that there is adequate staffing of the program on a 24hour year round basis. The Director will insure that there is communication and adequate liaison with referring entities as well as those entities that might need to receive clients from the program, either because of severity or because they have “graduated” from the program. The Director will enter into an agreement with a general medical physician to see the clients’ of the program for any non-psychiatric medical needs. Such visits would be on a fee for service basis with the charges being billed to the client.

There will be a “relief” masters level trained individual to perform the duties of the Director when they are on vacation. The Director will be available on their “off” hours by pager or cell phone when they are not on vacation

The program will also have a contracted Medical Director. This individual will be a Board eligible or Board Certified psychiatrist. This physician shall accomplish an initial psychiatric intake on each new client within 1 working day of their admission. This will be a part of the total intake process for each client. The psychiatrist, as a part of their initial intake will evaluate whether medications might be helpful for an individual client. If such is the case, then the psychiatrist should discuss this “choice” with the client in an informed manner. This informed manner shall be done in a way that all information required for informed consent under AS47.30.837(d)(2) is met. If medications are indeed the choice of the client, the psychiatrist would then be the prescribing physician and appropriate procedures followed such as medication monitoring, recording on a medication sheet and the face to face medication management meetings will be noted in the client’s chart. The psychiatrist will also be available and expected to consult with the Executive director about the clinical aspects of the program and for program development issues. The psychiatrist may also become involved in the group process and even occasionally in a 1:1 therapeutic intervention with the clients. The psychiatrist shall

ensure that there is another qualified psychiatrist who is knowledgeable about and supportive of the Soteria-Alaska modality and can service the program when the psychiatrist is either away or unavailable. The psychiatrist or those covering for them shall be available for phone consultations at all times throughout the year.

There shall be a part-time Licensed Practical Nurse who will be available each morning when there are patients who are in the program taking medications. To prepare "Mediset" trays for each client. This would be for both the client's psychiatric and non-psychiatric medications. The nurse would do this for both the live-in and day clients. Once having "dispensed" the medications in this way, the mediset trays would be left in the care of the house staff to be available to the client's at appropriate times.

There will be an administrative assistant. This individual will work a standard work week. This individual will be responsible for organizing the records, for HIPAA compliance, and for billing, coding and the other office functions of the program.

The majority of the staff shall be "milieu" or "community" workers. These individuals shall have at least a bachelor's degree, preferably in the social sciences. The greatest criteria for these individuals, however, will be an assessment that they are empathetic, that they are people oriented, and that they philosophically agree with the program's goals and format and they are comfortable being with acutely mentally ill clients.. Because these individuals are not "trained mental health professionals", a specific training course will be provided. This will be taught by knowledgeable individuals in Soteria and Milieu models of care provision. These staff will also be monitored and mentored regularly for their contacts with clients and their growth. This mentoring will be by the Executive director and the knowledgeable consultants. These milieu workers shall staff the facility on a 24 hour seven day a week basis. They will participate with the clients in all of the activities. They shall participate in all of the groups, but lead them in any traditional sense, and be available to clients who wish to discuss issues on an individual basis. From 8am to 8pm there shall be 2 workers on duty and there shall be one worker on from 8pm to 8am. This will be true on a 7 day a week basis. One of the day staff shall have their own private space within the facility so that indeed there will be a 2nd staff member who would be potentially available during the evening hours, if a crisis occurred with the clients.

COSTS

In addition to Soteria programs affording choice to clients they have actually been found to be cost effective. It is true that the expected length of stay in the program far exceeds the average length of stay for hospital-based programs. However, the cost per day is of such a smaller magnitude that the previous Soteria programs have actually had a more minimal total cost of care. The articles that are appended also indicate that the recidivism rate is equal to or better than in a traditional program. They also show that the recipients of these programs have enjoyed a better quality of life after having been in this program.

As a start-up, the program will need both Capital and Operational Costs.

Capital Costs

It is anticipated that the capital costs would be between \$500,000 and \$ 600,000 depending on the availability and cost of a venue

The costs would include:

1. A house or structure to hold the program
2. Any necessary modifications to the structure to accommodate the program
3. Programmatic and living furnishings
4. Office and business furnishings and equipment
5. A van to transport clients to activities and appointments

Operational Costs Appendix B shows the estimated costs over the next several fiscal years, the costs for the 1st full year of operation would include

Personnel costs:

Salaried individuals:

- | | |
|---|------------|
| 1. Executive Director | \$ 60,000 |
| 2. 5.5 milieu workers at \$ 15/hr | \$ 166,100 |
| 3. Administrative assistant | \$ 35,000 |
| 3. Benefits of above at 28% including FICA and Workman's compensation | \$ 73,108 |

Subtotal \$ 334,208

Contracted Labor:

- | | |
|--|-----------|
| 1. Medical Director (psychiatrist) 8 hrs/wk, 50 wks a year at \$110/hr | \$ 44,000 |
| 2. Masters level alternate for Executive director 0.2 FTE | \$ 12,500 |
| 3. LPN 5 hrs/wk at \$ 19/hr | \$ 4940 |
| 4. Training consultants 60 hours/year at \$ 75/hr | \$ 4500 |
| 5. Tax Consultants | \$ 5000 |

Subtotal \$ 70,940

Total Personnel costs \$ 405,148

Other Expenses:

- | | |
|---------------------------|-----------|
| 1. Supplies | |
| a. cleaning | \$ 5,000 |
| b. office | \$ 5,000 |
| c. program and activities | \$ 10,500 |
| 2. Contracts ie:faxes etc | \$7500 |

3. Utilities	\$3600
4. Telephone	\$ 4800
5. Insurance	
a. malpractice for employed individuals	\$ 4500
b. Bldg/land/vehicle	\$ 5,000
6. Fees for activities	\$ 4,000
7. Gasoline and maintenance for vehicle	\$ 1600
8. Food 3 meals a day	\$ 55,300
 Total other expenses	 \$ 106,800
 Total operational expenses for program in first full year	 \$ 511,948

FUNDING

The Soteria-Alaska Pilot Project has submitted to the Mental Health Trust for the initial Capital monies in FY 2006

The Soteria-Alaska Pilot Project operating budget has also been submitted to the Mental Health Trust for funding for a partial year for FY 2006 and all of FY 2007. It is expected that for FY 2008 and FY 2009 that the program will be able to move to 50% grant supported and 50% 3rd party supported, the majority of this being Medicaid for those services that meet reimbursable standards.

INITIAL SWOT ANALYSIS

Strengths

1. The addition of 10 slots for treatment within the community
2. The ability to integrate this program State-wide with outpatient and inpatient treatment facilities
3. The ability to provide Clients with needs for Choices in their treatment
4. The use of a treatment modality that has been shown to be effective in NIMH funded studies
5. Use of modalities from the successful Ionia/Alaska program
6. use of modalities from the Soteria House model
7. A cost effective treatment for those wishing this alternative

Weaknesses

1. A program new to the Alaska treatment environment
2. No locally trained staff in this form of treatment
3. An untried balance between current practices with medication and those of long term community approaches
4. Perhaps a more complicated referral pattern than that needed for traditional hospitalization

Opportunities

1. The opportunity to develop a new program as an addition to the Alaska environment
2. The opportunity to take some of the admissions pressure off API and the community mental health centers
3. The opportunity to train Alaska staff in several modalities of treatment that are client-centered
4. The opportunity to use this program for basic research on this model of care provision
5. The opportunity to look into expansion of this program as an alternative to the centralization of costly hospital beds
6. the opportunity to be a leader in the nation in demonstrating the effectiveness of this type of approach

Threats

1. Lack of, or inadequate initial funding
2. Inability to find a suitable venue
3. Inability to gain appropriate zoning /NIMBY reaction from neighbors
4. Inability to gain appropriate licenses for the project
5. Inability to find adequate and interested staff for the project
6. Non-acceptance by the professional psychiatric and other mental health community
7. Possible lack of integration with community treatment programs to allow a continuation of treatment philosophy.

Proposed timeline

August 2004--- Presentation to the Mental Health Trust –and decisions on funding

September 2004

1. Gain approval of Soteria-Alaska Board for moving ahead with the proposal
2. Engage an interim Consultant to begin the development process
3. Discussions with Medicaid on requirements for reimbursement
4. Begin process to acquire venue
5. Begin process to develop guidelines, rules and regulations for the program include a specific job description for the Executive director

October 2004

1. Begin process to hire the Executive Director
2. Begin process to explore research opportunities for the program

3. Begin to engage knowledgeable consultants to aid in the program development guidelines

November 2004-June 2005

1. Choose Venue
2. Get appropriate zoning issues
3. Begin process for appropriate licensing
4. Choose Executive Director
5. Presentations to both the professional and business communities

July-September 2005

1. The Executive Director begins work and transitions the work from the initial consultant
2. Modification of venue
3. Acquire furnishing and supplies as well as van
4. Finish program guidelines
5. Negotiate agreements with other agencies as needed
6. Write job descriptions for other staff
7. Begin Hiring of other staff including milieu staff, the medical director and the licensed practical nurse.
8. Obtain all licenses necessary to the program
9. Begin intensive staff training

October 2005

1. Admit the first 4- 5 clients

November 2005

1. Admit the 2nd 5 clients so that the program is in full operation

Soteria-Alaska

A Pilot Project Proposal

August 8, 2004

I. Background

This proposal is the result of a process that began with Robert Whitaker's December 13, 2002, presentation to the Alaska Mental Health Board regarding his findings as revealed in *Mad in America*¹ and the growing consensus that a pilot project along the lines of the successful Soteria House project² should be initiated for Alaska.³ This project has also garnered offers of help to make it a success from prominent psychiatrists experienced in working with people under Soteria concepts.

The 1971-1983 National Institute of Mental Health funded Soteria House Research Project, by Loren R. Mosher, M.D., demonstrated that many people suffering from acute psychiatric difficulties could be successfully treated with no or little psychotropic medication and, that people who responded well to such treatment had substantially better outcomes than those treated and then maintained on such drugs. These findings, however, were overwhelmed by the psychiatric medication juggernaut and have yet to significantly impact public mental health policy development in this country.⁴

Mr. Whitaker, in his presentation to the Board, suggested it would be very desirable for Alaska to initiate a non-traditional alternative, such as a Soteria House, for people in acute psychiatric crises. In such a program, while psychiatric drugs could play a role, they would be used minimally, and for short periods if at all possible. This was receptively received by the Board and recent indications are that the Alaska Mental Health Trust Authority (Trust) may be willing to favorably entertain funding such a proposal.

The Soteria-Alaska Pilot Project would go a long way in enhancing the choices that are available for patients in the Alaska community. This program would certainly enhance the patient's ability to have not only a choice in the focus of programs, but would also

¹ Earlier this year, Mr. Whitaker published, "The case against antipsychotic drugs: a 50-year record of doing more harm than good," in *Medical Hypotheses*, Volume 62, Issue 1, 2004, Pages 5-13, (Appendix A) which was reviewed in the *British Medical Journal*, Vol. 328/414, February, 2004 as follows:

Maintaining people with schizophrenia on neuroleptics (the accepted standard care) may actually be doing them a disservice. According to a 50 year review, long term treatment worsens long term outcomes, and up to 40% of people would do better without neuroleptics. Initiation of treatment only after a subsequent episode and helping patients who are stabilised on neuroleptics to gradually withdraw from them would increase recovery rates and reduce the proportion of patients who become chronically ill (*Medical Hypotheses* 2004;62:5-13).

² See, e.g., Soteria and Other Alternatives to Acute Psychiatric Hospitalization A Personal and Professional Review, by Loren R. Mosher, M.D., *The Journal of Nervous and Mental Disease*, 187:142-149, 1999, Appendix B.

³ The availability of such an alternative has been endorsed by the CEO of API. See Appendix C.

⁴ There are, however, very successful Soteria and Soteria-like programs in other countries.

enhance their informed choice of whether to take medications as a part of their treatment. Such a choice would be in concert with a possible decision by the Alaska supreme court requiring a less restrictive alternative to the involuntary administration of psychotropic medications when possible.⁵

The Consumers Consortium has also felt so strongly about the need for such a program that it has engaged Dr. Aron Wolf to write a preliminary business plan for a Soteria like project and an alternative community program. Dr. wolf is currently working on this project and plans to have it accomplished by September 15, 2004.

All of these factors augur for the implementation of a Soteria or Soteria-like alternative to acute hospitalization in Alaska.

II. Population to be Served

The Soteria-Alaska Pilot Project would be a direct alternative to hospitalization at the Alaska Psychiatric Institute (API). Subject to availability of beds and eligibility, prospective clients would be given the option of going to the Soteria-Alaska Pilot Project rather than API. All admissions must be voluntary. In addition to people being faced with involuntary commitment at API, people who have been hospitalized in the past and feel they are spiraling down and need somewhere to go to prevent hospitalization would also be eligible on a space available basis.

III. The Soteria-Alaska Pilot Project

The proposal is for a Soteria⁶ or Soteria-like alternative to acute hospitalization operating under the principles enunciated by Dr. Mosher in "Soteria and Other Alternatives to Acute Psychiatric Hospitalization." Prior to his passing last month, Dr. Mosher e-mailed what resources it would take (edited somewhat as to form):

What is needed is a house that can get a license to "treat acutely mentally ill" persons. It needs to be zoned so 6-8 unrelated persons can live there. Detached houses are best as there is then space to allow for noise and some odd goings on. As for a budget you need 2 staff on at all times-we were able to use non-mental health trained staff supervised by a licensed social worker or psychologist. These are all full time positions although the supervisor need only work 40 hours (i.e. no back up), so you need 2 X 52 X 168 hours of line staff money plus vacation and sick leave time at whatever the going rate is up there for college grads with no specialized training in mental health.

We always got by with 10 hours a week of psychiatric time to do admission workups and discharge notes (usually required by law if you

⁵ See, website on *Myers v. Alaska Psychiatric Institute*, S-11021 in the Alaska Supreme Court, <http://psychrights.org/States/Alaska/CaseOne.htm>.

⁶ Soteria is a Greek word meaning salvation or deliverance.

want to operate as an alternative to hospitalization). The last one we ran cost about \$150/person/day in 1994 dollars. This included everything-rent, food, utilities and staff cost etc. That came to about \$ 300,000 per year so I guess you'd need about \$400,000 as an annual budget. Several states have Medicaid rehab waivers by which they've established per diem rates for alternatives. The current one for places here in San Diego is \$215/day. The problem is, sometimes getting involved with Medicaid forces you to have nurses as part of the staff and they add lots to the cost.

To reassure the powers that be you should have a staff training budget in addition to what the house director/supervisor can provide. The chapter in our book, Community Mental Health: a Practical Guide, on staffing-chap 10 as I recall-we give some criteria for staff selection and deselection for working in Soteria like places. I used them successfully with 3 different house director social workers. We also have a training manual that will be contained in a new Soteria book that should appear this year. The problem is of course that there are not many folks around who have actually done this work. There is no "cook book" because each place has to differ according to the context in which it will exist.

IV. Budget

The Budget (in thousands) for the Soteria-Alaska Pilot Project, starting in FY 06, is as follows:

Fund Source	FY06	FY07	FY08	FY09	FY10
Authority Grants - Capital	\$500				
Authority Grants - Operating	\$300	\$350	\$300	\$250	\$200

It is essential that these be Authority Grants rather than Mental Health Trust Authority Authorized Receipts (MHTAAR) funds in order to ensure fidelity to the Soteria principles in implementation.

The one time capital grant of \$500,000 is to acquire a suitable residential property.

The \$300,000 in operating funds for FY 06 assumes an annualized budget of \$400,000 and that it will take one quarter to begin operations.⁷ Thereafter the Authority Grants requirements goes down to half of the anticipated annual cost through use of other payers, such as Medicaid and even private insurers.⁸ This very well could be improved by changing the Medicaid Regulations and/or obtaining a waiver(s) so that the Soteria

⁷ It also assumes that it does not have to be staffed by nurses.

⁸ Dr. Wolf, who is consulting on this project has indicated he is in a position to try to negotiate this with the four main private insurers in Alaska.

services can access these sources of funds. The great reduction in costs should be grounds enough to for such payers to agree.

V. Implementation

Implementation is critical to the success of this project and the key to implementation for the Soteria-Alaska Pilot Project is having people experienced in Soteria-like programs involved. Before his untimely death last month, Dr. Mosher had agreed to come to Alaska for three months to help get Soteria-Alaska off the ground and on the right direction in funding was obtained. There are, however, other psychiatrists with appropriate experience who have expressed willingness to help.

Dr. Peter Stastny is Associate Professor of Psychiatry at Albert Einstein College of Medicine, and Senior Psychiatrist at Bronx Psychiatric Center. Dr. Stastny is the author of numerous scholarly papers on psychosocial treatments, advance directives, self-help and empowerment, film history and mental health and subjective experiences. He has spearheaded innovative programs, such as peer specialist services, consumer-run businesses, and transitional living groups. Dr. Stastny is convening a working-conference this fall in New England of the key people involved in alternatives such as Soteria-type programs from around the world.

Dr. Ann-Louise Silver practiced psychiatry for 25 years at Chestnut Lodge Hospital, from 1976 to the time of its closing in April, 2001. She worked with patients both in the non-medication and the medication phases of the history of this famous institution and found that the patients with whom she worked during the non-medication phase did far better than did those who were chronically medicated.⁹ Dr. Silver is currently the president of the US Chapter of the International Society for the Psychological treatments of the Schizophrenias and other psychoses (ISPS-US). Dr. Silver also practiced for over two years at the Northern Region of Alaska in the late 1960's while her husband served a tour of duty at Fort Wainwright and has maintained her Alaska medical license on an inactive basis since then.

Dr. Dan Dorman is Assistant Clinical Professor of Psychiatry at the UCLA School of Medicine. He has a background in family medicine, psychoanalysis and research in neurophysiology. Dr. Dorman has practiced and taught psychotherapy for over thirty years. His recently published and acclaimed book "Dante's Cure" chronicles his work with Catherine Penney, who was considered a hopeless case, but with Dr. Dorman's help, fully recovered from her descent into madness and is now a psychiatric nurse in southern California.

Jim Gottstein has made arrangements to meet with both Drs. Silver and Dorman on an upcoming trip to Chicago in September.

As mentioned above, Aron S. Wolf M.D., M.M.M., of Wolf Healthcare P.C., is currently working on developing a model using both Soteria modules as well as community type

⁹ See, e.g., http://www.isps-us.org/articles/ISPS_Debate/I_Oppose/i_oppose.html.

models as demonstrated by the Ionia community in Kasilof. Dr. Wolf is a well known, longtime Alaskan psychiatrist. Dr. Wolf accomplished his psychiatric training in Baltimore. One of his principal mentors was Otto Will of Chestnut Lodge and later the Director of the Institute of Living. As a part of his mentoring, Dr. Wolf spent considerable time at Chestnut Lodge learning their interactive ways of relating to severely psychotic individuals. Dr. Wolf more recently obtained a Master of Medical Management Degree from Tulane University and used his administrative knowledge as the first Regional Medical Director for the Providence Health System in Alaska prior to opening his own consulting practice.

Appendix A

"The case against antipsychotic drugs: a 50-year record of doing more than good," in *Medical Hypotheses*, Volume 62, Issue 1 , 2004, Pages 5-13



The case against antipsychotic drugs: a 50-year record of doing more harm than good[☆]

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Summary Although the standard of care in developed countries is to maintain schizophrenia patients on neuroleptics, this practice is not supported by the 50-year research record for the drugs. A critical review reveals that this paradigm of care worsens long-term outcomes, at least in the aggregate, and that 40% or more of all schizophrenia patients would fare better if they were not so medicated. Evidence-based care would require the selective use of antipsychotics, based on two principles: (a) no immediate neuroleptisation of first-episode patients; (b) every patient stabilized on neuroleptics should be given an opportunity to gradually withdraw from them. This model would dramatically increase recovery rates and decrease the percentage of patients who become chronically ill.

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Introduction

The standard of care for schizophrenia calls for patients to be maintained indefinitely on antipsychotic drugs. The evidence for this practice comes from research showing the drugs are effective in treating acute psychotic symptoms and in preventing relapse [1,2]. Historians also argue that the introduction of neuroleptics in the 1950s made it possible to empty the mental hospitals, and that this is further proof of the drugs' merits [3]. Yet, long-term outcomes with schizophrenia remain poor, and may be no better than they were 100 years ago, when water therapies and fresh air were the treatment of the day [4–7].

There is an evident paradox in the research record. The efficacy of neuroleptics appears to be well established, yet there is a lack of evidence showing that these drugs have improved patients' lives over the long-term. That paradox recently stirred an unusual editorial in *Eur. Psychiatry*,

which posed this question: "After fifty years of neuroleptic drugs, are we able to answer the following simple question: Are neuroleptics effective in treating schizophrenia?" [8] A close review of the research literature provides a surprising answer. The preponderance of evidence shows that the current standard of care – continual medication therapy for all patients so diagnosed – does more harm than good.

Did neuroleptics enable deinstitutionalization?

The belief that the introduction of chlorpromazine, marketed in the US as Thorazine, made it possible to empty state hospitals stems from research by Brill and Patton. In the early 1960s, they reported that the patient census at state mental hospitals in the US declined from 558,600 in 1955 to 528,800 in 1961. Although they did not compare discharge rates for drug-treated versus placebo-treated patients, they nevertheless concluded that neuroleptics must have played a role in the decline since it coincided with their introduction. The fact that the two occurred at the same time was seen as the proof [9,10].

[☆] Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill (Perseus Publishing, 2002).

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However, there were obvious confounding factors. In the early 1950s, the Council of State Governments in the US urged the federal government to share the fiscal burden of caring for the mentally ill, and proposed that “out-patient clinics should be extended and other community resources developed to care for persons in need of help, but not of hospitalization” [11,12]. As part of this agenda, states began developing community care initiatives, funneling the mentally ill into nursing homes and halfway houses. This change in social policy could easily have been responsible for the slight drop in patient numbers observed by Brill and Patton.

Moreover, there was one state that did compare discharge rates for schizophrenia patients treated with and without drugs, and its results do not support the historical claim made for neuroleptics. In a study of 1413 first-episode male schizophrenics admitted to California hospitals in 1956 and 1957, researchers found that “drug-treated patients tend to have longer periods of hospitalization... furthermore, the hospitals wherein a higher percentage of first-admission schizophrenic patients are treated with these drugs tend to have somewhat higher retention rates for this group as a whole”. In short, the California investigators determined that neuroleptics, rather than speed patients’ return to the community, apparently *hindered* recovery [13].

The true period of deinstitutionalization in the US was from 1963 to the late 1970s, the exodus of patients driven by social and fiscal policies. In 1963, federal government began picking up some of the costs of care for the mentally ill not in state institutions, and two years later, Medicare and Medicaid legislation increased federal funding for care of mental patients provided they were not housed in state hospitals. Naturally, states responded by discharging their hospital patients to private nursing homes and shelters. In 1972, an amendment to the Social Security act authorized disability payments to the mentally ill, which accelerated the transfer of hospitalized patients into private facilities. As a result of these changes in *fiscal* policies, the number of patients in state mental hospitals dropped from 504,600 to 153,544 over a 15-year period (1963–1978) [14].

Establishing efficacy: the pivotal NIMH trial

The study that is still cited today as proving the efficacy of neuroleptics for curbing acute episodes of schizophrenia was a nine-hospital trial of 344 patients conducted by the National Institute of Mental Health in the early 1960s. At the end of six weeks,

75% of the drug-treated patients were “much improved” or “very much improved” compared to 23% of the placebo patients. The researchers concluded that neuroleptics should no longer be considered mere “tranquilizers” but “antischizophrenic” agents. A magic bullet had apparently been found for this devastating disorder [1].

However, three years later, the NIMH researchers reported on one-year outcomes for the patients. Much to their surprise, they found that “patients who received placebo treatment were less likely to be rehospitalized than those who received any of the three active phenothiazines” [15]. This result raised an unsettling possibility: While the drugs were effective over the short-term, perhaps they made people more biologically vulnerable to psychosis over the long run, and thus the higher rehospitalization rates at the end of one year.

The NIMH withdrawal studies

In the wake of that disturbing report, the NIMH conducted two medication-withdrawal studies. In each one, relapse rates *rose* in correlation with neuroleptic dosage before withdrawal. In the two trials, only 7% of patients who were on placebo relapsed during the following six months. Twenty-three percent of the patients on less than 300 mg of chlorpromazine daily relapsed following drug withdrawal; this rate climbed to 54% for those receiving 300–500 mg and to 65% for patients taking more than 500 mg. The researchers concluded: “Relapse was found to be significantly related to the dose of the tranquilizing medication the patient was receiving before he was put on placebo – the higher the dose, the greater the probability of relapse” [16].

Once more, the results suggested that neuroleptics increased the patients’ biological vulnerability to psychosis. Other reports soon deepened this suspicion. Even when patients reliably took their medications, relapse was common, and researchers reported in 1976 that it appeared that “relapse during drug administration is greater in severity than when no drugs are given” [17]. A retrospective study by Bockoven also indicated that the drugs were making patients chronically ill. He reported that 45% of patients treated at Boston Psychopathic Hospital in 1947 with a progressive model of care did not relapse in the five years following discharge, and that 76% were successfully living in the community at the end of that follow-up period. In contrast, only 31% of patients treated in 1967 with neuroleptics at a community health center remained relapse-free over the next five years, and as a group they were much more “socially dependent” – on welfare and

needing other forms of support – than those in the 1947 cohort [18].

Drug treatment versus experimental forms of care

With debate over the merits of neuroleptics rising, the NIMH revisited the question of whether newly admitted schizophrenia patients could be successfully treated without drugs. There were three NIMH-funded studies conducted during the 1970s that examined this possibility, and in each instance, the newly admitted patients treated without drugs did better than those treated in a conventional manner.¹

In 1977, Carpenter reported that only 35% of the nonmedicated patients in his study relapsed within a year after discharge, compared to 45% of those treated with neuroleptics. The non-medicated patients also suffered less from depression, blunted emotions, and retarded movements [20]. A year later, Rappaport et al. [21] reported that in a trial of 80 young male schizophrenics admitted to a state hospital, only 27% of patients treated without neuroleptics relapsed in the three years following discharge, compared to 62% of the medicated group. The final study came from Mosher, head of schizophrenia research at the NIMH. In 1979, he reported that patients who were treated without neuroleptics in an experimental home staffed by nonprofessionals had lower relapse rates over a two-year period than a control group treated with drugs in a hospital. As in the other studies, Mosher reported that the patients treated without drugs were the better functioning group as well [22,23].

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

There is no question that, once patients are placed on medication, they are less vulnerable

¹ In the early 1960s, May conducted a study that compared five forms of treatment: drug, ECT, psychotherapy, psychotherapy plus drug, and milieu therapy. Over the short-term, the drug-treated patients did best. As a result, it came to be cited as proof that schizophrenia patients could not be treated with psychotherapy. However, the long-term results told a more nuanced story. Fifty-nine percent of patients initially treated with milieu therapy but no drugs were successfully discharged in the initial study period, and this group "functioned over the follow-up (period) at least as well, if not better, than the successes from the other treatments". Thus, the May study suggested that a majority of first-episode patients would fare best over the long-term if initially treated with "milieu therapy" rather than drugs [19].

to relapse if maintained on neuroleptics. But what if these patients had never been treated with drugs to begin with? . . . We raise the possibility that antipsychotic medication may make some schizophrenic patients more vulnerable to future relapse than would be the case in the natural course of the illness [20].

In the late 1970s, two physicians at McGill University in Montreal, Guy Chouinard and Barry Jones, offered a biological explanation for why this was so. The brain responds to neuroleptics – which block 70–90% of all D₂ dopamine receptors in the brain – as though they are a pathological insult. To compensate, dopaminergic brain cells increase the density of their D₂ receptors by 30% or more. The brain is now "supersensitive" to dopamine, and this neurotransmitter is thought to be a mediator of psychosis. The person has become more biologically vulnerable to psychosis and is at particularly high risk of severe relapse should he or she abruptly quit taking the drugs. The two Canadian researchers concluded:

Neuroleptics can produce a dopamine supersensitivity that leads to both dyskinetic and psychotic symptoms. An implication is that the tendency toward psychotic relapse in a patient who has developed such a supersensitivity is determined by more than just the normal course of the illness. . . the need for continued neuroleptic treatment may itself be drug induced [24,25].

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

The world health organization studies

In 1969, the World Health Organization initiated a study to compare outcomes for schizophrenia in "developed" countries with outcomes in "undeveloped" countries. Once again, the results were surprising. Patients in the three poor countries –

India, Nigeria and Colombia – were doing dramatically better at two-year and five-year follow-ups than patients in the US and four other developed countries. They were more likely to be fully recovered and faring well in society – “an exceptionally good social outcome characterized these patients”, the WHO researchers wrote – and only a small minority had become chronically sick. At five years, about 64% of the patients in the poor countries were asymptomatic and functioning well. In contrast only 18% of patients in the rich countries were in this best-outcomes category. The difference in outcomes was such that the WHO researchers concluded living in a developed nation was a “strong predictor” that a schizophrenic patient would never fully recover [26].

These findings naturally stung psychiatrists in the US and other rich countries. Faced with such dismal results, many argued the WHO study was flawed and that a number of the patients in the poor countries must not have been schizophrenic but ill with a milder form of psychosis. With that criticism in mind, the WHO conducted a study that compared two-year outcomes in 10 countries, and it focused on first-episode schizophrenics all diagnosed by Western criteria. The results were the same. “The findings of a better outcome of patients in developing countries was confirmed”, the WHO investigators wrote. In the poor countries, 63% of schizophrenics had good outcomes. Only slightly more than one-third became chronically ill. In the rich countries, the ratio of good-to-bad outcomes was almost precisely the reverse. Only 37% had good outcomes, and the remaining patients did not fare so well [27].

The WHO investigators did not identify a cause for the stark disparity in outcomes. However, they did note there was a difference in the medical care that was provided. Doctors in the poor countries generally did not keep their patients on neuroleptics, while doctors in the rich countries did. In the poor countries, only 16% of the patients were maintained on neuroleptics. In the developed countries, 61% of the patients were kept on such drugs.

Once again, the research record told the same story. In the WHO studies, there was a correlation between use of the medications on a continual basis and poor long-term outcomes.

MRI studies

While most researchers have used MRIs to investigate possible causes of schizophrenia, a small number have employed this technology to study the effects of neuroleptics on the brain. These

investigators have found that the drugs cause atrophy of the cerebral cortex and an enlargement of the basal ganglia [28–30]. Moreover, researchers at the University of Pennsylvania reported in 1998 that the drug-induced enlargement of the basal ganglia is “associated with greater severity of both negative and positive symptoms” [31]. In other words, they found that the drugs cause changes in the brain associated with a *worsening* of the very symptoms the drugs are supposed to alleviate.

Relapse studies

As discussed earlier, evidence for the efficacy of neuroleptics is stated to be two-fold. First, the NIMH trial in the 1960s found that neuroleptics are more effective than placebo in curbing acute episodes of psychosis. Second, the drugs have been shown to prevent relapse. In 1995, Gilbert reviewed 66 relapse studies, involving 4365 patients, and summed up the collective evidence: Fifty-three percent of patients withdrawn from neuroleptics relapsed within 10 months, versus 16% of those maintained on the drugs. “The efficacy of these medications in reducing the risk of psychotic relapse has been well documented,” she wrote [2].

At first glance, this conclusion seems to contradict the research showing that the drugs made patients chronically ill. There is an answer to this puzzle however, and it is a revealing one. The studies by Rappaport, Mosher and Carpenter involved patients who, at the start of the experiment, were not on neuroleptics but were then treated either with placebo or a neuroleptic. And in those studies, relapse rates were lower for the placebo group. In contrast, the 66 studies reviewed by Gilbert were *drug-withdrawal* studies. In the studies she analyzed, patients who had been stabilized on neuroleptics were divided into two cohorts: One would keep on taking the drugs and the other would not, and the studies reliably found that people withdrawn from their neuroleptics were more likely to become sick again.

Thus, the literature suggests that relapse rates fall into three groups: lowest for those not placed on neuroleptics in the first place, higher for those who take the drugs continuously, and highest of all for those withdrawn from the drugs. Yet even that picture is misleading.

First, for the most part, the drug-withdrawal studies were conducted in a select group of “good responders” to neuroleptics, rather than in the general patient population. In the real world, up

to 30% of hospitalized patients do not respond to neuroleptics. Among those who do and are discharged, more than one-third relapse within the next 12 months and need to be rehospitalized, even though they reliably take their medications. Thus, fewer than 50% of people who suffer a schizophrenic break respond to standard neuroleptics and remain relapse-free for as long as a year, but the relapse studies, to a large degree, were conducted in this group of good responders. In 1998, Hogarty pointed out how this study design led to a mistaken understanding of true relapse rates with antipsychotics: “A reappraisal of the literature suggests a one-year, post-hospital, relapse rate of 40% on medication, and a substantially higher rate among patients who live in stressful environments, rather than earlier estimates of 16%” [32].

At the same time, the relapse studies were designed in ways that exaggerated the risk of relapse in the drug-withdrawn groups. In response to Gilbert, Baldessarini reanalyzed the same 66 studies, only he divided the drug-withdrawn cohort into “abrupt-withdrawal” and “gradual-withdrawal” groups. He determined that the relapse rate in the abruptly withdrawn group was *three times higher* than in the gradual group [33]. In other words, it was the abrupt cessation that caused much of the excess relapse risk. Indeed, in a further review of the relapse literature, Baldessarini found that only one-third of schizophrenia patients gradually withdrawn from their drugs relapsed within six months and that those who reached this six-month point without become sick again had a good chance of remaining well indefinitely. “The later risk of relapsing was remarkably limited,” he concluded [34].

The relapse studies are cited to support a paradigm of care that emphasizes continual drug therapy for schizophrenia patients. But upon closer examination, a new picture emerges. The real-world first-year relapse rate for patients maintained on neuroleptics is understood to be 40%, while the rate for patients gradually withdrawn from the drugs is 33%. Thus, once bad trial design is eliminated, the evidence for continual medication disappears. At the same time, evidence appears showing that a majority of patients – two-thirds in the gradual withdrawal studies – can do fairly well without the drugs.

Doing more harm than good

Although this review of neuroleptics may seem surprising, the research record actually is quite

consistent. The pivotal NIMH study in the early 1960s found that the drugs had a short-term benefit, but that over the long-term the drug-treated patients had higher relapse rates. Similarly, in his retrospective study, Bockoven found that patients treated with neuroleptics were more likely to become chronically ill. The experiments by Carpenter, Mosher, and Rappaport all showed higher relapse rates for drug-treated patients, and in 1979, Canadian investigators put together a biological explanation for why this would be so. The World Health Organization reported higher recovery rates in poor countries where patients were not regularly maintained on the drugs. Finally, the MRI studies by investigators at the University of Pennsylvania confirmed the problem of drug-induced chronicity in a compelling way. The drug treatment caused a pathological change in the brain associated with a worsening of symptoms – that is a convincing example of cause and effect.

Thus, there is a preponderance of evidence showing that standard neuroleptics, over the long-term, increase the likelihood that a person will become chronically ill. This outcome is particularly problematic when one considers that the drugs also cause a wide range of troubling side effects, including neuroleptic malignant syndrome, Parkinsonian symptoms, and tardive dyskinesia. Patients maintained on standard neuroleptics also have to worry about blindness, fatal blood clots, heat stroke, swollen breasts, leaking breasts, impotence, obesity, sexual dysfunction, blood disorders, painful skin rashes, seizures, diabetes, and early death [35–40].

Once all these factors are considered, it is hard to conclude that standard neuroleptics are therapeutically neutral. Instead, the research record shows harm done, and the record is consistent across nearly 50 years of research. [See “Timeline to Failure” in Appendix A.]

A better model: the selective use of neuroleptics

At the very least, this history argues that the best model of care would involve selective use of neuroleptics. The goal would be to minimize their use. Several investigators in Europe have developed programs based on that goal, and in every instance they have reported good results. In Switzerland, Ciompi established a house modeled on Mosher’s Soteria Project, and in 1992 he concluded that first-episode patients treated with no or very low doses of medication “demonstrated

significantly better results” than patients treated conventionally [41]. In Sweden, Cullberg reported that 55% of first-episode patients treated in an experimental program were successfully off neuroleptics at the end of three years, and the others were being maintained on extremely low doses of chlorpromazine. Moreover, patients treated in this manner spent fewer days in the hospital than conventionally treated patients during the follow-up period [42,43]. Lehtinen and his colleagues in Finland now have five-year results from a study that involved treating first-episode patients without neuroleptics for the initial three weeks and then initiating drug treatment only when “absolutely necessary”. At the end of five years, 37% of the experimental group had never been exposed to neuroleptics, and 88% had never been rehospitalized during the two-to-five-year follow-up period [44,45].

Those results are much better than any achieved in the US following the standard model of continual medication. Indeed, in his meta-analysis of such experimental studies, John Bola at the University of Southern California concluded that most “show better long-term outcomes for the unmedicated subjects” [23].

The atypicals: dawn of a new era?

Admittedly, the record of poor long-term results reviewed here was produced by standard neuroleptics. The poor outcomes may also reflect prescribing practices in the US that, until the late 1980s, involved putting patients on high dosages. The long-term research record for clozapine and other atypicals like risperidone and olanzapine has yet to be written.

One hopes that these newer drugs will lead to better outcomes, but there are reasons to be skeptical. As is now widely acknowledged, the clinical trials of the atypicals were biased by design against the old ones, and thus there is no compelling evidence that the new ones are truly better [46]. While the risk of tardive dyskinesia may be reduced with the atypicals, they bring their own set of new problems, such as an increased risk of obesity, hyperglycemia, diabetes, and pancreatitis [47–49]. Together, these side effects raise the concern that the atypicals regularly induce metabolic dysfunction of some kind, and thus their long-term use will lead to early death. The atypicals also have been shown to cause an increase in D2 receptors, just like the old ones do, and that is believed to be the mechanism that makes medicated patients more biologically vulnerable to psychosis [50].

Summary

The history of medicine is replete with examples of therapies that were eagerly embraced for a period and then later discarded as harmful. A scientific examination of the evidence is supposed to save us from such folly today. And science has in fact provided research data to guide prescribing practices. The evidence consistently reveals that maintaining all schizophrenia patients on antipsychotics produces poor long-term outcomes, and that there is a large group of patients – at least 40% of all people so diagnosed – who would do better if they were never exposed to neuroleptics, or, in the alternative, were encouraged to gradually withdraw from the drugs. (The percentage of patients diagnosed with schizoaffective disorder, or some milder form of psychosis, that could do well without the drugs is undoubtedly much higher.)

This conclusion is not a new one, either. Nearly 25 years ago, Jonathan Cole, one of the pioneering figures in psychopharmacology, published a paper provocatively titled “Maintenance Antipsychotic Therapy: Is the Cure Worse than the Disease?” After reviewing the research data, he concluded that “an attempt should be made to determine the feasibility of drug discontinuance in every patient” [17]. The evidence supported a standard of care that involved gradual withdrawal. The research record of neuroleptics since that time – most notably the WHO studies and the MRI study by investigators at the University of Pennsylvania – confirms the wisdom of his advice.

Indeed, Harding’s long-term study shows that gradual withdrawal is an essential step on the path to full recovery. She found that one-third of the schizophrenia patients on the back wards of a Vermont state hospital in the 1950s were completely recovered thirty years later, and that this group shared one characteristic: all had long since stopped taking neuroleptics [51]. She concluded that it was a “myth” that patients must be on medication all their lives, and that in “reality it may be a small percentage who need medication indefinitely” [52].

Yet, in spite of all this evidence, today there is almost no discussion within psychiatry of adopting practices that would involve using neuroleptics in a selective manner, and that would integrate gradual withdrawal into the standard of care. Instead, psychiatry is moving in the opposite direction and prescribing antipsychotics to an ever larger patient population, including those said simply to be “at risk” of developing schizophrenia. While this expansion of the use of antipsychotics serves obvious financial interests, it is treatment that is certain to harm many.

Appendix A

A timeline for neuroleptics.

Preclinical

- 1883 Phenothiazines developed as synthetic dyes.
- 1934 USDA develops phenothiazines as insecticide.
- 1949 Phenothiazines shown to hinder rope-climbing abilities in rats.
- 1950 Rhone Poulenc synthesizes chlorpromazine, a phenothiazine, for use as an anesthetic.

Clinical history/standard neuroleptics

- 1954 Chlorpromazine, marketed in the US as Thorazine, found to induce symptoms of Parkinson's disease.
- 1955 Chlorpromazine said to induce symptoms similar to encephalitis lethargica.
- 1959 First reports of permanent motor dysfunction linked to neuroleptics, later named tardive dyskinesia.
- 1960 French physicians describe a potentially fatal toxic reaction to neuroleptics, later named neuroleptic malignant syndrome.
- 1962 California Mental Hygiene Department determines that chlorpromazine and other neuroleptics prolong hospitalization.
- 1963 Six-week NIMH collaborative study concludes that neuroleptics are safe and effective "antischizophrenic" drugs.
- 1964 Neuroleptics found to impair learning in animals and humans.
- 1965 One-year followup of NIMH collaborative study finds drug-treated patients more likely than placebo patients to be rehospitalized.
- 1968 In a drug withdrawal study, the NIMH finds that relapse rates rise in direct relation to dosage. The higher the dosage that patients are on before withdrawal, the higher the relapse rate.
- 1972 Tardive dyskinesia is said to resemble Huntington's disease, or "postencephalitic brain damage".
- 1974 Boston researchers report that relapse rates were lower in pre-neuroleptic era, and that drug-treated patients are more likely to be socially dependent.
- 1977 A NIMH study that randomizes schizophrenia patients into drug and non-drug arms reports that only 35% of the non-medicated patients relapsed within a year after discharge, compared to 45% of those treated with medication.
- 1978 California investigator Maurice Rappaport reports markedly superior three-year outcomes for patients treated without neuroleptics. Only 27% of the drug-free patients relapsed in the three years following discharge, compared to 62% of the medicated patients.
- 1978 Canadian researchers describe drug-induced changes in the brain that make a patient more vulnerable to relapse, which they dub "neuroleptic induced supersensitive psychosis".
- 1978 Neuroleptics found to cause 10% cellular loss in brains of rats.
- 1979 Prevalence of tardive dyskinesia in drug-treated patients is reported to range from 24% to 56%.
- 1979 Tardive dyskinesia found to be associated with cognitive impairment.
- 1979 Loren Mosher, chief of schizophrenia studies at the NIMH, reports superior one-year and two-year outcomes for Soteria patients treated without neuroleptics.
- 1980 NIMH researchers find an increase in "blunted effect" and "emotional withdrawal" in drug-treated patients who don't relapse, and that neuroleptics do not improve "social and role performance" in non-relapsers.
- 1982 Anticholinergic medications used to treat Parkinsonian symptoms induced by neuroleptics reported to cause cognitive impairment.
- 1985 Drug-induced akathisia is linked to suicide.
- 1985 Case reports link drug-induced akathisia to violent homicides.
- 1987 Tardive dyskinesia is linked to worsening of negative symptoms, gait difficulties, speech impairment, psychosocial deterioration, and memory deficits. They conclude it may be both a "motor and dementing disorder".
- 1992 World Health Organization reports that schizophrenia outcomes are much superior in poor countries, where only 16% of patients are kept continuously on neuroleptics. The WHO concludes that living in a developed nation is a "strong predictor" that a patient will never fully recover.

Appendix A (continued)

Clinical history/standard neuroleptics

- 1992 Researchers acknowledge that neuroleptics cause a recognizable pathology, which they name neuroleptic induced deficit syndrome. In addition to Parkinson's, akathisia, blunted emotions and tardive dyskinesia, patients treated with neuroleptics suffer from an increased incidence of blindness, fatal blood clots, arrhythmia, heat stroke, swollen breasts, leaking breasts, impotence, obesity, sexual dysfunction, blood disorders, skin rashes, seizures, and early death.
- 1994 Neuroleptics found to cause an increase in the volume of the caudate region in the brain.
- 1994 Harvard investigators report that schizophrenia outcomes in the US appear to have worsened over past 20 years, and are now no better than in first decades of 20th century.
- 1995 "Real world" relapse rates for schizophrenia patients treated with neuroleptics said to be above 80% in the two years following hospital discharge, which is much higher than in pre-neuroleptic era.
- 1995 "Quality of life" in drug-treated patients reported to be "very poor".
- 1998 MRI studies show that neuroleptics cause hypertrophy of the caudate, putamen and thalamus, with the increase "associated with *greater* severity of both negative and positive symptoms".
- 1998 Neuroleptic use is found to be associated with atrophy of cerebral cortex.
- 1998 Harvard researchers conclude that "oxidative stress" may be the process by which neuroleptics cause neuronal damage in the brain.
- 1998 Treatment with two or more neuroleptics is found to increase risk of early death.
- 2000 Neuroleptics linked to fatal blood clots.
- 2003 Atypicals linked to an increased risk of obesity, hyperglycemia, diabetes, and pancreatitis.

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Appendix B

Soteria and Other Alternatives to Acute Psychiatric Hospitalization A
Personal and Professional Review, by Loren R. Mosher, M.D., *The
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Soteria and Other Alternatives to Acute Psychiatric Hospitalization

A Personal and Professional Review

LOREN R MOSHER, M.D.^{1,2}

ABSTRACT: The author reviews the clinical and special social environmental data from the Soteria Project and its direct successors. Two random assignment studies of the Soteria model and its modification for long-term system clients reveal that roughly 85% to 90% of acute and long-term clients deemed in need of acute hospitalization can be returned to the community without use of conventional hospital treatment. Soteria, designed as a drugfree treatment environment, was as successful as anti-psychotic drug treatment in reducing psychotic symptoms in 6 weeks. In its modified form, in facilities called Crossing Place and McAuliffe House where so-called long-term "frequent flyers" were treated, alternative-treated subjects were found to be as clinically improved as hospital-treated patients, at considerably lower cost. Taken as a body of scientific evidence, it is clear that alternatives to acute psychiatric hospitalization are as, or more, effective than traditional hospital care in short-term reduction of psychopathology and longer- social adjustment. Data from the original drug-free, home-like, nonprofessionally staffed Soteria Project and its Bern, Switzerland, replication indicate that persons without extensive hospitalizations (<30 days) are especially responsive to the positive therapeutic effects of the well-defined, replicable Soteria-type special social environments. Reviews of other studies of diversion of persons deemed in need of hospitalization to "alternative" programs have consistently shown equivalent or better program clinical results, at lower cost, from alternatives. Despite these clinical and cost data, alternatives to psychiatric hospitalization have not been widely implemented, indicative of a remarkable gap between available evidence and clinical practice. J Nerv Ment Dis 187:142-149, 1999

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Introduction

In 1961, while serving as a medical intern, knowing I was soon to embark on a career as a psychiatrist, I suffered what retrospectively could be labeled an existential crisis. For the first time I experienced the responsibility of caring for persons who would soon die-and I was powerless to do anything about it-except to try to understand their experience of it. They frequently expressed how helpless and depersonalized they felt, "I'm just the one with lung cancer" or "Why can't you do something so I can breathe-- drowning" or "All this place has done is to make me into a nobody-you can't do anything for me so you steer clear." For the first time I faced my own mortality and with it the degrading, dehumanizing and helplessness of the process that could accompany it-particularly if I had the misfortune of being in a hospital like the one in which I worked.

Previous intensive psychotherapy as a medical student had obviously not prepared me to face mortality compounded by the degradation ceremonies I presided over within the institution. As a sometime intellectual, I sought help with my conundrum in the library. Rollo May's *Existence* (1958) was the beginning of a quest for an intellectual foundation for the depth of what I was experiencing personally. With the help of May's book and an existential analytic tutor (Dr. Ludwig Lefebre), I studied the writings of a number of the phenomenologic/existential thinkers (e.g., Allers, 1961; Boss, 1963; Hegel, 1967; Husserl, 1967; Sartre, 1956; Tillich, 1952; and others) in greater depth. I concluded that their open minded, noncategorizing, no preconceptions approach was a breath of fresh air in the era of rationalistic theory driven approaches (such as psychoanalysis) to disturbed and disturbing persons.

So, I brought to my psychiatric residency a phenomenology-based "what you see is what you've got" bias to my interactions with patients and a sensitivity to the issues of a degradation and power especially as embodied in conventional institutional practices. The good mentors (e.g., Drs. Elvin Semrad and Norman Paul) in my psychiatric training

taught me how to listen and attempt to find meaning in the distorted communications of my patients and their families (in 1962!) by doing my best to put my feet into their shoes. Harry Stack Sullivan (1962) and the double bind theory (Bateson et al., 1956) provided intellectual support. I also learned how to ask and look for answers to questions of interest from research gods (e.g., Dr. Martin Orne). On the other hand, the institution itself gave me master classes in the art of the "total institution" (Goffman, 1961); authoritarianism, the degradation ceremony, the induction and perpetuation of powerlessness, unnecessary dependency, labeling, and the primacy of institutional needs over those of the persons it was ostensibly there to serve--the patients. These institutional lessons were not part of the training program. In fact, my efforts to be helpful to my patients were interrupted by these institutional needs. When brought up they were denied, rationalized, or simply invalidated, "You're just a resident and aren't yet able to understand why these processes are not as you see them." From a series of such experiences, I began to believe that psychiatric hospitals were not usually very good places in which to be insane.

Although the Thorazine assault troops (Smith, Klein, and French's own terminology for its 1956 charge to the company's detail men--see BradenJohnson [1990]) had already successfully done their job --selling the neuroleptics -- never became a true believer in the "magic bullet" attribution commonly ascribed the neuroleptic drugs. Despite being trained by psychopharmacologic icons (e.g., Dr. Gerald Klerman), I somehow never found a Lazarus among those I treated with the major tranquilizers. Again, my experience led me to question the emerging psychopharmacologic domination of the treatment of very disturbed and disturbing persons. Actually those persons seemed to appreciate my sometimes clumsy attempts to understand them and their lives. Because I hadn't found a large role for drugs in the helping process, I was led to believe more in interpersonal than neuroleptic "cures." I did worry about what went on in the 164 hours a week when my patients were not with me -- was the rest of their world trying to understand and relate meaningfully to them?

So, as a career unfolded, the questioning of conventional wisdom remained part of me, albeit not always acted upon in a way that would bring undue attention and consequent retribution. To interests in the meaningfulness of madness, understanding families, and the conduct of research, I added one from my institutional experience; if places called hospitals were not good for disturbed and disturbing behavior, what kinds of social environments were? In 1966-1967, this interest was nourished by R.D. Laing and his colleagues in the Philadelphia Association's Kingsley Hall in London. The deconstruction of madness and the madhouse that took place there generated ideas about how a community-based, supportive, protective, normalizing environment might facilitate reintegration of psychologically disintegrated persons without artificial institutional disruptions of the process. This, combined with my existential/phenomenologic-psychotherapy and anti-neuroleptic drug biases resulted, in 1969-1971, in the design and implementation of the Soteria Research Project. Soteria is a Greek word meaning salvation or deliverance. In addition to my interests, the project included ideas from the era of "moral treatment" in American psychiatry (Bockhoven, 1963), Sullivan's (1962) interpersonal theory and his specially designed milieu for persons with schizophrenia at

Sheppard and Enoch Pratt Hospital in the 1920s, labeling theory (Scheff, 1966), intensive individual therapy based on Jungian theory (Perry, 1974) and Freudian psychoanalysis (Fromm-Reichman, 1948; Searles, 1965), the notion of growth from psychosis (Laing, 1967; Menninger, 1959), and examples of community-based treatment such as the Fairweather Lodges (Fairweather et al., 1969).

The Soteria Project (1971-1983)

This project's design was a random assignment, 2-year follow-up study comparing the Soteria method of treatment with "usual" general hospital psychiatric ward interventions for persons *newly diagnosed as having schizophrenia* and deemed in need of hospitalization. It has been extensively reported (see especially Mosher et al., 1978, 1995). In addition to less than 30 days previous hospitalization (i.e., "newly diagnosed"), the Soteria study selected 18- to 30- unmarried subjects about whom three independent raters could agree met DSM-11 criteria for schizophrenia and who were experiencing at least four of seven Bleulerian symptoms of the disorder (Table 1). The early onset (18 to 30 years) and marital status criteria were designed to identify a subgroup of persons diagnosed with schizophrenia who were at statistically high risk for long- disability. We believed that an experimental treatment should be provided to those individuals most likely to have high service needs over the long term. All subjects were public sector clients screened at the psychiatric emergency room of a suburban San Francisco Bay Area county hospital.

TABLE 1: The Soteria Project: research admission/selection criteria

1. Diagnosis: DSM II schizophrenia (3 independent clinicians)
2. Deemed in need of hospitalization
3. Four of seven Bleulerian diagnostic symptoms (2 independent clinicians)
4. Not more than one previous hospitalization for 30 d or less
5. Age: 18-30
6. Marital status: single

Basically, the Soteria method can be characterized as the 24 hour a day application of interpersonal phenomenologic interventions by a nonprofessional staff, usually without neuroleptic drug treatment, in the context of a small, homelike, quiet, supportive,

protective, and tolerant social environment. The core practice of interpersonal phenomenology focuses on the development of a nonintrusive, noncontrolling but actively empathetic relationship with the psychotic person without having *to do* anything explicitly therapeutic or controlling. In shorthand, it can be characterized as "being with," "standing by attentively," "trying to put your feet into the other person's shoes," or "being an LSD trip guide" (remember, this was the early 1970s in California). The aim is to develop, over time, a shared experience of the meaningfulness of the client's individual social context-current and historical. Note, there were no therapeutic "sessions" at Soteria. However, a great deal of "therapy" took place there as staff worked gently to build bridges, over time, between individuals' emotionally disorganized states to the life events that seemed to have precipitated their psychological disintegration. The context within the house was one of positive expectations that reorganization and reintegration would occur as a result of these seemingly minimalist interventions.

The original Soteria House opened in 1971. A replication facility ("Emanon") opened in 1974 in another suburban San Francisco Bay Area city. This was done because clinically we soon saw that the Soteria method "worked." Immediate replication would address the potential criticism that our results were a one-time product of a unique group of persons and expectation effects. The project first published systematic 1-year outcome data in 1974 and 1975 (Mosher and Menn, 1974; Mosher et al., 1975). Despite the publication of consistently positive results (Mosher and Menn, 1978; Matthews et al., 1979) for this subgroup of newly diagnosed psychotic persons from the first cohort of subjects (1971-1976), the Soteria Project ended in 1983. Because of administrative problems and lack of funding, data from the 1976-1983 cohort were not analyzed until 1992. Because of our selection criteria and the suburban location of the intake facilities, both Soteria-treated and control subjects were young (age 21), mostly white (10% minority), relatively well educated (high school graduates) men and women raised in typical lower middle class, blue-collar suburban families.

Results

Cohort 1 (1971-1976)

Briefly summarized, the significant results from the initial, Soteria House only, cohort were:

Admission Characteristics. Experimental and control subjects were remarkably similar on 10 demographic, 5 psychopathology, 7 prognostic, and 7 psychosocial preadmission (independent) variables.

Six-Week Outcome. In terms of psychopathology, subjects in both groups improved significantly and comparably, despite Soteria subjects not having received neuroleptic drugs. All control patients received adequate anti-psychotic drug treatment in hospital and were discharged on maintenance dosages. More than half stopped medications over

the 2-year follow-up period. Three percent of Soteria subjects were maintained on neuroleptics.

Milieu Assessment. Because we conceived the Soteria program as a recovery-facilitating social environment, systematic study and comparison with the CMHC were particularly important. We used Moos' Ward Atmosphere Scale (WAS) and COPES scale for this purpose (Moos, 1974, 1975). The differences between the programs were remarkable in their magnitude and stability over 10 years. COPES data from the experimental replication facility, Emanon, was remarkably similar to its older sibling, Soteria House. Thus, we concluded that the Soteria Project and CMHC environments were, in fact, very different and that the Soteria and Emanon milieus conformed closely to our predictions (Wendt et al., 1983).

Community Adjustment. Two psychopathology, three treatment, and seven psychosocial variables were analyzed. At 2 years postadmission, Soteriatreated subjects from the 1971-1976 cohort were working at significantly higher occupational levels, were significantly more often living independently or with peers, and had fewer readmissions; 571/16 had never received a single dose of neuroleptic medication during the entire 2-year study period.

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 Soteria and 1-month hospital initial lengths of stay because of Soteria's low per them cost and extensive use of day care, group, individual, and medication therapy by the discharged hospital control clients. (Matthews et al., 1979; Mosher et al., 1978).

Cohort II (1976-1982; includes all Emanon-treated subjects)

Admission, 6-week, and milieu assessments replicated almost exactly the findings of the initial cohort. Nearly 25% of experimental clients in this cohort received some neuroleptic drug treatment during their initial 6 weeks of care. Again, all hospital-treated subjects received anti- drugs during their index admission episode. In this cohort, half of the experimental and 70% of control subjects received postdischarge maintenance drug treatment. However, in contrast to Cohort 1, after 2 years, no significant differences existed between the experimental and control groups in symptom levels, treatment received (including medication and rehospitalization), or global good versus poor outcomes. Consistent with the psychosocial outcomes in Cohort I, Cohort II experimental subjects, as compared with control subjects, were more independent in their living arrangements after 2 years.

Interestingly, independent of treatment group, good or poor outcome is predicted by four measures of preadmission psychosocial competence (Mosher et al., 1992): level of education (higher), precipitating events (present), living situation (independent), and

work (successful). Good outcome was narrowly defined as having no more than mild symptoms *and* either living independently or working or going to school at both 1- and 2-year follow-up (Mosher et al., 1995).

The Second Generation

Although closely involved in the California-based Soteria Project throughout the study's life, I lived in Washington, D.C., while working for the NIMH. In 1972, I became psychiatric consultant to Woodley House, a half-way house founded in Washington, D.C., in 1958. In consultation, staff were often distressed when describing house residents who went into crisis, and there was no option but to hospitalize them. Recovery from such institutionalizations they saw as taking nearly 18 months. So, in 1977, a Soteria-like facility (called "Crossing Place") was opened by Woodley House Programs that differed from its conceptual parent in that it:

- 1) admitted any nonmedically ill client deemed in need of psychiatric hospitalization regardless of diagnosis, length of illness, severity of psychopathology, or level of functional impairment;
- 2) was an integral part of the local public community mental health system, which meant that most patients who came to Crossing Place were receiving psychotropic medications; and
- 3) had an informal length of stay restriction of about 30 days to make it economically appealing.

So, beginning in 1977, a modified Soteria method was applied to a much broader patient base, the so-called "seriously and persistently mentally ill". Although a random assignment study of a Crossing Place model has only recently been published (Fenton et al., 1998), it was clear from early on that the Soteria method "worked" with this nonresearchcriteria-derived heterogeneous client group. Because of its location and "open" admissions Crossing Place clients, as compared with Soteria subjects, were older (37), more nonwhite (70%), multiadmission, long-term system users (averaging 14 years) who were raised in poor urban ghetto families. From the outset, Crossing Place was able to return 90% or more of its 2000 plus (by 1997) admissions directly to the community-completely avoiding hospitalization (Kresky-Wolff et al., 1984). In its more than 20 years of operation, there have been no suicides among clients in residence, and no serious staff injuries have occurred. Although the clients were different, as noted above, the two settings (Soteria and Crossing Place) shared staff selection processes (Hirschfeld et al., 1977; Mosher et al., 1973), philosophy, institutional and social structure characteristics, and the culture of positive expectations.

In 1986 the social environments at Soteria and Crossing Place were compared and contrasted as follows:

In their presentations to the world, Crossing Place is conventional and Soteria unconventional. Despite this major difference, the actual in-house interpersonal interactions are similar in their informality, earthiness, honesty, and lack of professional jargon. These similarities arise partially from the fact that neither program ascribes the usual patient role to the clientele. Crossing Place admits "chronic" patients, and its public funding contains broad length-of-stay standards (1 to 2 months). Soteria's research focus views length of stay as a dependent variable, allowing it to vary according to the clinical needs of the newly diagnosed patients. Hence, the initial focus of the Crossing Place staff is: What do the clients need to accomplish relatively quickly so they can resume living in the community?

This empowering focus on the client's responsibility to accomplish a goal(s) is a technique that Woodley House has used successfully for many years. At Soteria, such questions were not ordinarily raised until the acutely psychotic state had subsided-usually 4 to 6 weeks after entry. This span exceeds the average length of stay at Crossing Place. In part, the shorter average length of stay at Crossing Place is made possible by the almost routine use of neuroleptics to control the most flagrant symptoms of its clientele. At Soteria, neuroleptics were almost never used during the first 6 weeks of a patient's stay. Time constraints also dictate that Crossing Place will have a more formalized social structure than Soteria. Each day there is a morning meeting on "what are you doing to fix your life today" and there are also one or two evening community meetings.

The two Crossing Place consulting psychiatrists each spend an hour a week with the staff members reviewing each client's progress, addressing particularly difficult issues, and helping develop a consensus on initial and revised treatment plans. Soteria had a variety of ad-hoc crisis meetings, but only one regularly scheduled house meeting per week. The role of the consulting psychiatrist was more peripheral at Soteria than at Crossing Place: He was not ordinarily involved in treatment planning and no regular treatment mee

In summary, compared to Soteria, Crossing Place is more organized, has a tighter structure, and is more oriented toward practical goals. Expectations of Crossing Place staff members are positive but more limited than those of Soteria staff. At Crossing Place, psychosis is frequently not addressed directly by staff members, while at Soteria the client's experience of acute psychosis is often a central subject of interpersonal communication. At Crossing Place, the use of neuroleptics restricts psychotic episodes. The immediate social problems of Crossing Place clients (secondary to being system "veterans" and also because of having come mostly from urban lower social class minority families) must be addressed quickly: no money, no place to live, no one with whom to talk. Basic survival is often

the issue. Among the new to the system, young, lower class, suburban, mostly white Soteria clients, these problems were present but much less pressing because basic survival was usually not yet an issue.

Crossing Place staff members spend a lot of time keeping other parts of the mental health community involved in the process of addressing client needs. The clients are known to many other players in Lite system. Just contacting everyone with a role in the life of any given client can be an all-day process for a staff member. In contrast, Soteria clients, being new to the system, had no such cadre of involved mental health workers. While in residence, Crossing Place clients continue their involvement with their other programs if clinically possible. At Soteria, only the project director and house director worked with both the house and the community mental health system. At Crossing Place, all staff members negotiate with the system. Because of the shorter lengths of stay, the focus on immediate practical problem solving, and the absence of clients from the house during the daytime, Crossing Place tends to be less consistently intimate in feeling than Soteria. Although individual relationships between staff members and clients can be very intimate at Crossing Place, especially with returning clients ... it is easier to get in and out of Crossing Place without having a significant relationship (Mosher et al., 1986, pp. 262-264).

A Second Generation Sibling

In 1990, McAuliffe House, a Crossing Place replication, was established in Montgomery County, Maryland. This county's southern boundary borders Washington, D.C. Crossing Place helped train its staff; for didactic instruction there were numerous articles describing the philosophy, institutional characteristics, social structure, and staff attitudes of Crossing Place and Soteria and a treatment manual from Soteria. My own continuing influence as philosopher/clinician/godfather/supervisor is certain to have made replicability of these special social environments easier. In Montgomery County, it was possible to implement the first random assignment study of a residential alternative to hospitalization that was focused on the seriously mentally ill "frequent flyers" in a living, breathing, never before researched, "public" system of care. Because of this well funded system's early crisis-intervention focus, it hospitalized only about 10% of its more than 1500 long-term clients each year. Again, because of a well-developed crisis system, less than 10% of hospitalizations were involuntary- our voluntary research sample was representative of even the most difficult multi-problem clients. The study excluded *no one* deemed in need of acute hospitalization except those with complicating medical conditions or who were acutely intoxicated. The subjects were as representative of suburban Montgomery County's public clients as Crossing Place's were of urban Washington, D.C.; mid-thirties, poor, 25% minority, long durations of illness, and multiple previous hospitalizations. However, many of the Montgomery County

nonminority clients came from well-educated affluent families. The results (Fenton et al., 1998) were not surprising. The alternative and acute general hospital psychiatric wards were clinically equal in effectiveness, but the alternative cost about 40% less. For a system, this means a savings of roughly \$19,000 per year for each seriously and persistently mentally ill person who uses acute alternative care exclusively (instead of a hospital). Based on 1993 dollars, total costs for the hospital in this study were about \$500 per day (including ancillary costs) and the alternative about \$150 (including extramural treatment and ancillary costs).

Important Therapeutic Ingredients

Descriptively, the therapeutic ingredients of these residential alternatives, ones that clearly distinguish them from psychiatric hospitals, in the order they are likely to be experienced by a newly admitted client, are:

- 1) The setting is indistinguishable from other residences in the community, and it interacts with its community.
- 2) The facility is small, with space for no more than 10 persons to sleep (6 to 8 clients, 2 staff). It is experienced as home-like. Admission procedures are informal and individualized, based on the client's ability to participate meaningfully.
- 3) A primary task of the staff is to understand the immediate circumstances and relevant background that precipitated the crisis necessitating admission. It is anticipated this will lead to a relationship based on shared knowledge that will, in turn, enable staff to put themselves into the client's shoes. Thus, they will share the client's perception of their social context and what needs to change to enable them to return to it. The relative paucity of paperwork allows time for the interaction necessary to form a relationship.
- 4) Within this relationship the client will find staff carrying out multiple roles: companion, advocate, case worker, and therapist-although no therapeutic sessions are held in the house. Staff have the authority to make, in conjunction with the client, and be responsible for, on-the-spot decisions. Staff are mostly in their mid-20s, college graduates, selected on the basis of their interest in working in this special setting with a clientele in psychotic crisis. Most use the work as a transitional step on their way to advanced mentalhealth-related degrees. They are usually psychologically tough, tolerant, and flexible and come from lower middle class families with a "Problem" member. (Hirschfeld et al., 1977; Mosher et al., 1973, 1992) In contrast to psychiatric ward staff, they are trained and closely supervised in the adoption and validation of the clients' perceptions. Problem solving and supervision focused on relational difficulties (*e.g.*, "transference" and "counter-transference") that they are experiencing is available from fellow staff, onsite program directors, and the consulting psychiatrists (these last two will be less obvious to clients). Note that the M.D.s are not in charge of the program.

5) Staff is trained to prevent unnecessary dependency and, insofar as possible, maintain autonomous decision making on the part of clients. They also encourage clients to stay in contact with their usual treatment and social networks. Clients frequently remark on how different the experience is from that of a hospitalization. This process may result in clients reporting they feel in control and a sense of security. They also experience a continued connectedness to their usual social environments.

6) Access and departure, both initially and subsequently, is made as easy as possible. Short of official readmission, there is an open social system through which clients can continue their connection to the program in nearly any way they choose; phone-in for support, information or advice, drop-in visits (usually at dinner time), or arranged time with someone with whom they had an especially important relationship. All former clients are invited back to an organized activity one evening a week.

Characteristics of Healing Social Environments

Both clinical descriptive and systematic staff and client perception data (from Moos, 1974, 1975) are available to compare and contrast Soteria, Crossing Place, and McAuliffe House with their respective acute general hospital wards and each other (Mosher, 1992; Mosher et al., 1986, 1995; Wendt et al., 1983).

Clinical characteristics of the hospital comparison wards included in the original Soteria study have been previously described (see Wendt et al., 1983) and are applicable to the hospital psychiatric ward studied in the Montgomery County research. The clinical Soteria-Crossing Place description and "Important Therapeutic Ingredients" explicated earlier are applicable across all three alternative settings. The Moos scale data comparing Soteria with Crossing Place and McAuliffe House are consistent between the three settings and different from the findings from the comparison wards in the general hospitals.

The Moos instrument, the Community-Oriented Program Environment Scales (COPES), is a 100-item true/false measure that yields 10 psychometrically distinct variables that can be grouped into three supraordinate categories: relationship/psychotherapy, treatment, and administration. The patterns of similarities and differences between the two types of alternatives (Soteria vs. Crossing Place and McAuliffe House) have remained constant over many testings, as have the hospital differences and similarities to the two kinds of alternatives. The alternative programs share high scores on all three relationship variables (involvement, spontaneity, and support) and two of four treatment variables: personal problem orientation and staff tolerance of anger. Crossing Place and McAuliffe House, however, differ from Soteria in two of three administrative variables: the second generations are perceived as more organized and exerting more staff control (somewhat similar to the hospital scores) than the parent (Soteria). The differences are to be expected, given the differing nature of the clientele and the much shorter average length of stay (<30 days) in the Soteria offspring.

Other Alternatives to Hospitalization

In the 25 plus years since the Soteria Project's successful implementation, a variety of alternatives to psychiatric hospitalization have been developed in the U.S. Their results (including those of the Soteria Project) have been extensively reviewed by Braun et al., 1981; Mesler et al., 1982a, 1982b; Straw, 1982; Stroul, 1987. A subset were described in greater detail by Warner (1995).

Each of these reviews found consistently more positive results from descriptive and research data from a variety of alternative interventions as compared with control groups. Straw, for example, found that in 19 of 20 studies he reviewed, alternative treatments were as, or more, effective than hospital care and on the average 43% less expensive. The Soteria study was noted to be the most rigorous available in describing a comprehensive treatment approach to a subgroup of persons labeled as having schizophrenia. It was also noted that, for the most part, the effects of various models of hospitalization had not been subjected to equally serious scientific scrutiny.

Except in California, where there are a dozen, few "true" residential alternatives to acute hospitalization have been developed. Within the public sector, because of cost concerns, there is now a movement to develop "crisis houses." Their extent or success has not been completely described. However, they are not usually viewed or *used* as alternatives to acute psychiatric hospitalization-although this is subject to local variation. It is surprising that managed care, with its focus on reducing use of expensive hospitalization, has neither developed nor promoted the use of these cost-effective alternatives. It is truly notable that nearly all residential alternatives to acute psychiatric hospitalization are in the public mental health system. Private insurers and HMOs have been extremely reluctant to pay for care in such facilities (see Mosher, 1983).

The Fate of Soteria

As a clinical program Soteria closed in 1983. The replication facility, Emanon, had closed in 1980. Despite many publications (37 in all), without an active treatment facility, Soteria disappeared from the consciousness of American psychiatry. Its message was difficult for the field to acknowledge, assimilate, and use. It did not fit into the emerging scientific, descriptive, biomedical character of American psychiatry, and, in fact, called nearly every one of its tenets into question. In particular, it demedicalized, dehospitalized, deprofessionalized, and deneuroleptized what Szasz (1976) has called "psychiatry's sacred cow"-- As far as mainstream American psychiatry is concerned, it is, to this day, an experiment that appears to be the object of studied neglect. Neither of the two recent "comprehensive" literature reviews and treatment recommendations for schizophrenia references the project (Frances et al., 1996; Lehman and Steinwachs, 1998).

There are no new U.S. Soteria replications. It is possible that, if a replication were proposed as research, it might not receive I.R.B. approval for protection of human subjects as it would involve withholding a known effective treatment (neuroleptics) for a minimum of 2 weeks.

Surprisingly, Soteria has reemerged in Europe. Dr. Luc Ciompi, professor of social psychiatry in Bern, Switzerland, is primarily responsible for its renaissance. Operating since 1984, Soteria Bern has replicated the original Soteria study findings. That is, roughly two-thirds of newly diagnosed persons with schizophrenia recover with little or no drug treatment in 2 to 12 weeks (Ciompi, 1994, 1997a, 1997b; Ciompi et al., 1992). As original Soteria Project papers diffused to Europe and Ciompi began to publish his results, a number of similar projects were developed. At an October 1997 meeting held in Bern, a Soteria Association was formed, headed by Professor Weiland Machleidt of the Hannover University Medical Faculty. Soteria lives, and thrives, admittedly as variations on the original theme, in Europe.

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Appendix C

Letter from Ron Adler, CEO of Alaska Psychiatric Institute to Nelson Page, chair
of the Alaska Mental Health Trust Authority Finance Committee

STATE OF ALASKA
DEPT. OF HEALTH AND SOCIAL SERVICES
DIVISION OF BEHAVIORAL HEALTH

FRANK H. MURKOWSKI, GOVERNOR

ALASKA PSYCHIATRIC INSTITUTE
2900 PROVIDENCE DRIVE
ANCHORAGE, ALASKA 99508-4677
PHONE: (907) 269-7100
FAX: (907) 269-7128

Mr. Nelson Page
Chair, AMHTA Finance Committee
550 West 7th Ave., Suite 1820
Anchorage, Alaska 99501

RECEIVED

JUL 15 2004

Dear Mr. Page:

This correspondence concerns the Trust Budget Planning Process and focus areas for FY 06/07. I understand that a request for funding has been submitted to establish a 'Soteria-type' program in the state of Alaska. Such a program can provide an alternative to acute psychiatric hospitalization for those individuals interested in a different recovery pathway.

In my 25+ years of experience in this field, consumer and family members have taught me that recovery from serious and persistent mental illness is an individualized process. What works for some people does not always work for others. With absolutely no desire to be engaged in the medication vs. 'no' medication debate in Alaska, certain facts are evident: (1) there is sufficient debate, nationally, on this topic; (2) not all persons benefit from psychotropic drugs; (3) the newer atypical drugs yield the best results when combined with evidence-based psychosocial treatments; (4) some individuals can and will recover in alternative settings.

The fact that some individuals can and will recover in alternative settings was demonstrated during my employment at *THE CLUB*, a Fountain House psychosocial rehabilitation program operated by the University of Medicine and Dentistry of New Jersey. For several years, this internationally known program had 12 residential beds attached to the main clubhouse program. Since it was located in a very large CMHC, medical intervention was available if needed. Clubhouse members (consumers) had the opportunity to use a residential bed as an alternative to acute hospitalization under the following circumstances: (a) the member was 'active' in the program; (b) the treatment team supported the use of the alternative to hospitalization; (c) the member participated in the daily clubhouse activities to the best of his/her ability. Medication was not a requirement for club membership, therefore, not insisted upon for the residential bed. However, the member must be regularly engaged with the treating physician (phone calls, visits, etc.).

 **COPY**

My experience at Alaska Psychiatric Institute reinforces what I have been taught during my 'clubhouse' years. API admits over 1300 consumers each year to the hospital. It is estimated that approximately 10% of this population would benefit from an alternative environment for recovery. Such a program, located in the community, should have trained 'peer' counselors with no limitation on length of stay.

In summary, know that I support a planning, development and implementation strategy to establish such a program in Alaska. Moreover, please do not hesitate to use my experience in the planning process.

On a separate issue, Nelson, how about taking a tour of the new facility as it is 80 % complete. I'll follow up with a phone call in a couple of weeks.

Sincerely,

A handwritten signature in black ink, appearing to read "Ron Adler", with a long horizontal flourish extending to the right.

Ron Adler, CEO
Alaska Psychiatric Institute

cc: Jim Gottstein

Aron S. Wolf

Personal Data: Birth Date: August 25, 1937
Birth Place: Newark, New Jersey
Marital Status: Married 3/30/61
SS #: 143-30-5854

Education:

Dartmouth College, B.A. June 1959 – Rufus Choate Scholar, 1958-59
University of Maryland School of Medicine, MD June 1963 – Wendell Muncie Award, 1963
University of Alaska - Anchorage, Masters of Public Administration program (enrolled 1992 - 1999), with transition of credits to: American College of Physician Executives/Tulane University
American College of Physician Executives/Tulane University, Certificate in Medical Management, 1999
Tulane University, School of Public Health Masters of Medical Management, 2000

Medical Postgraduate Training:

Internship: University of Maryland Hospital, 1963 - 1964, mixed medicine, pediatrics
Residency: The Psychiatric Institute, University of Maryland, 1964 - 1967
Chief Resident 1966 - 1967

Board Certification:

American Board of Psychiatry and Neurology, 1971
American Board of Forensic Psychiatry, 1979

Licensure of Practice:

Maryland 1963 - present
Alaska 1967 – present

Positions:

Wolf Health Care Consulting 2000-present

Specializing in:

- Physician/Health System Issues
- Medical/legal consultations
- Rehabilitation issues
- Education Issues
- Mediation Issues
- Psychiatric consultations
- Forensic Issues

Clients 2000-2004

- State of Alaska Division of Vocational Rehabilitation –Chief Medical Consultant
- Various Statewide and National Rehabilitation Agencies
- Native Corporations
 - Ahtna Development Corporation
 - Koniag Corporation
- Bethel Family clinic
- Consultations to various Anchorage Legal firms on behalf of their clients
 - Including: The Anchorage School District
- My E Phit.com Salt Lake City Consultant and Advisory Board Member
- Anchorage Neighborhood Health Center
- Aadland Marketing
- The Lords Ranch Warm Springs Arkansas
- Oregon Health Sciences University-Department of Psychiatry Portland Oregon
- Medical West Associates Agawam Mass
- PBMG/Langdon Clinic, Contract Medical Director and Psychiatrist

Affiliations

- ECG Management Consultants- Seattle and Boston
- The Andrews Group Anchorage
- Gnosis consulting Group LLC Member and Consultant- Seattle Washington
- The Litebook Company –Medicine Hat Alberta Canada—Alaska Distributor

Providence Health System in Alaska

Prior Responsibilities

Rural Administrator, 2001 to 2003

- Lead Administrator for North Slope Borough Health Care Design Project
- Lead Administrator Critical Access Peer Review Project
- Coordinator Rural Physicians Council
- Co-Professor and Co-Developer Physician Executive Course with University of Alaska
- Liaison from PHSA to Rural Health Entities and Rural Physician Clinics
- Member Providence Alaska Senior Operational Council

Physician Project Coordinator, 2000 – 2001

- Ongoing Projects of Medical Director until Replacement was Employed
- Beginning Development of Rural Projects

Regional Medical Director 1995 – 2000

Operational responsibilities:

Medical Staff Services, 1995 – 2000

Alaska Family Practice Residency, 1998 – 2000

Diabetes Program, 1997 – 2000

Quarterly Physician Newsletter, 1997 – 2000

Risk Management, 1996 – 2000

Infection Control Department, 1996 – 2000

Physician Education, 1995 – present

Medical Director Supervision, 1996 – 2000

Member – Alaska Service Area and PAMC Administrative Councils, 1995 – 2000

Providence Alaska Medical Center Committees:

Site & Facilities Committee, 1996 – 2000

Quality Council, 1996 – 2000

Information Systems Steering Committee, 1998 – 2000

Providence Corporate Responsibilities

Member – Providence System Leadership Forum, 1998 – 2000

Member – Providence System Physician Leadership Council, 1998 – 2000

Co-chair – System Core Competency Task Force, 1998 – 2000

Co-chair – 5 Star Nursing Leadership Task Force, 1999 – 2000

Langdon Clinic (1960 – 1997)

Partner, 1970 – 1997

Staff Psychiatrist, 1970 – 1982

President and Managing Partner, 1981 – 1996

President Emeritus, 1996 – 1998

Dale Street Medical Building

Partner, 1980 – 2002

General Managing Partner, 1984 – 1996

Providence Hospital/Langdon Clinic Joint Ventures (Breakthrough & Discovery)

Operations Board Member, 1989 – 1995

Department of Defense, U.S. Air Force, Elmendorf Air Force Base

Staff Psychiatrist, 1967 – 1969

Chief, Psychiatric Services, 1969 – 1970

Faculty Positions Held:

University of Alaska Anchorage

Co-Coordinator/Adjunct Professor, School of Business Physician Executive Training, 1996 – present

University of Washington, School of Medicine, Department of Psychiatry, 1974 – present

Clinical Professor, 1985 – present

University of New Mexico, School of Medicine, Department of Psychiatry

Clinical Associate, 1987 – present

Oregon Health Sciences University, Department of Psychiatry
Clinical Professor, 1989 – present
University of Colorado, National Center for American Indian and Alaska Native
Mental Health Research, Research Associate, 1989 – present
University of Alaska Fairbanks, WAMI Program, Psychiatry, 1974 – 1987
Clinical Professor, 1985 – 1987
Anchorage Community College, Instructor in Psychology, 1968 – 1977
Brooklyn College, Psychology Assistant, 1959 – 1960

Elected Positions:

Elmendorf Air Force Base Advisory School Board
Member and Chair, 1969 – 1970
Municipality of Anchorage, Anchorage School District, School Board
Assistant Treasurer, 1971 – 1972
Vice President, 1972 – 1973
President, 1973 – 1974

Hospital Affiliations:

Present: Providence Alaska Medical Center, Active Staff, 1969 – 2003
Chief, Psychiatric Dept., 1971 – 1975, 1977 – 1981, 1994-1995, 2001-2004
Medical Director, Chemical Dependency, 1989 – 1994
At Large Member Executive Committee, 2000 - 2002

Past: Columbia Alaska Regional Hospital, Courtesy Staff, 1970 – 2000
Valdez Community Hospital, Courtesy Staff, 1980 – 1997. 2002-present
Cordova Community Hospital, Courtesy Staff, 1975 – 1994
Yukon-Kuskokwim Delta Regional Hospital, Courtesy Staff, 1980 – 1989
Charter North Hospital, Active Staff, 1984 – 1990
Credentials Committee, 1984 – 1985
Medical Executive Committee, 1984 – 1985, 1989
Elmendorf Air Force Base Hospital, Active Staff, 1967 – 1970

Consultations For Langdon Clinic

Valdez Community Mental Health Center, Valdez, Alaska, 1979 – 1996
Copper River Community Mental Health Center, Copper Center, Alaska,
1979 – 1980 and 1988 – 1994
Seward Life Action Council, 1994 – 1996
Coordinated Anchorage Alcoholism Programs, Salvation Army, (Clitheroe),
1979 – 1989
State of Alaska, Dept. of Health and Social Services, McLaughlin Youth Center,
1969 – 1972
Child Study Center, 1970 – 1972
Coordinator, Langdon Methadone Maintenance Grant, 1972 – 1974
Lutheran Youth Center, Wasilla, Alaska, 1970 – 1974

Glenmore Rehabilitation Center (now PECC), 1970 – 1975
Alaska Children's Services, 1970 – 1973
Cordova Medical Clinic, Cordova, Alaska, 1975 – 1977
Cordova Mental Health Center, Cordova, Alaska, 1977 – 1980 and 1984 – 1994
Alaska Native Medical Center, Psychiatric Day Treatment, 1975 – 1977
Alaska Women's Resource Center, 1977 – 1980
Yukon-Kuskokwim Health Corporation Mental Health Center, Bethel, Alaska, 1980 – 1985
State of Alaska, Dept. of Corrections, Statewide Sexual Offender Program,
Hiland Mountain Correctional Center, Coordinator, Contracts,
1981 – 1992
State of Alaska, DHSS, Medicaid Program, Quality Improvement Services, 1983 – 1997
Aleutian-Pribilof Mental Health Center, Cold Bay, Alaska, 1983 – 1987

Professional Organizations:

Corporation for American Psychiatry, 1980 – 2003

Board Member, National Political Action Committee, 1980 – 2004

Alaska State and Anchorage Medical Associations, 1970 – present

Ad Hoc Committee to Study Marijuana, Co-Chair, 1971 – 1972

Mental Health Committee, 1971 – 1975

Medico - Legal Committee, 1980

Ethics Committee, 1980

Impaired Physicians Committee, Co-Chair, 1988 – 1993

American Medical Association, 1970 – 1982

Society of Air Force Psychiatrists, 1967 – 1983

American Psychiatric Association, 1969 – present

Associate Member, 1969

General Member, 1970 – 1976

Fellow, 1976 – 2000

Life Fellow, 2000-2003

Distinguished Life Fellow 2003-present

Committee Service:

Presidential Nominating Committee, 1978

Membership Committee, 1979 - 1987, 1989 – 1997, Chair, 1991 – 1995

Ad Hoc Committee on Membership Retention, Chair, 1991

Peer Review Commission, Co-Chair, 1984 – 1986

Joint Board & Assembly Reference Committee, 1984 – 1985

Confidentiality Committee, 1985 - 1990, Chair, 1985 – 1990

Quality Assurance Committee, 1986 – 1988

Candidate for Area 7 Board Trustee, 1988, 1993

Telemedicine Committee, 1997 – 2001

Assembly of the American Psychiatric Association, 1978 – 1985, 1986 – 1993

Recorder (Secretary), 1984 – 1985

Executive Committee, 1980 – 1985

Rules Committee, 1978 – 1981

Nominating Committee, 1979 – 1985

Procedures Committee, 1979 – 1984, Chair, 1981 – 1984

Long Range Planning Committee, 1979 – 1984

Liaison to Minority groups, 1980 – 1984

Committee on Public Psychiatry, 1987

Assembly Membership Committee, 1988 – 1993, Chair, 1988 – 1993

Candidate for Speaker Elect, 1985 & 1992

Area VII of the American Psychiatric Association

Deputy Representative, 1980 – 1984

Nominating Committee, 1980 – 1982, 1990 – 1993

CME Committee, 1980 – 1984, 1986 – 1990

Alaska District Branch of the American Psychiatric Association, 1969 – present

CME Chair, 1978 – 1997

Alternative Delegate to the APA Assembly, 1976 – 1978, 1986 – 1990

Delegate to the APA Assembly, 1978 – 1981, 1990 – 1993

Legislative Representative, 1975 – 1979

President - Elect, 1974 – 1975

President, 1975 – 1976

Community Boards:

Member UAA Chancellor's Advisory Committee, 1999 – present

UAA Advisory Committee for the Masters in Public Administration Program, 1997 – present

Co-chair Tulane-USC-Carnegie Mellon MMM alumnae organization 2002-present

Anchorage symphony Orchestra Board 2003-present

Anchorage symphony Foundation Board 2004

Men's Run for Health, 1996 – 1999

Alaska Chamber singers, 1996

Challenge Alaska, 1990 – 1996

Finance Committee, 1991

Executive Committee, 1993 – 1994

Vice President, 1994 – 1996

Alaska Mental Health Association, 1969 – 1973

Alaska Cancer Society 1970 – 1975

Chugach Optional School, Parent Advisory Council, 1975 – 1977, Chair, 1976 – 1977

Homemakers Council of Alaska, 1976 – 1977

Citizens Advisory Board for Northern Television, Inc., 1978 – 1990, Chair, 1982 – 1986

Downtown Rotary, 1992 – 1993

Resource Development Council, 1995 – 1997

Health Access Program Initiative, Board Member, 1998 – 2001
Anchorage 2000, Health System Chair, 1998 – 2001

Special Local, Statewide and National Responsibilities:

- National:* National Institute of Health HIV/AIDS Grant Review Team, 1994
American Board of Neurology and Psychiatry, Chief Proctor of Written Exam, for Alaska
1975 – present
American Journal of Psychiatry, Book Review Forum
Reviewer for Substance Abuse Issues, 1988 – present
Reviewer for Administrative Issues, 2000-present
- Statewide:* Governor's Mental Health Board, 1976 - 1983, Chair, 1982 – 1983
Governor's Task Force on Criminally Committed Patients, 1982
State Mental Health Manpower Grant, Professional Committee, 1980
University of Alaska Statewide Committee to Plan for the Health Care Needs of Alaska,
1986 – 1987
State of Alaska, Senate, Speaker's Office, Liaison for WAMI Issues, 1987 – 1989
University of Alaska and University of Washington Committee on Medical Education in Alaska,
1988 – 1989
- Anchorage:* Weekly Mental Health/Medical Public Affairs Television appearance,
KTVA, 1970 – present
Monthly Health Related Articles, Alaska Journal of Commerce, 1996 – 2001
Greater Anchorage Drug Management Board, 1972 – 1973, Chair, 1973
Federal Youth Services Grant, Parent Advocate Board, 1974
Anchorage Health Planning Council, 1978 – 1979
Recipient of Hero's of healthcare award from Hospice of Anchorage 2003
Frequent Community presentations on Health and Mental Health Issues

Bibliography:

- Thesis for Residency, "A Study of the Attitudes of Mothers of Negro Schizophrenics," 1967, on file University of Maryland Psychiatric Institute Library
- Wolf, A., "Participation of the Aged in Group Process," Mental Hygiene, July 1967
- Wolf, A., "The Depressive Syndrome, A Review", Alcom Chaplain, June 1969
- Wolf, A., "T Group Participation and Level of Performance in USAF Hospital Corpsmen", USAF Behavioral Science Series, September 1969, Medicine, January 1972, Volume 14, No. 1
- Wolf, A., and Raffe, D., "A New Approach to Addict Therapy", Alaska Medicine, March, 1975, Volume 17, No. 2
- Wolf, A., and Middleton, C., "A.L.I. or Bust", USAF Behavioral Science Series, June 1975
- Wolf, A., "Psychiatry in Alaska, An Overview", Alaska Medicine, May 1977, Volume 19, No. 3
- Wolf, A., "Review of Psychiatric Practices", Modes Coping, May 1978, Volume 1, No. 1
- Wolf, A., "Homicide and Blackout in the Alaska Native", Journal of Studies on Alcohol, May 1980, Volume 41, No.5, pas. 456-62
- Wolf, A., "Alcohol and Violence", Alaska Native Alcoholism Treatment Quarterly, Spring 1984, Volume 1, No. 1
- Philips, M., Coons, D., and Wolf, A., "Forensic Psychiatry in Alaska", State of Alaska Monograph, July 1984
- Wolf, A., "Could We Save Our Practice from Bankruptcy?" Medical Economics, Nov. 11, 1985,

- pas. 191-200
- Wolf, A., "Expulsion from a Village", Psychiatric House Calls, Ed. John Talbott, M.D., APPI Press, Washington, D.C., Chapter 45
- Wolf, A., Committee Chair and Editor, "Guidelines of Confidentiality", Journal of American Psychiatric Association, November, 1987
- Philips, M., Coons, D., and Wolf, A., "Psychiatry and the Criminal Justice System: Testing the Myths", The American Journal of Psychiatry, Vol. 145, No. 5, May 1988
- Wolf, A., Smith, B., and Schenker, D., "A Mental Health-Correctional Milieu Approach to the Treatment of Sex Offenders", presented at APA, May 1989
- Donald, R., Cook, R., Wolf, A., et al., "The Stress-Related Impact of the Valdez Oil Spill on the Residents of Cordova and Valdez, Alaska", Monograph, June, 1990
- Wolf, A., "Commentary on Alcohol Policy Considerations for Indian Reservations and Bordertown Communities", American Indian and Alaska Native Mental Health Research, The Journal of the National Center, Vol. 4, No. 3, 1992
- Wolf, A., Alaska Journal of Commerce, monthly articles on health care, 1997 – 2001

Mental Health Division
Department of Health
State of Hawaii
Honolulu

Project Director 1974-1982
Mental Health Center Staffing Grant
Soteria House
Institute for Psychosocial Interaction
Palo Alto, California

Research Associate 1971-1985
Mental Research Institute
Palo Alto, California

Project Director 1980-1981
Contra Costa House, An Alternative of
Hospitalization for Children
Concord, California

Principal Investigator, 1971-1984
Project Director
Soteria Project, "Community
Alternatives for Treatment of Schizophrenia
Mental Research Institute
Palo Alto, California

Principal Investigator 1976-1981
Replication of an Alternative
to Hospitalization
Mental Research Institute
Palo Alto, California

Social Worker 1969-1971
Research Department
Agnews State Hospital
San Jose, California

Social Worker 1968-1970
Experimental Ward
Silverman-Rappaport Study
Agnews State Hospital
San Jose, California

Social Worker
Alcohol Program 1967-1968
Social Worker 1955-1967
Regional Ward, Santa Cruz
Agnews State Hospital

San Jose, California

GRANTS:

"Community Support Systems 1982-1985
Strategy Development and Implementation"
NIMH Grant #MH136271

"Community Alternatives for 1971-1984
Treatment of Schizophrenia "
NIMH Grants #MH-20123
and #MH-35928

"Replication of an Alternative to
Hospitalization"
NIMH Grant #MH-25570 1976-1980
NIMH Grant #MH35960 1981

Staffing Grant for Soteria House 1974-1979
San Jose Mental Health Center
Grant #09-H-001204

"Alternatives to Hospitalization
for Adolescents" 1980-1981
Contra Costa County

CETA Training Grant 1975-1978 (circa)
Provided training experiences for
15 unemployed persons who assisted in the
houses and in research activities

MEMBERSHIPS:

Board of Directors 1979-1985
Institute for Psychosocial Interaction

Board of Trustees 1979-1983
Saybrook Institute
(a psychology graduate school)

America Academy of Family 1979-2001
Therapy

California Assn of Rehabilitation
Agencies (CASRA) 1978-1983

Board of Advisory Editors 1977-2001
Family Process
New York, New York

Board of Directors 1972-1980
Mental Research Institute
Palo Alto, California

CONSULTING EXPERIENCE:

My consulting experience is too lengthy to describe here. Further information will be provided on request. However, I will list a few of the institutions where I have consulted: Denver Research Institute; Division of Mental Health, State of Hawaii; Center for Training in Community Psychiatry in Los Angeles; Community Companions Program in San Jose, State Hospital in Phoenix. I also served as a Technical Expert/Reviewer for the Rehabilitation Services Administration, NIMH in Washington, DC.

PAPERS PUBLISHED:

During my time as Director and Principal Investigator of the Soteria Project I was co-author of all the papers published on the work (approximately 25 papers). During my appointment in Hawaii, an article on a needs assessment for alternative housing for the mentally ill was also published. Further information will be provided on request.

PRESENTATIONS/DISCUSSIONS:

It should be noted that the "Replication Grant" (NIMH#MH-25570 and #MH-35960) mandated the the research on Soteria House be disseminate. As part of that mandate, I presented each year at the annual meetings of the APA (psychiatry), the American Psychological Assn, the Orthopsychiatry Assn.,and the Assn for Research on Schizophrenia. In 1977, with consultation with Loren Mosher, I organized an international meeting in Palo Alto called "Madness and Social Policy. Further information will be provided on request.

ADDITIONAL DETAILS ON MY WORK ON THE SOTERIA PROJECT:

I was the first employee of the Project. I located the property, hired the research and the clinical staff, implemented the data collection and subject recruitment, trained the staff, did home visits and family histories of all the resident who came for help at the house, obtained the required licenses. As the funding was increased, I was able to hire Subject recruiters and a research director, devoting my time to setting up the second Soteria House, and, later, the residence for Adolescents. I also served on the Board of Directors of the local Mental Health Association and represented the Project in the community.

