
In the Matter of the Civil Commitment
of David Austin Russell,
Respondent

Court File No. 85-PR-24-46

**Motion for Appointment of a New Attorney
and
to Stay Hearing on Petition for Administration of
Electroconvulsive Therapy**

Respondent hereby moves (1) for the appointment of a new attorney who will effectively represent me, including abide by my decisions concerning the objectives in this case, and act with reasonable diligence in doing so, and (2) to stay the hearing on the Petition for Administration of Electroconvulsive Therapy (Electroshock Petition), until such new attorney has been appointed and has had a sufficient amount of time to prepare for the hearing.

A. Appointment of New Attorney

David Jones, my current court appointed attorney, is not effectively representing me. I have raised this in the past and been ignored, but on November 7th, after reviewing the transcripts, James B. Gottstein, Esq., an experienced mental health attorney, wrote a letter to the court in which he detailed Mr. Jones' failure to properly represent me, including extensive evidence of the type that Mr. Jones should have introduced in representing me (Gottstein Letter). The Gottstein Letter, including exhibits, is incorporated herein as though fully set forth.¹

Exhibit 3 to the Gottstein Letter (Exhibit 3) is a review of Dr. Schak's testimony in favor of electroshocking me against my will by John Read, PhD, one of the world's

¹ The Gottstein letter was removed from the court file by order of this court upon the request of Mr. Jones upon the grounds that Mr. Gottstein was not a party and did not represent any party.

foremost experts on electroshock. Dr. Read notes that much of Dr. Schak's testimony was not supported by any research and other testimony by Dr. Schak was inaccurate. For example, Dr. Read noted Dr. Schak's testimony that electroshock is an accepted "treatment" for schizoaffective disorder² and psychotic disorders³ is not true. Most importantly, Dr. Read noted that Dr. Schak's testimony regarding the potential side effects of electroshock grossly understated and omitted the serious and permanent loss of memory many people administered electroshock experience whether or not that might technically be considered brain damage, also noting that one of the electroshock machine manufacturers includes brain damage in its list of risks.⁴

Mr. Gottstein had brought Mr. Jones' attention to these types of negative effects prior to the May 5th hearing to electroshock me against my will.⁵ Mr. Jones did nothing to present this type of evidence.

Most recently, a supporter/friend has obtained an expert on electroshock to testify in support of me and conveyed that information to Mr. Jones on multiple occasions in multiple ways and Mr. Jones has failed to respond to him at all.

Whether or not the court would ultimately decide to order me to be further electroshocked against my will, it certainly must agree I have the right to have this type of evidence introduced by my appointed counsel. Since Mr. Jones is not doing so, I should be appointed one who will.

B. Stay of Hearing

I understand the hearing on the Petition is currently set for November 21st. It is apparent that a new attorney could not be appointed and ready to effectively represent me in that time period. Therefore, the hearing should be stayed until such time as a new attorney has been appointed who will effectively represent me and such attorney has had time to prepare to do so.

² Exhibit 3 to Gottstein Letter (Exhibit 3), page 3.

³ Exhibit 3, page 4.

⁴ Exhibit 3, pages 5-10.

⁵ Exhibit 2 to Gottstein Letter.

The permanent memory loss from the electroshock constitutes irreparable harm that warrants granting the Stay. Frankly, so is the failure of Mr. Jones to effectively represent me.

C. Conclusion

For the foregoing reasons, this court should

- (a) appoint a new attorney to represent me who will do so effectively, including abide by my decisions concerning the objectives in this case, and act with reasonable diligence in doing so, and
- (b) stay the hearing on the Petition for Administration of Electroconvulsive Therapy until such time as such an attorney has been appointed and has had time to prepare.

Dated: _____

David Russell⁶
Respondent

⁶ This Motion has been mailed to David Jones and Paul Ellison.



November 4, 2024

Judge Carmaine Sturino
Winona County Courthouse
171 West Third Street
Winona, MN 55987

Re: *In the Matter of the Civil Commitment of David
Austin Russell*, Respondent, Case No 85-PR-24-46

Dear Judge Carmaine:

I have had a chance to review the transcripts of the following hearings in the above captioned case:

- 01/10/2024 Preliminary/Probable Cause Hearing
- 01/22/2024 Commitment/Jarvis Hearing
- 05/06/2024 ECT Hearing

They demonstrate Mr. Russell's counsel, David A Jones, has not only provided ineffective legal representation, but has also violated the Minnesota Rules of Professional Conduct.¹

At the January 22, 2024 Commitment and Jarvis hearing, all of Mr. Jones' questions were of a type to support the involuntary commitment and forced drugging petitions rather than oppose them, and he did not even ask that the petitions be denied.

Mr. Russell has raised Mr. Jones' failure to represent him properly and this has been unfairly and inaccurately attributed to his mental illness. The same has been true when Mr. Russell objects to the psychiatric drugs forced into him and the electroshock forced on him as being harmful. Mr. Russell is correct on all three points.

The way psychiatric drugs are given to people diagnosed with serious mental illness such as Mr. Russell, reduce the recovery rate from a possible 80% to 5%, reduce average life spans by 20-25 years, and destroy people's quality of life. *See*, the Report on Improving Mental Health Outcomes.² I know this is so startling it is hard to accept, but it is true and as most relevant here, Mr. Jones should have introduced this kind of evidence. The Report on Improving Mental Health Outcomes is meticulously supported with 12 pages of citations.

¹ I am including the ethics violation because while it does not specifically refer to mental health cases, the Minnesota Lawyers Professional Responsibility Board Office of Lawyers Professional Responsibility Complaints and Investigations publication states complaints against appointed counsel should be first raised with the court handling the matter.

² Exhibit 1.

The failure to present this type of evidence is not only ineffective representation, it is a violation of Mr. Jones' duty of zealous representation,³ to abide by Mr. Russell's decisions concerning the objectives of representation,⁴ and to act with reasonable diligence.⁵

Mr. Jones' failure to contest electroshocking Mr. Russell is even more egregious because I wrote him before the hearing providing him with compelling evidence he could present to oppose it.⁶ The referenced letter includes evidence of the following harms caused by electroshock.

- Amnesia, Other Memory & Cognitive Deficits
- Brain damage
- Lack of Efficacy
- High mortality and no beneficial effect on suicide

Even though this evidence was drawn to Mr. Jones' attention he failed to present anything to oppose the petition.

In addition to the evidence against electroshock, my e-mail noted that nonconsensual electroshock is a violation of international law and can constitute torture. While Mr. Russell probably does not have the right to invoke this violation of international law directly, that the United Nations has concluded forcing electroshock can constitute torture is a compelling argument against it that should have been presented.

A review of the transcript of the May 6th, 2024, electroshock hearing reveals that not a single question posed by Mr. Jones was designed to oppose the petition. He did, however, inadvertently ask a question of Mr. Russell that was helpful in opposing the electroshock petition:

Q. Has any medical provider, a psychologist or psychiatrist, told you that ECT is not appropriate for you at this time?

A. Numerous. The staff at Prairie St. John's said that this is not beneficial and we don't support that. In addition, we don't think that the antipsychotics are doing anything other than making your life more miserable than it is.

In addition, the staff at Horizon Homes, until I blew up, agreed with the assessment that the antipsychotics were part of the problem. And for over six months was not on any antipsychotics and doing just fine, despite being only given \$25 a week for personal needs.⁷

This should have been followed up on and corroborated by St. John's and staff at Horizon Homes, but Mr. Jones followed this with a question to undercut his client's position and ended his examination.

³ "As advocate, a lawyer zealously asserts the client's position under the rules of the adversary system." Preamble to the Minnesota Rules of Professional Conduct.

⁴ Rule 1.2(a) of the Minnesota Rules of Professional Conduct.

⁵ Rule 1.3 of the Minnesota Rules of Professional Conduct.

⁶ Exhibit 2.

⁷ May 6, 2024, TR 47: 1-12.

In short, Mr. Jones submitted not a single piece of evidence, nor made a single argument against electroshock being administered to Mr. Russell against his will. He did not even ask for the petition to be denied. He only said that Mr. Russell opposed the petition.

However, I asked John Read, PhD, one of the world's foremost experts on electroshock to review Dr. Schak's testimony against Mr. Russell.⁸ Dr. Read notes that while Dr. Schak testifies at page 9 that the proposed electroshock is targeting Schizoaffective Disorder, Schizoaffective Disorder is not listed as a target diagnosis for ECT anywhere he knows of and it is not in the Mayo Clinic's own document.⁹

Similarly, Dr. Read comments with respect to Dr. Schak's testimony at page 11 of the transcript that electroshock is "a well-documented treatment for primary psychotic disorders" by stating "there is no meaningful evidence that ECT is effective for people diagnosed with psychosis or schizophrenia."¹⁰

At page 13 of the transcript Dr. Schak was asked and answered as follows:

Q. Has Mayo Clinic determined if ECT is medically necessary?

A. Yes, we have. And that is due to the lack of response to antipsychotic medication.

Dr. Read notes there is "No evidence that psychological therapy has been offered /tried," and that Mayo's own protocol is other forms of therapy should be tried first.¹¹

Dr. Read comments that the following testimony by Dr. Schak at pages 16-17 of the transcript is "inaccurate and inconsistent with the relevant research."

Q. Are there any potential side effects associated with ECT treatment?

A. Yeah. Most common are going to be body aches, possible memory loss around the time of treatment -- so that's within the days to a week of treatment but generally not long-term memories from childhood or events prior to hospitalization -- are going to be the most common from the ECT.

Dr. Read cites many studies on the serious and long-lasting memory loss and brain damage suffered by many from electroshock.¹²

With extensive citations, Dr. Read also contradicts Dr. Schak's testimony at page 25 of the transcript that past memories are not affected and electroshock does not cause brain damage.¹³

Finally, I want to convey my personal experience with Mr. Russell. I think I first spoke with him on April 29, 2024, and have spoken with him most days since then. I don't believe Mr. Russell meets commitment criteria and evidence to that effect could and should have been

⁸ Exhibit 3.

⁹ Exhibit 3, page 3.

¹⁰ Exhibit 3, page 4.

¹¹ Exhibit 3, page 4.

¹² Exhibit 3, pages 5-8.

¹³ Exhibit 3, pages 8-10.

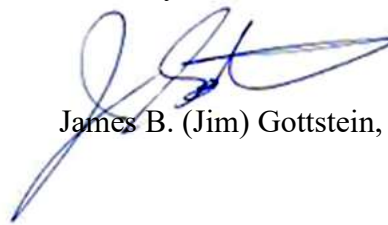
introduced. In fact, Mr. Russell had arranged for a couple of witnesses to testify to that effect and Mr. Jones failed to call them.

Mr. Russell acknowledges he could use some help and has asked for psychotherapy. Involuntary commitment is not allowed if a less restrictive alternative could reasonably be provided and forced drugging or electroshock is not allowed if a less intrusive alternative could reasonably be provided. There is no doubt in my mind a less restrictive alternative to involuntary commitment and a less intrusive alternative to forced drugging and electroshock are feasible for Mr. Russell. The point being here that this is another element of Mr. Russell's defense that his appointed counsel, David Jones, failed to present.

In sum, not only has Mr. Jones' abjectly failed to effectively represent Mr. Jones in the above captioned matter, he has actively acted against Mr. Jones' objectives, violating his ethical obligations under the Minnesota Rules of Professional Conduct preamble and Rules 1.2(a), & 1.3, to zealously assert Mr. Russell's positions, abide by Mr. Russell's objectives, and act with reasonable diligence in doing so.

Mr. Russell should be appointed counsel who will abide by the Minnesota Rules of Professional Conduct and properly represent him.

Sincerely,

A handwritten signature in blue ink, appearing to read "J. B. Gottstein", with a long horizontal flourish extending to the right.

James B. (Jim) Gottstein, Esq.

Cc: David Russell
David Jones
Paul Ellison

REPORT
ON
IMPROVING
MENTAL HEALTH
OUTCOMES

James B. (Jim) Gottstein, Esq.; Peter C. Gøtzsche, MD;
David Cohen, PhD; Chuck Ruby, PhD; Faith Myers

September 2023

I. EXECUTIVE SUMMARY

The mental health system's standard treatments are colossally counterproductive and harmful, often forced on unwilling patients. The overreliance on psychiatric drugs is reducing the recovery rate of people diagnosed with serious mental illness from a possible 80% to 5% and reducing their life spans by 20 years or so. Psychiatric incarceration, euphemistically called "involuntary commitment," is similarly counterproductive and harmful, adding to patients' trauma and massively associated with suicides. Harmful psychiatric interventions are being imposed on people without consideration of the facts about treatments and their harms, and are a violation of International Law.

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

By implementing these approaches, mental health systems can move towards, and even achieve, the 80% possible recovery rate.

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

II. TABLE OF CONTENTS

I.	Executive Summary	i
II.	Table of Contents	1
III.	The Current Mental Health System is Extremely Counterproductive and Harmful 2	
	The Overuse of Psychiatric Drugs	2
	The Clinical Trial Literature on Psychiatric Drugs is Unreliable.....	9
	Inpatient Hospitalizations Associated with Astronomically Higher Suicide Rates	11
	Treatment Should Be Voluntary	12
	Unwanted Psychiatric Interventions Violate International Law and Can Constitute Torture	14
	Patients' Rights Are Uniformly Violated.....	14
	Children and Youth Should Not be Given Psychiatric Drugs	18
IV.	Voluntary, Effective, Safe and Humane Approaches	20
	The Power of Peer Support.....	20
	World Health Organization Recommendations	21
	Peer Respite.....	23
	Housing First.....	24
	Employment.....	24
	Soteria Houses	26
	Drug Free Hospitals	29
	Open Dialogue.....	29
	Hearing Voices Network.....	30
	Warmlines	31
	Emotional CPR (eCPR)	31
	Non-Police Community Response Teams.....	32
	Psychotherapy	33
	Other Person-Centered and Rights-Based Approaches	34
V.	Acknowledgments	37
VI.	Authors	38
	James B. (Jim) Gottstein, Esq.	38
	Peter C. Gøtzsche, MD	39
	David Cohen, PhD.....	40
	Chuck Ruby, PhD	40
	Faith J. Myers	41
VII.	Bibliography	42
	Federal laws	42
	Court cases	42
	Articles, Books, Reports, Websites	42

III. THE CURRENT MENTAL HEALTH SYSTEM IS EXTREMELY COUNTERPRODUCTIVE AND HARMFUL

The Overuse of Psychiatric Drugs

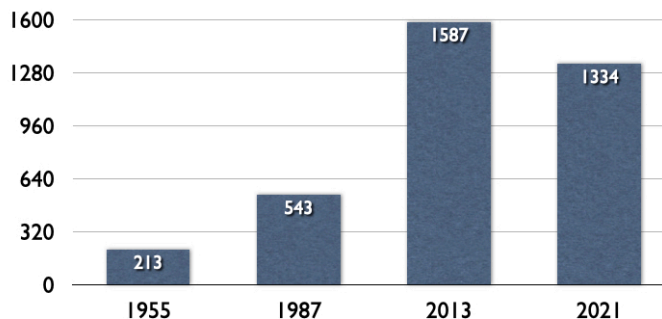
It is fairly universally accepted that the mental health system is a failure, especially regarding what has been accomplished with the most noteworthy feature of psychiatric treatment since the 1950s and exponentially so since the early 1980s, psychiatric drugs. At great public expense, the system’s ubiquitous deployment of psychiatric drugs, including being forced upon unwilling patients, often by holding them down and injecting them against their will, or threatening to do so to obtain “compliance,” dramatically worsens outcomes and suffering.

Since the introduction of the so-called miracle drug Thorazine (chlorpromazine) in the mid-1950s, the disability rate of people diagnosed with serious mental illness has increased more than six-fold.¹

The Disabled Mentally Ill in the United States, 1955-2021

(under government care)

■ Per 100,000 population



Source: Silverman, C. *The Epidemiology of Depression* (1968): 139. U.S. Social Security Administration Reports, 1987-2021.

¹ The charts in this section are from award winning journalist Robert Whitaker, author of *Anatomy of an Epidemic* (2010) and *Mad in America* (2002) including his highly recommended July 16, 2021, talk to the Soteria Network in the UK, “[Soteria Past, Present, and Future: The Evidence For This Model of Care.](#)”

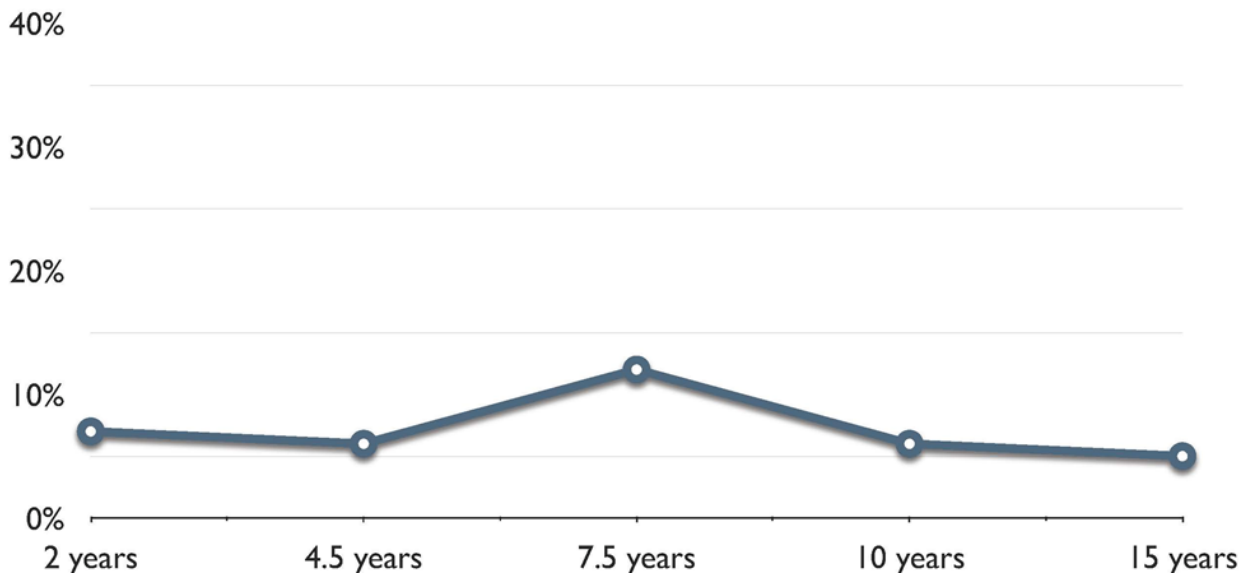
It is likely at least some of the increase after 1987 was because people were thrown off welfare under the “welfare to work” legislation passed in 1996,² and had to be certified as disabled to continue to receive financial assistance. The decrease since 2013 is in large part due to the government making it harder to qualify for such disability payments. This in turn may very well have increased the number of homeless people.

Thomas Insel, who for 12 years was Director of the National Institute of Mental Health (NIMH) frankly stated in 2009 and repeatedly thereafter that, “despite five decades of antipsychotic medication and deinstitutionalization, there is little evidence that the prospects for recovery have changed substantially in the past century.”³

We now have a recovery rate of only 5% for people diagnosed with schizophrenia who are maintained on neuroleptics.^{4,5}

Long-term Recovery Rates for Schizophrenia Patients on Antipsychotics

(Martin Harrow’s study)



² [Personal Responsibility and Work Opportunity Reconciliation Act of 1996](#), Pub. Law. 104–193, August. 22, 1996; 110 Stat. 2105.

³ Insel, Thomas R. (2009). [“Translating Scientific Opportunity Into Public Health Impact: A Strategic Plan for Research on Mental Illness.”](#) *Archives of General Psychiatry* 66(2): 128–133.

⁴ Harrow, Martin; & Jobe, Thomas H. (2007). [“Factors Involved in Outcome and Recovery in Schizophrenia Patients Not on Antipsychotic Medications: A 15-Year Multifollow-Up Study.”](#) *Journal of Nervous and Mental Disease* 195(5): 406–414.

⁵ Neuroleptics are marketed as “antipsychotics” even though they don’t have specific anti-psychotic effects for most people.

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

Outcomes in Select Studies from Pre-Antipsychotic Era

(Patients diagnosed as insane, schizophrenic or psychotic)

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

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

Yet if we try to avoid the use of neuroleptics when people experience their first psychotic break, a nearly 80% recovery rate can be achieved. The following chart shows results from the “Open Dialogue” program in Northern Finland in which the use of neuroleptics is avoided if possible.⁶

Five-Year Outcomes for First-Episode Psychotic Patients in Finnish Western Lapland Treated with Open-Dialogue Therapy

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

Source: Seikkula, J. “Five-year experience of first-episode nonaffective psychosis in open-dialogue approach.” *Psychotherapy Research* 16 (2006):214-28.

⁶ Seikkula, Jaakko, et al. (2006). “[Five-Year Experience of First-Episode Nonaffective Psychosis in Open-Dialogue Approach: Treatment Principles, Follow-Up Outcomes, and Two Case Studies.](#)” *Psychotherapy Research* 16(2): 214–228.

Similar results were achieved during the Soteria-House study in the 1970s conducted by Loren Mosher, MD, then Chief of Schizophrenia Research at the NIMH:

Soteria-House Study

At six weeks, psychopathology reduced comparably in both groups.

At two years:

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

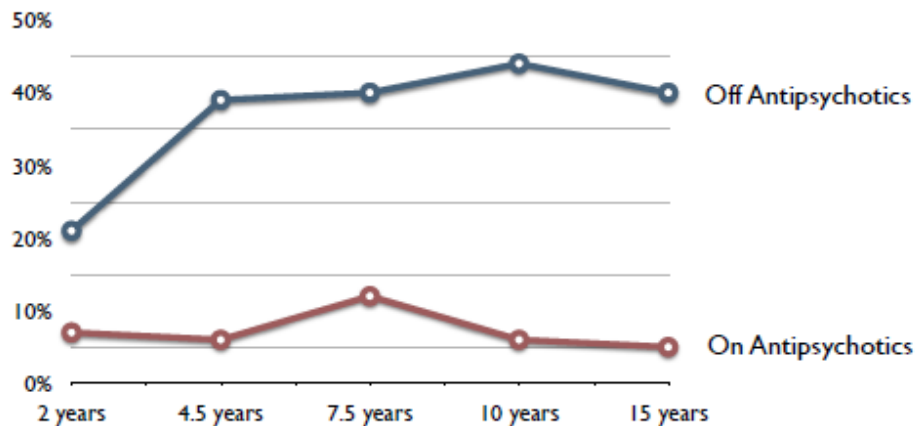
Neuroleptic use in Soteria patients:

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

Mosher (1999). *J Nerv Ment Dis* 187(3):142-149
Bola & Mosher (2003). *J Nerv Ment Dis* 191(4): 219-229

The recovery rate of people who get off neuroleptics after they have been on them goes from 5% to 40%.⁷

Long-term Recovery Rates for Schizophrenia Patients



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

⁷ Harrow, Martin; & Jobe, Thomas H. (2007). "Factors Involved in Outcome and Recovery in Schizophrenia Patients Not on Antipsychotic Medications: A 15-Year Multifollow-Up Study." *Journal of Nervous and Mental Disease* 195(5): 406-414.

While this is 8 times better than staying on them (40% vs. 5%), it is half of what can be achieved by avoiding the use of neuroleptics in the first place (80%), as established by the Open Dialogue and Soteria House studies.⁸ **This demonstrates the importance of avoiding the use of neuroleptics in the first place.** In addition to their lives being so much better, allowing 16 times more people to recover not only saves a tremendous amount of treatment expense, it converts people who would otherwise be receiving life-long publicly paid services and transfer payments into productive, taxpaying citizens.⁹

The Harrow and Jobe results were so unexpected and contrary to mainstream psychiatry's beliefs that other explanations were proposed, such as it was the people with the best prognosis in the first place who got off the drugs and therefore had better outcomes, that additional analysis was undertaken. None of the alternate explanations proved correct.¹⁰

In addition to dramatically reducing the recovery rate, **the ubiquitous use of psychiatric drugs is extremely harmful physically, reducing lifespans by 20 years or so.**¹¹ In a given time period, the relative risk of dying increases markedly with the number of neuroleptics the person takes.¹² Neuroleptic users have an increased risk of cardiac mortality, all-cause mortality, and sudden cardiac death compared to psychiatric patients

⁸ While there might not be a 100% overlap between the 80% who recovered and the 80% who were not taking the neuroleptics long term, clearly minimizing the use of the neuroleptics produces dramatically better outcomes.

⁹ The best book to understand the impact of psychiatric drugs in general, not just the neuroleptics, is *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America* (2010) by Robert Whitaker, from whose work this section is largely drawn.

¹⁰ Harrow, Martin; Jobe, Thomas H.; & Faull, Robert N. (2012). ["Do All Schizophrenia Patients Need Antipsychotic Treatment Continuously Throughout Their Lifetime? A 20-Year Longitudinal Study."](#) *Psychological Medicine* 42(10): 2145–2155; Harrow, Martin; & Jobe, Thomas H. (2013). ["Does Long-Term Treatment of Schizophrenia With Antipsychotic Medications Facilitate Recovery?"](#) *Schizophrenia Bulletin* 39(5): 962–965; Harrow, M.; Jobe, T. H.; & Faull, R. N. (2014). ["Does Treatment of Schizophrenia With Antipsychotic Medications Eliminate or Reduce Psychosis? A 20-Year Multi-Follow-up Study."](#) *Psychological Medicine* 44(14): 3007–3016; Harrow, Martin, et al. (2017). ["A 20-Year Multi-Followup Longitudinal Study Assessing Whether Antipsychotic Medications Contribute to Work Functioning in Schizophrenia."](#) *Psychiatry Research* 256: 267–274; and Harrow, Martin; & Jobe, Thomas H. (2018). ["Long-Term Antipsychotic Treatment of Schizophrenia: Does it Help or Hurt Over a 20-Year Period?"](#) *World Psychiatry* 17(2): 162–163; Harrow, Martin; Jobe, Thomas H; & Tong, Liping. (2022). ["Twenty-Year Effects of Antipsychotics in Schizophrenia and Affective Psychotic Disorders."](#) *Psychological Medicine* 52(13): 2681–2691.

¹¹ Gøtzsche, Peter C. (2015), *Deadly Psychiatry and Organized Denial*, p. 165, et. seq. (Copenhagen: People's Press). See also Parks, Joe, et al. (2006), *Morbidity and Mortality in People With Serious Mental Illness* (Alexandria, VA: National Association of State Mental Health Program Directors). The report documents mortality in people diagnosed with serious mental illness in the public mental health system has accelerated to the point where they are now dying 25 years earlier than the general population. The report does not attribute this to psychiatric drugs, but it is clear the major change is the advent of the second generation neuroleptics, and the great increase in polypharmacy.

¹² Joukamaa, Matti, et al. (2006). ["Schizophrenia, Neuroleptic Medication and Mortality."](#) *British Journal of Psychiatry* 188(2): 122–127.

not taking them.¹³ People prescribed even moderate doses of neuroleptics have large relative and absolute increases in the risk of sudden cardiac death.¹⁴

Citing Robert Whitaker's 2002 book, *Mad in America*, Gøtzsche, recently wrote about the drug companies hiding large numbers of deaths in their clinical trials of neuroleptics:

One in every 138 [initial number, later updated to 145] patients who entered the trials for newer neuroleptics died, but none of these deaths were mentioned in the scientific literature, and the FDA didn't require them to be mentioned. Many patients killed themselves, and the suicide rate was two to five times the usual rate for patients with schizophrenia. A major reason was drug-withdrawal akathisia.¹⁵

The result of introducing more and more psychiatric drugs is the standard mortality rates of schizophrenia patients worsen over time, which Robert Whitaker of *Mad in America* recently summarized:¹⁶

Standard mortality rates (SMRs) tell of the higher mortality rates for patient groups compared to the general population. For instance, a standard mortality rate of 2 for schizophrenia patients means that they are twice as likely to die over a set period than the general population. SMRs for schizophrenia and bipolar patients have *worsened* over the last 50 years.

In 2007, [Australian researchers](#) conducted a systematic review of published reports of mortality rates of schizophrenia patients in 25 nations. They found that the SMRs for "all-cause mortality" rose from 1.84 in the 1970s to 2.98 in the 1980s to 3.20 in the 1990s.

Here is a summary of the increase in SMRs for the seriously mentally ill from various studies:

¹³ Murray-Thomas, Tarita, et al. (2013). "[Risk of Mortality \(Including Sudden Cardiac Death\) and Major Cardiovascular Events in Atypical and Typical Antipsychotic Users: A Study With the General Practice Research Database.](#)" *Cardiovascular Psychiatry and Neurology* 2013: 247486.

¹⁴ Ray, Wayne A., et al. (2001). "[Antipsychotics and the Risk of Sudden Cardiac Death.](#)" *Archives of General Psychiatry* 58(12): 1161-1167.

¹⁵ Gøtzsche, Peter C. (25 Feb 2023). "[A New Paradigm for Testing Psychiatric Drugs is Needed.](#)" *Mad in America*.

¹⁶ Whitaker, Robert. (6 Apr 2023). "[Answering Awaits Aftab: When it Comes to Misleading the Public, Who is the Culprit?](#)" *Mad in America*, citing Saha, Sukanta; Chant, David; & McGrath, John. (2007). "[A Systematic Review of Mortality in Schizophrenia: Is the Differential Mortality Gap Worsening Over Time?](#)" *Archives of General Psychiatry* 64(10): 1123-1131; Hayes, Joseph F., et al. (2017). "[Mortality Gap for People With Bipolar Disorder and Schizophrenia: UK-Based Cohort Study 2000-2014.](#)" *British Journal of Psychiatry* 211(3): 175-181; Lilly, Samantha (6 Oct 2022). "[Long Term Antidepressant Use Associated With Increased Morbidity and Mortality.](#)" *Mad in America*.

All-Cause Mortality Among The Seriously Mentally Ill

Investigator	Patient Population	Country	Time Period	Standardized Mortality Rate
Saha	Schizophrenia	Global	1970s-1990s	2.98
Joukamaa	Schizophrenia	Ireland	1978-1995	1 antipsychotic = 2.97 2 antipsychotics = 3.21 3 antipsychotics = 6.83
Tiihonen	Schizophrenia/ Schizoaffective	Finland	1995-2004	4.5
Olson	Schizophrenia	United States	2001-2007	3.7
Torniainen	Schizophrenia	Sweden	2006-2010	4.8

In 2017, [UK investigators](#) reported that the SMR for bipolar patients had risen steadily from 2000 to 2014, increasing by 0.14 per year, while the SMR for schizophrenia patients had increased gradually from 2000 to 2010 (0.11 per year) and then more rapidly from 2010 to 2014 (0.34 per year.) “The mortality gap between individuals with bipolar disorders and schizophrenia, and the general population, is widening,” they wrote.

Long-term use of antidepressants has also been found to be associated with [increased morbidity and mortality](#).

In addition to the neuroleptics killing people due to direct physical harm, such as cardiac arrest and diabetes, they dramatically increase the suicide rate,¹⁷ as do the so-called antidepressants,¹⁸ anti-seizure/anti-epileptic drugs marketed as “mood stabilizers,”¹⁹

¹⁷ Lehmann, Peter. (2012). [“About the Intrinsic Suicidal Effects of Neuroleptics: Towards Breaking the Taboo and Fighting Therapeutic Recklessness.”](#) *International Journal of Psychotherapy* 16(1): 30-49; Whitaker, Robert. (2 May 2020). [“Do Antipsychotics Protect Against Early Death? A Review of the Evidence.”](#) *Mad in America*; Healy, David, et al. (2006). [“Lifetime Suicide Rates in Treated Schizophrenia: 1875-1924 and 1994-1998 Cohorts Compared.”](#) *British Journal of Psychiatry* 188(3): 223-228.

¹⁸ Healy, David; & Aldred, Graham. (2005). [“Antidepressant Drug Use & the Risk of Suicide.”](#) *International Review of Psychiatry* 17(3): 163-172; Hengartner, Michael P.; & Plöderl, Martin. (2019). [“Newer-Generation Antidepressants and Suicide Risk in Randomized Controlled Trials: A Re-Analysis of the FDA Database.”](#) *Psychotherapy and Psychosomatics* 88(4): 247-248; Hengartner, Michael P.; & Plöderl, Martin. (2019). [“Reply to the Letter to the Editor: ‘Newer-Generation Antidepressants and Suicide Risk: Thoughts on Hengartner and Plöderl’s Re-Analysis’.”](#) *Psychotherapy and Psychosomatics* 88(6): 373-374; Fergusson, Dean, et al. (2005). [“Association Between Suicide Attempts and Selective Serotonin Reuptake Inhibitors: Systematic Review of Randomised Controlled Trials.”](#) *BMJ* 330,7488: 396.

¹⁹ Britton, Jeffery W.; & Shih, Jerry J. (2010). [“Antiepileptic Drugs and Suicidality.”](#) *Drug, Healthcare and Patient Safety* 2: 181-189; Food and Drug Administration, Center for Drug Evaluation and Research. (2008). [Statistical Review and Evaluation: Antiepileptic Drugs and Suicidality](#). As a result, the FDA requires the labels for these drugs to carry the warning “Antiepileptic drugs, including increase the risk of suicidal thoughts or behavior.” See the FDA labels for [Neurontin \(gabapentin\)](#), and [Lyrica \(pregabalin\)](#).

and benzodiazapines.²⁰ Also, as discussed in the next section, psychiatric incarceration itself is associated with a massive increase in suicides.

While some people find these drugs helpful, on the whole, they are harmful and counterproductive, dramatically reducing recovery rates and life spans. **Forcing psychiatric drugs into people is an atrocity.**

The Clinical Trial Literature on Psychiatric Drugs is Unreliable

Since psychiatric drugs are so harmful and counterproductive the question naturally arises as to why they are so predominant. One reason, as Marcia Angell, MD, former editor of *The New England Journal of Medicine* points out, is the unreliability of the clinical drug trial literature.

It is simply no longer possible to believe much of the clinical research that is published, or to rely on the judgment of trusted physicians or authoritative medical guidelines. I take no pleasure in this conclusion, which I reached slowly and reluctantly over my two decades as an editor of *The New England Journal of Medicine*.²¹

Dr. Angell states psychiatry is the worst (the problems with psychiatry reach "their most florid form").

As a general matter this is because the studies are designed and reported in ways to promote drug sales, rather than reveal the truth. This is often accomplished by misleading or even outright dishonest statistical manipulations.²² Drug companies publish as positive trials the FDA has classified as negative,²³ and much of the clinical drug trial literature is ghost written.²⁴ "Study 329" of paroxetine (Paxil) in teenagers and the two pivotal studies of fluoxetine (Prozac) in children and adolescents diagnosed with depression are examples

²⁰ Dodds, Tyler J. (2017). "[Prescribed Benzodiazepines and Suicide Risk: A Review of the Literature.](#)" *Primary Care Companion for CNS Disorders* 19(2): 16r02037.

²¹ Angell, Marcia (19 Jan 2009). "[Drug Companies & Doctors: A Story of Corruption.](#)" *The New York Review*.

²² *Ibid.* and Gøtzsche, Peter C. (2013). [Deadly Medicines and Organised Crime: How Big Pharma Has Corrupted Healthcare.](#) London: CRC Press.

²³ Turner, Erick H., et al. (2008). "[Selective Publication of Antidepressant Trials and Its Influence on Apparent Efficacy.](#)" *New England Journal of Medicine* 358(3): 252–260; Gøtzsche, Peter C.; & Healy, David. (2022). "[Restoring the Two Pivotal Fluoxetine Trials in Children and Adolescents With Depression.](#)" *International Journal of Risk & Safety in Medicine* 33(4): 385–408.

²⁴ PLoS Medicine Editors. (2009). "[Ghostwriting: The Dirty Little Secret of Medical Publishing That Just Got Bigger.](#)" *PLOS Medicine* 6(9): e1000156; Gøtzsche, Peter C., et al. (2007). "[Ghost Authorship in Industry-Initiated Randomised Trials.](#)" *PLOS Medicine* 4(1): e19.

of negative studies that were published as positive and of omission of serious harms in the publications.²⁵

The truth is hard to ferret out because drug companies claim the clinical data are trade secrets and deny even the listed authors, let alone peer reviewers, and other potential reviewers access to the trial data.²⁶ The validity of clinical trials cannot be assessed without access to the underlying data. When this has been investigated, usually when data has been revealed through litigation, some serious harms – including suicidal events – have often occurred in the clinical trials but have been omitted in the published results. Companies state their drugs have no known serious side effects to be concerned about when they know the opposite is true.²⁷

The claimed benefit in psychiatric drug trials typically involves a minor change in a rating scale score, which is not clinically relevant, while at the same time more people die from the active treatment than die on placebo.²⁸ Many of these deaths are hidden in the published studies. About half of the deaths including half of the suicides occurring in trials of psychiatric drugs have been left out of published trial reports.²⁹

One of the ways drug companies make neuroleptics look beneficial is to have a so-called placebo arm consisting of people abruptly withdrawn from a neuroleptic, which is known to cause many people to become psychotic, thereby making the drug company drug look good by comparison. These trials are highly unethical as well as flawed because they harm patients in the placebo group in order to make the company's drug look better.³⁰

²⁵ Le Noury, Joanna, et al. (2015). [“Restoring Study 329: Efficacy and Harms of Paroxetine and Imipramine in Treatment of Major Depression in Adolescence.”](#) *BMJ* 351: h4320; Gøtzsche, Peter C.; & Healy, David. (2022). [“Restoring the Two Pivotal Fluoxetine Trials in Children and Adolescents With Depression.”](#) *International Journal of Risk & Safety in Medicine* 33(4): 385–408; Gøtzsche, Peter C. (2015). [Deadly Psychiatry and Organised Denial.](#) Copenhagen: People’s Press; Healy, David; Le Noury, Joanna; & Jureidini, Jon. (2019). [“Paediatric Antidepressants: Benefits and Risks.”](#) *International Journal of Risk & Safety in Medicine* 30(1): 1–7.

²⁶ Gøtzsche, Peter C., et al. (2006). [“Constraints on Publication Rights in Industry-Initiated Clinical Trials.”](#) *JAMA* 295(14): 1641–1646.

²⁷ Gøtzsche, Peter C. (2013). [Deadly Medicines and Organised Crime: How Big Pharma Has Corrupted Healthcare.](#) London: CRC Press; Hudson, Ian. (2000). [“Video Deposition of Ian R. B. Hudson, M.R.C.P., M.D.”](#) *Tobin v SmithKline Beecham*. In the United States District Court for the Eastern District of Pennsylvania, Case No. 00CV0025; Healy, David; Germán Roux, Augusto; & Dressen, Brianne. (2023). [“The Coverage of Medical Injuries in Company Trial Informed Consent Forms.”](#) *International Journal of Risk & Safety in Medicine*: 1–8; Healy, David. (2023). [“Diagnosis, Verdict, Conclusion, and Causality.”](#) *Ethical Human Psychology and Psychiatry*.

²⁸ Gøtzsche, Peter C. (2015). [Deadly Psychiatry and Organized Denial.](#) Copenhagen: People’s Press.

²⁹ Hughes, Shannon; Cohen, David; & Jaggi, Rachel. (2014). [“Differences in Reporting Serious Adverse Events in Industry Sponsored Clinical Trial Registries and Journal Articles on Antidepressant and Antipsychotic Drugs: A Cross-Sectional Study.”](#) *BMJ Open* 4(7): e005535.

³⁰ Gøtzsche, Peter C. (2022). [Critical Psychiatry Textbook.](#) Copenhagen: Institute for Scientific Freedom (freely available); Gottstein, Jim (2021). [The Zyprexa Papers.](#) Toronto: Samizdat Health Writer’s Co-operative, Jackson, Grace E. (2003). [“An Analysis of the Olanzapine Clinical Trials— Dangerous Drug, Dubious Efficacy”](#) [affidavit]. *In the Matter of the Hospitalization of Faith J. Myers*. Anchorage Superior Court, Case No. 3AN 03-277 P/S.

Because people in the so-called placebo group were unethically withdrawn abruptly from the neuroleptic they were taking, causing additional deaths, it is not possible to accurately estimate the effect on mortality, but we do know that "One in every 145 patients who entered the trials—for risperidone, olanzapine, quetiapine, and a fourth atypical called sertindole—died, and yet those deaths were never mentioned in the scientific literature."³¹

In sum, the ubiquitous use of psychiatric drugs for treating people diagnosed with serious mental illness, including forcing them into people, is driven in part by unreliable and often fraudulent clinical trial literature.

Inpatient Hospitalizations Associated with Astronomically Higher Suicide Rates

Similarly, the notion people need to be psychiatrically incarcerated to keep them from harming themselves is directly contradicted by suicides dramatically increasing following hospitalization. For example, a 2019 study concluded: "Among patients recently discharged from psychiatric hospitalization, rates of suicide deaths and attempts were far higher than...in unselected clinical samples of comparable patients."³²

Another study of all suicides in Denmark between 1981 and 1997 found the risk of suicide 102 times higher for men and 246 times higher for women in the first week after discharge (compared to hundreds of thousands of control subjects matched for age, sex, and calendar time of suicide). These rates decline the longer someone is hospitalized and after discharge, but still greatly exceed what would otherwise be expected.³³

Gøtzsche describes another Danish study in his 2015 book, *Deadly Psychiatry and Organised Denial*:³⁴

The fact that forced treatment can be fatal was recently underlined in a Danish register study of 2,429 suicides.³⁵ It showed that the closer the contact with psychiatric staff — which often involves forced treatment — the worse the outcome. Compared to people who had not received any psychiatric treatment in the preceding year, the adjusted rate ratio for suicide was six for people receiving only psychiatric medication, eight for people with psychiatric outpatient contact, 28 for people with psychiatric emergency room contacts, and 44 for people who had been admitted to a

³¹ Whitaker, Robert. (2002). *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill*. New York: Basic Books; Whitaker, Robert (17 Nov 1998). "Lure of Riches Fuels Testing." *Boston Globe*, p. A01.

³² Forte, Alberto, et al. (2019). "Suicidal Risk Following Hospital Discharge: A Review." *Harvard Review of Psychiatry* 27(4): 209–216.

³³ Qin, Ping; & Nordentoft, Merete. (2005). "Suicide Risk in Relation to Psychiatric Hospitalization: Evidence Based on Longitudinal Registers." *Archives of General Psychiatry* 62(4): 427–432.

³⁴ Gøtzsche, Peter C. (2015). *Deadly Psychiatry and Organized Denial*. Copenhagen: People's Press.

³⁵ Hjorthøj, Carsten Rygaard, et al. (2014). "Risk of Suicide According to Level of Psychiatric Treatment: A Nationwide Nested Case–Control Study." *Social Psychiatry and Psychiatric Epidemiology* 49(9): 1357–1365.

psychiatric hospital. Patients admitted to hospital would of course be expected to be at greatest risk of suicide because they were more ill than the others (confounding by indication), but the findings were robust and most of the potential biases in the study were actually conservative, i.e. favoured the null hypothesis of there being no relationship. An accompanying editorial noted that there is little doubt that suicide is related to both stigma and trauma and that it is entirely plausible that the stigma and trauma inherent in psychiatric treatment — particularly if involuntary — might cause suicide.³⁶ The editorialists believed that a proportion of people who commit suicide during or after an admission to hospital do so because of conditions inherent in that hospitalisation.

Thus, the justification that someone should be psychiatrically incarcerated to prevent suicide is fallacious, even absurd.³⁷ If the best society has to offer someone grappling with a life-and-death decision is to remove their agency and lock them up until they say what others want to hear, then it is easy to imagine why people would lose faith in society's ability to help them, and be more likely to commit suicide as soon as they are released.

Treatment Should Be Voluntary

All of this makes clear psychiatric incarceration and forced drugging should be abolished.³⁸ Unwanted psychiatric interventions are violence perpetrated against the patient. Restraining psychiatric patients, pulling down their pants and injecting them with psychiatric drugs they do not want is violence, justified on the grounds patients don't know what is good for them. Patients protesting and saying what is true—that the drugs hurt them and do not help—are said to be delusional, and their statements prove they "lack insight" and should be drugged against their will.³⁹ That this occurs every day does not make it right.

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

[The] coercive function is what society and most people actually appreciate most about psychiatry. That families and other people in crisis can call upon

³⁶ Large, Matthew M.; & Ryan, Christopher J. (2014). "[Disturbing Findings About the Risk of Suicide and Psychiatric Hospitals.](#)" *Social Psychiatry and Psychiatric Epidemiology* 49(9): 1353–1355.

³⁷ See, e.g., Harris, Leah. (14 Jan 2023). "[You Can't Coerce Someone Into Wanting to be Alive: The Carceral Heart of the 988 Lifeline.](#)" *Mad in America*.

³⁸ The same is true of electroshock. See Andre, Linda. (2009). *Doctors of Deception: What the Doctors Don't Want You to Know About Shock Treatment*. New Brunswick, NJ: Rutgers University Press.

³⁹ Tasch, Gail; & Gøtzsche, Peter C. (2023). "[Systematic Violations of Patients' Rights and Safety: Forced Medication of a Cohort of 30 Patients in Alaska.](#)" *Psychosis*: 1–10; Gøtzsche, Peter C; & Sørensen, Anders. (2020). "[Systematic Violations of Patients' Rights and Safety: Forced Medication of a Cohort of 30 Patients.](#)" *Indian Journal of Medical Ethics* 5(4): 312–318.

the police to restrain someone acting in a seemingly incomprehensible or dangerous way and have that person taken by force to a place run by psychiatrists is truly where psychiatry as a profession distinguishes itself.⁴⁰

Many effective and non-coercive services exist for the treatment of psychiatric patients. They are psychosocially focused rather than medically focused, and always voluntary. While they differ because they have been developed within different geographical and cultural contexts, they share the following values:

1. Voluntariness and informed choice.
2. Relationships as the first line of treatment.
3. Respect for the individual and their life experience.
4. Emphasizing community inclusion (continuing to participate as student, worker, family member).

When Dr. Loren Mosher testified as a court-qualified expert witness at the trial in *Myers v. Alaska Psychiatric Institute*⁴¹ he stated involuntary treatment should be difficult to implement and should be used only in the direst of circumstances, and then:

[I]n the field of psychiatry, it is the therapeutic relationship which is the single most important thing ... Now, if because of some altered state of consciousness, somebody is about to do themselves grievous harm or someone else grievous harm, well then, I would stop them in whatever way I needed to ... In my career I have never committed anyone ... I make it my business to form the kind of relationship [through which the mentally ill person and I] can establish a[n] ongoing treatment plan that is acceptable to both of us.⁴²

In addition to the other state-sanctioned violence inflicted on psychiatric inmates, forcing unwanted psychiatric drugs into a patient, especially when the patient is knowledgeable about their counterproductive and harmful effects, is traumatic, often extremely so. Even when a patient agrees to take the drug(s), they are not giving informed consent because they are not told about the likely or common outcomes, or the agreement is not a true agreement because the patients know that if they disagree, they will be forced to take the drug anyway. While some states have changed this, at common law, failure to

⁴⁰ Cohen, David. (21 Oct 2014). "It's the Coercion, Stupid!" *Mad in America*. See also Kirk, Stuart A.; Gomory, Tomi; & Cohen, David. (2017). *Mad Science: Psychiatric Coercion, Diagnosis, and Drugs*. New York: Routledge.

⁴¹ *Myers v. Alaska Psychiatric Institute*. 138 P.3d 238 (Alaska 2006).

⁴² *In the Matter of F.M. Transcript of proceedings (March 5 and March 10, 2003)*, p. 177. Anchorage Superior Court, Case No. 3AN-02-00277 CI.

obtain informed consent constitutes a battery.⁴³ This is also a recognition that forced drugging is violence perpetrated against the patient.

If it is not voluntary it is not treatment. In short, unwanted psychiatric interventions are traumatic, counterproductive and harmful, and should be abolished. They are also violations of International Law.

Unwanted Psychiatric Interventions Violate International Law and Can Constitute Torture

Under Articles 12 and 14 of the United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD),⁴⁴ governments are prohibited from denying people decision-making authority, from confining people, or administering any unwanted psychiatric intervention on the basis of a disability, including being diagnosed with a mental illness. Because there was a general misunderstanding of the scope of Article 12 of the CRPD, the United Nations Committee on the Rights of Persons with Disabilities issued General Comment No. 1 (2014) to clarify that taking away someone's decision making rights and forced psychiatric interventions are prohibited.⁴⁵ See also Guidelines on the right to liberty and security of persons with disabilities (the practice of detaining people on the grounds of actual or perceived impairment provided there are other reasons including that they are deemed dangerous to themselves or others is incompatible with article 14).⁴⁶

The UN has also repeatedly stated such **unwanted psychiatric interventions can amount to torture**.⁴⁷

Patients' Rights Are Uniformly Violated

While the United States has not ratified the CRPD there are constitutional and statutory rights and procedures in the United States that are uniformly violated to the great

⁴³ Gottstein, James B. (2007). "Psychiatrists' Failure to Inform: Is There Substantial Financial Exposure?" *Ethical Human Psychology and Psychiatry* 9(2): 117–125.

⁴⁴ United Nations General Assembly. (2006). Convention on the Rights of Persons With Disabilities (CRPD). A/RES/61/106. New York: United Nations.

⁴⁵ UN Committee on the Rights of Persons with Disabilities (11th Session). (2014). "General Comment No. 1 (2014): Article 12, Equal Recognition Before the Law." CRPD/C/GC/1. Geneva: United Nations.

⁴⁶ UN Committee on the Rights of Persons with Disabilities. (2017). "Guidelines on the Right to Liberty and Security of Persons With Disabilities." In Report of the Committee on the Rights of Persons With Disabilities (13th Through 16th Sessions (2015–2016)), pp. 16–21. A/72/55. Geneva: United Nations.

⁴⁷ UN Human Rights Council. (19 June 2020). "Mental Health and Human Rights: Resolution 43/13 Adopted 19 June 2020." A/HRC/RES/43/13. Geneva: United Nations; UN Human Rights Council. (20 Mar 2020). Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment: Report of the Special Rapporteur. A/HRC/43/49. Geneva: United Nations; Méndez, Juan E. (4 Mar 2013). "Statement By Mr. Juan E Méndez, Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 22nd Session of the Human Rights Council of the United Nations." Geneva: United Nations. See also the related Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Juan E. Méndez (2013), A/HRC/22/53. Geneva: United Nations.

detriment of people ensnared by the coercive psychiatric system. As a general rule, people cannot be constitutional confined for being mentally ill in the United States unless the government proves by clear and convincing evidence that

1. as a result of being mentally ill they are a danger to themselves or others, or
2. so disabled by mental illness they cannot survive safely in freedom without the help of willing friends and family,
3. and there is no less restrictive alternative.⁴⁸

"Clear and convincing evidence" is more than the "preponderance of the evidence" standard used in civil cases, meaning "more likely than not" or just over 50%, but less than the "beyond a reasonable doubt" standard used in criminal cases where defendants also face incarceration. In holding beyond a reasonable doubt was not required, the U.S. Supreme Court noted that meeting commitment criteria could never be proven beyond a reasonable doubt.⁴⁹

People diagnosed with mental illness are not significantly more violent than the general population,⁵⁰ and psychiatrists are notoriously bad at predicting violence, being no better than chance.⁵¹ This has been known for a long time. In fact, in the 1983 United States Supreme Court case of *Barefoot v. Estelle*,⁵² the American Psychiatric Association filed an *amicus* brief in which they stated psychiatrists cannot accurately predict violence. (See also *Reign of Error* by Lee Coleman, MD.)⁵³ Psychiatrists are no more able to accurately predict suicidality.⁵⁴

A related problem is the treatment patients universally get while psychiatrically incarcerated—psychiatric drugs—often against the person's wishes, are known to cause both violence and suicidality, including in people who have never exhibited these previously to being administered these drugs.

Before 1955, four studies found that patients discharged from mental hospitals committed crimes at either the same or a lower rate than the general population. However, eight studies conducted from 1965 to 1979 determined that discharged patients were being arrested at rates that exceeded those of the general population. And while there may have been

⁴⁸ *O'Connor v. Donaldson*, 422 U.S. 563, 95 S.Ct. 2486 (1975).

⁴⁹ *Addington v. Texas*, 441 U.S. 418, 99 S.Ct. 1804 (1979).

⁵⁰ Teplin, Linda A. (1985). "[The Criminality of the Mentally Ill: A Dangerous Misconception.](#)" *American Journal of Psychiatry* 142(5): 593–599; Fazel, Seena, et al. (2009). "[Schizophrenia and Violence: Systematic Review and Meta-Analysis.](#)" *PLoS Medicine* 6(8): e1000120; Elbogen, Eric B.; & Johnson, Sally C. (2009). "[The Intricate Link Between Violence and Mental Disorder: Results From the National Epidemiologic Survey on Alcohol and Related Conditions.](#)" *Archives of General Psychiatry* 66(2): 152–161.

⁵¹ Garrett, Brandon L.; & Monahan, John. (2020). "[Judging Risk.](#)" *California Law Review* 108(2): 439–493.

⁵² *Barefoot v. Estelle*. 463 U.S. 880, 103 S. Ct. 3383, 77 L. Ed. 2d 1090 (1983).

⁵³ Coleman, Lee. (1984). *Reign of Error: Psychiatry, Authority and Law*. Boston: Beacon Press. (Now a free download.)

⁵⁴ Franklin, Joseph C., et al. (2017). "[Risk Factors for Suicidal Thoughts and Behaviors: A Meta-Analysis of 50 Years of Research.](#)" *Psychological Bulletin* 143(2): 187–232.

many social causes for this change in relative arrest rates (homelessness among the mentally ill is an obvious cause), akathisia was also clearly a contributing factor.⁵⁵

Since then, there has been increasing evidence that diminished metabolism of psychiatric drugs due to cytochrome P450 gene variations is associated with an increase in violence.⁵⁶

As explained above, psychiatric incarceration dramatically increases suicides, so preventing self-harm cannot be a legitimate basis for locking someone up.

The United States Supreme Court has not specifically ruled on the constitutional limits for psychiatrically drugging someone against their will in the civil commitment context, but has in the competence to stand trial context, holding such drugging is constitutional only if,

1. Important governmental interests are at stake,
2. It will significantly further those state interests - substantially unlikely to have side effects that will interfere significantly (with achieving state interest),
3. It is necessary to further those interests. The court must find that any alternative, less intrusive treatments are unlikely to achieve substantially the same results, and
4. It is medically appropriate, i.e., in the patient's best medical interest in light of his medical condition, considered on drug-by-drug basis.⁵⁷

Civil forced drugging proceedings are usually prosecuted under state law and different state supreme courts considering the issue can take different positions, but many are consistent with *Sell*, holding forced drugging is only constitutional if it is proven by clear and convincing evidence the forced drugging is in the person's best interest and there is no less intrusive alternative.⁵⁸

While some people find psychiatric drugs helpful and adults at least should have access to them if so, as set forth above, on the whole psychiatric drugs are massively counter-productive and harmful. There are no studies showing psychiatric treatment improves patient outcomes.⁵⁹ Thus, **forced psychiatric drugging on the grounds it is in people's best interest can never be legally justified.**

Unfortunately, the inability to accurately predict violence or self-harm and the massively counterproductive and harmful nature of psychiatric drugs has proven to be no

⁵⁵ Whitaker, Robert. (2002). *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill*. New York: Basic Books, citing Rabkin, Judith Godwin. (1979). "[Criminal Behavior of Discharged Mental Patients: A Critical Appraisal of the Research.](#)" *Psychological Bulletin* 86(1): 1-27.

⁵⁶ Clarke, Catherine; Evans, Jan; & Brogan, Kelly. (2019). "[Treatment Emergent Violence to Self and Others: A Literature Review of Neuropsychiatric Adverse Reactions for Antidepressant and Neuroleptic Psychiatric Drugs and General Medications.](#)" *Advances in Mind-Body Medicine* 33(1): 4-21.

⁵⁷ *Sell v. United States*, 539 U.S. 166, 177-8, 123 S.Ct. 2174, 2183 (2003).

⁵⁸ See, e.g., *Rivers v. Katz* 495 N.E.2d 337 (New York, 1986); *Steele v. Hamilton County Community Mental Health Board*, 736 N.E.2d 10 (Ohio 2000); *Myers v. Alaska Psychiatric Institute*. 138 P.3d 238 (Alaska 2006).

⁵⁹ See chapter 22 of Wipond, Rob. (2023). *Your Consent is Not Required: The Rise in Psychiatric Detentions, Forced Treatment, and Abusive Guardianships*. Dallas, TX: BenBella Books.

impediment keeping courts from psychiatrically incarcerating people and drugging them against their will:

[C]ourts accept...testimonial dishonesty..., specifically where witnesses, especially expert witnesses, show a “high propensity to purposely distort their testimony in order to achieve desired ends.” ...

Experts frequently...and openly subvert statutory and case law criteria that impose rigorous behavioral standards as predicates for commitment....

This combination...helps define a system in which (1) dishonest testimony is often regularly (and unthinkingly) accepted; (2) statutory and case law standards are frequently subverted; and (3) insurmountable barriers are raised to ensure that the allegedly “therapeutically correct” social end is met.... In short, the mental disability law system often deprives individuals of liberty disingenuously and upon bases that have no relationship to case law or to statutes.⁶⁰

As a result, it has been estimated no more than 10% of the people psychiatrically incarcerated actually meet commitment criteria.⁶¹

The legal representation of people facing psychiatric incarceration and forced drugging is supposed to prevent this, but the assigned lawyers are almost universally ineffective or worse by taking the attitude “if my client wasn't crazy they'd know locking them up and drugging them against their will is good for them.”⁶² The information in this Report is not presented to the courts. This ineffective representation is not completely the assigned lawyers' fault as they are not allowed the time, nor given the resources, such as expert witness testimony, to present an adequate defense. The result is these proceedings can fairly be characterized as shams.⁶³ That people are being locked up and drugged against their will when there is such overwhelming proof the legal prerequisites for doing so do not exist is a failure of effective legal representation and the legal system as a whole, resulting in immense harm.

By abandoning their core principle of zealous advocacy, lawyers representing psychiatric respondents interpose little, if any, defense and are

⁶⁰ Perlin, Michael L. (1993). [“The ADA and Persons With Mental Disabilities: Can Sanist Attitudes be Undone.”](#) *Journal of Law and Health* 8(1): 15–45.

⁶¹ Gottstein, James B. (28 Oct 2005). [“How the Legal System Can Help Create a Recovery Culture in Mental Health Systems.”](#) Paper presented at Alternatives 2005: Leading the Transformation to Recovery, Phoenix, AZ.

⁶² Gottstein, James B. (2008). [“Involuntary Commitment and Forced Psychiatric Drugging in the Trial Courts: Rights Violations as a Matter of Course.”](#) *Alaska Law Review* 25(1): 51–106.

⁶³ Tasch, Gail; & Gøtzsche, Peter C. (2023). [“Systematic Violations of Patients' Rights and Safety: Forced Medication of a Cohort of 30 Patients in Alaska.”](#) *Psychosis*: 1–10; Gøtzsche, Peter C; & Sørensen, Anders. (2020). [“Systematic Violations of Patients' Rights and Safety: Forced Medication of a Cohort of 30 Patients.”](#) *Indian Journal of Medical Ethics* 5(4): 312–318.

not discovering and presenting to judges the evidence of the harm to their clients. By abandoning their core principle of being faithful to the law, judges have become instruments of oppression, rather than protectors of the rights of the downtrodden.⁶⁴

Children and Youth Should Not be Given Psychiatric Drugs

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

One of the most important things children and youth should learn is how to cope with their emotions without engaging in unacceptable behavior. In other words, take responsibility for their behavior. We should not be telling children and youth they are defective and unable to control themselves. Rather than take children and youth away from their parents, parents should be helped to raise their children to be successful, which is often a viable avenue.

One of the terms of the multi-state settlement of consumer fraud claims regarding the illegal marketing of the prescription drug Neurontin® was funding a rigorous review of psychiatric drugs administered to children and youth. This resulted in the [*CriticalThinkRx*](#) curriculum as a series of eight modules:⁶⁵

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

⁶⁴ Gottstein, James B. (2008). "[Involuntary Commitment and Forced Psychiatric Drugging in the Trial Courts: Rights Violations as a Matter of Course.](#)" *Alaska Law Review* 25(1): 51-106.

⁶⁵ Cohen, David; & Sengelmann, Inge; et al. (Jun 2008). "[A Critical Curriculum on Psychotropic Medications.](#)" *CriticalThinkRx*.

There are also 10–20 minute [videos](#) on each on these modules.

In Chapter Seven of [Drugging Our Children: How Profiteers Are Pushing Antipsychotics on Our Youngest, and What We Can Do to Stop It](#), child psychiatrist Tony Stanton describes Seneca, the extremely successful non-drug residential program where the most difficult youth were sent.⁶⁶ It turned out that whether the success achieved at Seneca lasted depended upon the environment to which the youth was returned. This illustrates that rather than blaming parents, we should be helping them raise their children to be resilient and successful. While there are some parents who deliberately abuse their children, almost all want the best for them and do the best they can. We should invest in parents' and children's and youths' success, not abusive children and youth-drugging prisons.⁶⁷

So-called residential treatment facilities for children and youth have been exposed as abusive.⁶⁸ **Children and youth should not be psychiatrically incarcerated or drugged.**

⁶⁶ Stanton, Tony. (2012). "Drug-Free Mental Health Care for Children and Youth: Lessons From Residential Treatment." In Sharna Olfman & Brent Dean Robbins (eds.), [Drugging Our Children: How Profiteers Are Pushing Antipsychotics on Our Youngest, and What We Can Do to Stop It](#), pp. 119–138. Santa Barbara, CA: Praeger.

⁶⁷ The very profitable abuse by what is called the Troubled Teen Industry has been the subject of recent exposés. See, e.g., Stockton, Alexander (11 Oct 2022). ["Can You Punish a Child's Mental Health Problems Away?"](#) *New York Times*.

⁶⁸ See, e.g., The National Youth Rights Association on ["The 'Troubled Teen' Industry"](#) (2023) and the American Bar Association's ["Five Facts About the Troubled Teen Industry"](#) (2021).

IV. VOLUNTARY, EFFECTIVE, SAFE AND HUMANE APPROACHES

In stark contrast to mainstream professionals driven psychiatric practices which are horrendously harmful and counterproductive, there are a number of very successful, **voluntary** programs that help people get through what they are going through and back on track. Many of these have been developed by people with lived experience of the coercive mental health system who know what is helpful, often called "peers."

The Power of Peer Support

Peer Support is one such proven approach for recovery, i.e., much better outcomes for people diagnosed with serious mental illness such as schizophrenia and bipolar disorder.⁶⁹ Peer Support arose from the Mental Health Consumer/Psychiatric Survivor Movement and is steeped in the use of relationship and support to help people get through a crisis or difficult time that is otherwise likely to result in hospitalization or some other form of hospital emergency services.⁷⁰

Peer-developed peer support is a non-hierarchical approach with origins in informal self-help and consciousness-raising groups organized in the 1970s by people in the ex-patients' movement. It arose in reaction to negative experiences with mental health treatment and dissatisfaction with the limits of the mental patient role. Peer support among people with psychiatric histories is closely intertwined with experiences of powerlessness within the mental health system and with activism promoting human rights and alternatives to the medical model.⁷¹

It is defined by the use of people who have experienced extreme states and/or the behavioral health system. Most have been subjected to psychiatric incarceration and forced drugging and/or electroshock.

The magic of peers is (1) their ability to relate and connect to people currently ensnared in the mental health system through shared experience and (2) they belie the mental health system's message of hopelessness by their example of recovery. True Peer Support is egalitarian and based on respect, reciprocity, validation, self-help and mutual aid. Peer Support is always voluntary. If it is not voluntary it is not Peer Support.

⁶⁹ See National Empowerment Center, "[Evidence for Peer-Run Crisis Alternatives](#)" (website). Accessed 18 Sep 2023.

⁷⁰ Judi Chamberlin's *On Our Own: Patient-Controlled Alternatives to the Mental Health System* (National Empowerment Center), originally published in 1978, is considered to have started this approach in the modern era.

⁷¹ Penney, Darby. (10 Feb 2018). "[Who Gets to Define 'Peer Support?'](#)" *Mad in America*.

The dramatic success of peer support has led the Substance Abuse and Mental Health Services Administration (SAMHSA) to designate it as an evidence based practice⁷² and it is now a Medicaid reimbursable service. This has also unfortunately led to the co-optation of peer support, especially when incorporated into traditional mental health programs.⁷³ It is not just the lived experience that works its magic; it must be combined with true Peer Support Principles. SAMHSA articulates the following core competencies for behavioral health peer workers.⁷⁴

1. Recovery oriented
2. Person centered
3. Voluntary
4. Relationship focused
5. Trauma informed

A peer specialist who is tasked with medication compliance, for example, is not engaging in true peer support and is not likely to achieve any more success than traditional mental health services. Thus, it is especially important to maintain fidelity to Peer Support Principles.⁷⁵ **It is pointless and counterproductive to deploy peers in violation of Peer Support Principles.**

World Health Organization Recommendations

In 2021, the World Health Organization published *Guidance on Community Mental Health Services: Promoting Person-Centered and Rights-Based Approaches*, (WHO Guidelines) identifying these key messages:

- Many people with mental health conditions and psychosocial disabilities face poor quality care and violations of their human rights, which demand profound changes in mental health systems and service delivery.
- In many parts of the world examples exist of good practice, community-based mental health services that are person-centered, recovery-oriented and adhere to human rights standards.
- In many cases these good practice, community-based mental health services show lower costs of service provision than comparable mainstream services.

⁷² See, e.g., “[Peer Support Services in Crisis Care.](#)” SAMHSA Advisory, June 2022.

⁷³ Alberta, Anthony J.; & Ploski, Richard R. (2014). “[Cooptation of Peer Support Staff: Quantitative Evidence.](#)” *Rehabilitation Process and Outcome* 2014(3): 25–29.

⁷⁴ SAMHSA. (2015). “[Core Competencies for Peer Workers in Behavioral Health Services.](#)” *Bringing Recovery Supports to Scale — Technical Assistance Center Strategy (BRSS TACS)*.

⁷⁵ The [International Peer Respite/Soteria Summit \(Summit\)](#) has posted a 35 minute video of one of its Mentoring Circle’s meetings discussing this, [Navigating a Misguided System](#) (2022).

- Significant changes in the social sector are required to support access to education, employment, housing and social benefits for people with mental health conditions and psychosocial disabilities.
- It is essential to scale up networks of integrated, community-based mental health services to accomplish the changes required by the CRPD.⁷⁶

Recognizing the requirements of the CRPD, the WHO Guidelines join the call for "eliminating the use of coercive practices such as forced admission and forced treatment, as well as manual, physical or chemical restraint and seclusion and tackling the power imbalances that exist between health staff and people using the services." In doing so the WHO acknowledges that complying with the CRPD "will require considerable changes in practice." And then states:

This guidance presents diverse options for countries to consider and adopt as appropriate to improve their mental health systems and services. It presents a menu of good practice options anchored in community-based health systems and reveals a pathway for improving mental health care services that are innovative and rights-based. There are many challenges to realizing this approach within the constraints that many services face. However, despite these limitations, the mental health service examples showcased in this guidance show concretely – it can be done. . . .

[C]ritical social determinants that impact people's mental health such as violence, discrimination, poverty, exclusion, isolation, job insecurity or unemployment, and lack of access to housing, social safety nets, and health services, are factors often overlooked or excluded from mental health discourse and practice.

The WHO Guidelines include seven "technical packages" on specific mental health categories and

- showcase, in detail, a number of mental health services from different countries that provide services and support in line with international human rights standards and recovery principles;
- outline in detail how the good practice services operate in order to respect international human rights standards of legal capacity, non-coercive practices, community inclusion, participation and the recovery approach;
- outline the positive outcomes that can be achieved for people using good practice mental health services;
- show cost comparisons of the good practice mental health services in contrast with comparable mainstream services;

⁷⁶ World Health Organization. (9 Jun 2021). [*Guidance on Community Mental Health Services: Promoting Person-Centered and Rights-Based Approaches*](#). Guidance and Technical Packages on Community Mental Health. Geneva: World Health Organization.

- discuss the challenges encountered with the establishment and operation of the services and the solutions put in place to overcome those challenges; and
- present a series of action steps towards the development of a good practice service that is person centred and respects and promotes human rights and recovery, and that is relevant to the local social and economic context.

Peer Respite

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

The premise behind Peer Respite is psychiatric emergency services can be avoided if non-coercive supports are available in the community. They are 100% staffed and operated by people who have lived experience of extreme states and/or the behavioral health system, normally psychiatric incarceration and/or forced drugging, and are either operated by a peer-run organization, or has an advisory group with over 50% or more of members having lived experience.⁷⁷

Since the first completely peer operated respite house was developed in 1997 in New Hampshire by Shery Mead (the originator of [Intentional Peer Support](#) — the approach implemented as a foundation of the house)⁷⁸ — they have proliferated around the country because of their outstanding success.⁷⁹ Three prominent Consumer Operated Service Programs (COSPs) that operate Peer Respite are [People USA's Rose Houses](#) in New York State, [Wildflower Alliance](#) in Massachusetts, formerly known as the Western Massachusetts Recovery Learning Community, and the [Promise Resource Network](#) in Mecklenburg, North Carolina. All three have a great deal of information about how these kinds of programs should be operated.⁸⁰

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

⁷⁷ This description of Peer Respite was pulled from Live & Learn, Inc. "[Peer Respite: Action + Evaluation](#)" (website).

⁷⁸ [Intentional Peer Support](#). (website). Accessed 18 Sep 2023. See also Mead, Shery; Kuno, Eri; & Knutson, Sarah. (2013). "[Intentional Peer Support.](#)" *Vertex* (Buenos Aires, Argentina) 24(112): 426-433.

⁷⁹ There is a [somewhat outdated list](#) at the National Empowerment Center website.

⁸⁰ [People USA's Rose Houses](#); [Wildflower Alliance](#); [Promise Resource Network](#). Websites Accessed 18 Sep 2023.

Housing First

“Without adequate housing, mental health ‘treatment’ is mostly a waste of time and money.”⁸¹ The [CRPD](#) promotes the right to housing for persons with disabilities including the right to a secure home and community. Housing is an important determinant of mental health and an essential part of recovery. Addressing adequate housing is not only a human right but should also be a public health priority.

The Housing First approach was pioneered in the 1990s by two organizations, Pathways to Housing in New York City (now [Pathways Housing First Institute](#)), and by what was then called the Downtown Emergency Service Center in Seattle, Washington (DESC).⁸² Its underpinnings were person-centered—asking people on the street “what do you need or how can I help you?” They didn’t say counselling. They didn’t say medication—they said “a home” and to not have strings attached. There is evidence to support the beneficial effects of the Housing First approach on people’s quality of life, including dimensions such as community adjustment and social integration, and some aspects of health.⁸³ As the research base is growing in favor of this approach, the Housing First model is now expanding across European countries and has even become national policy in Finland. Housing First is money well spent, reducing other costs, likely by multiples.

Employment

Behind housing, employment is perhaps the most important therapeutic element for people diagnosed with serious mental illness. In a 30-year longitudinal research study involving 269 subjects who were discharged from the backwards of public institutions, it was found the strongest link to successful recovery and integration into community roles was involvement in community based rehabilitation, particularly vocational rehabilitation leading to employment.⁸⁴

In “Employment is a Critical Mental Health Intervention,” Robert E. Drake and Michael A. Wallach, state, “[E]mployment improves the mental health and wellbeing of people with serious mental disorders, including improved self-esteem, symptom control, quality of life,

⁸¹ Mosher, Loren R. (5 Mar 2003). [Affidavit of Loren R. Mosher, M.D.](#) In *The Matter of the Hospitalization of Faith J. Myers*. Anchorage Superior Court, Case No. 3AN 03-277 P/S.

⁸² See Downtown Emergency Service Center (DESC). [“What is Housing First?”](#) (website). Accessed 18 Sep 2023.

⁸³ National Low Income Housing Coalition; & National Alliance to End Homelessness. (2020). [The Case for Housing First](#); Mackelprang, Jessica L.; Collins, Susan E.; & Clifasefi, Seema L. (2014). [“Housing First is Associated With Reduced Use of Emergency Medical Services.”](#) *Prehospital Emergency Care* 18(4): 476–482.

⁸⁴ DeSisto, Michael J., et al. (1995). [“The Maine and Vermont Three-Decade Studies of Serious Mental Illness: I. Matched Comparison of Cross-Sectional Outcome.”](#) *British Journal of Psychiatry* 167(3): 331–338.

social relationships and community integration, without harmful side effects.”⁸⁵ Drake and Wallach summarize the data on employment:

“The great majority of people with serious mental disorders desire employment as a primary treatment goal (Wescott et al., 2015).”

“[P]eople with mental disorders view ‘recovery’ as a meaningful, active, functional life, not as a complete absence of symptoms (Deegan, 1988). People can learn to tolerate and cope with symptoms if they have a life that they consider valuable.”

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

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

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

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

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

⁸⁵ Drake, Robert E.; & Wallach, Michael A. (2020). [“Employment is a Critical Mental Health Intervention.”](#) *Epidemiology and Psychiatric Sciences* 29: e178 — citing Drake, Robert E., et al. (2013). [“Assisting Social Security Disability Insurance Beneficiaries With Schizophrenia, Bipolar Disorder, or Major Depression in Returning to Work.”](#) *American Journal of Psychiatry* 170(12): 1433–1441.

Soteria Houses

Soteria House, whose outstanding outcomes are set forth above, was established in San Jose, California by Loren Mosher, MD, a psychiatrist and schizophrenia expert who was at the time the Chief of Schizophrenia Studies for the National Institute of Mental Health.⁸⁶ The original Soteria House was a research project for more than 10 years to answer the question: *Can people newly diagnosed with schizophrenia recover in the community without the conventional treatment of hospitalization and debilitating neuroleptic medications?* The answer was a resounding yes. Soteria is a home-like environment focusing on psychological and physical safety through compassionate relationships between staff and residents. The mantra of Soteria House is “being with, rather than doing to.”

A colleague of Dr. Mosher, Luc Ciompi, MD, opened a Soteria House in Berne, Switzerland in 1984 and ran it for decades. In 2004 or thereabouts, Dr. Ciompi and Dr. Mosher published the following Soteria Critical Elements:⁸⁷

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 to maintain attachments to ordinary life – e.g. cooking, cleaning, shopping, art, excursions etc.

⁸⁶ Mosher, Loren R. (1999). [“Soteria and Other Alternatives to Acute Psychiatric Hospitalization: A Personal and Professional Review.”](#) *The Journal of Nervous and Mental Disease* 187(3): 142-149.

⁸⁷ Ciompi, Luc, & Mosher, Loren, R. (ca. 2004). [Soteria Critical Elements](#). Accessed 18 Sep 2023 (psychiatrized.org).

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

The research demonstrated the typical Soteria resident became stabilized in about six weeks with an average stay of three months. At six weeks, when compared to hospitalized, medicated patients, persons served at Soteria House had similar outcomes. After one and two-year follow-ups the patients treated at Soteria House were doing significantly better than conventionally treated patients in terms of symptoms, rehospitalization, social functioning and employment, thus averting a trajectory of chronic mental illness.⁸⁸

⁸⁸ Bola, John R.; & Mosher, Loren R. (2003). ["Treatment of Acute Psychosis Without Neuroleptics: Two-Year Outcomes From the Soteria Project."](#) *Journal of Nervous and Mental Disease* 191(4): 219-229.

With respect to cost:

In the first cohort, despite the large differences in lengths of stay during the initial admissions (about 1 month versus 5 months), the cost of the first 6 months of care for both groups was approximately \$4000. Costs were similar despite 5-month Soteria and 1-month hospital initial lengths of stay because of Soteria's low per diem cost and extensive use of day care, group, individual, and medication therapy by the discharged hospital control clients.⁸⁹

The original Soteria House closed after its study funding ended. Its extremely good results challenged bio-psychiatry and was largely buried by the psychiatric establishment until Robert Whitaker wrote about it in his influential 2002 book, *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill*.⁹⁰ Since then the approach has seen increased interest, directly leading to the establishment of Soteria Houses in Alaska, Vermont and Israel.

The Burlington, Vermont Soteria House is funded by the state of Vermont and operated by Pathways Vermont.⁹¹ In Israel, there are several Soteria Houses and other similar programs incorporated into the mental health system to the point where they are not considered alternatives, but part of Israel's mainstream mental health system.⁹²

Despite its success, Soteria-Alaska closed due to a change in leadership and direction by the organization operating it, impacted by several factors including, but not limited to the fatigue of securing sufficient funding in the face of chronic inadequate governmental financial support. This is a cautionary tale — sustainability is impacted, not just by funding but by commitment and fidelity to a vision and historical purpose.⁹³

Similarly, Soteria Berne operated successfully for decades by Dr. Ciompi under the *Soteria Critical Elements* principles they developed. However, since Dr. Ciompi retired, Soteria Berne has drifted away from these elements. This demonstrates the danger of backsliding when the visionary founder leaves. This was also a key factor in Soteria-Alaska's closure. It is thus extremely important to develop a critical mass of people who understand and support Soteria principles. There are also other programs that claim to be Soteria programs even though they do not comply with the Soteria Critical Elements and may even be involved in psychiatric incarceration and forced drugging.

As demonstrated above, it is critically important to prevent people from being put on neuroleptics and Soteria Houses should be the first option for people who experience a first episode of psychosis who would otherwise be psychiatrically hospitalized and drugged

⁸⁹ Mosher, Loren R. (1999). "*Soteria and Other Alternatives to Acute Psychiatric Hospitalization: A Personal and Professional Review.*" *Journal of Nervous and Mental Disease* 187(3): 142-149.

⁹⁰ Whitaker, Robert. (2002). *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill*. New York: Basic Books.

⁹¹ *Pathways Vermont Soteria House*. Accessed 18 Sep 2023.

⁹² Friedlander, Avraham; Tzur Bitan, Dana; & Lichtenberg, Pesach. (2022). "*The Soteria Model: Implementing an Alternative to Acute Psychiatric Hospitalization in Israel.*" *Psychosis* 14(2): 99-108.

⁹³ Gottstein, Jim. (29 Jun 2015). "*Lessons From Soteria-Alaska.*" *Mad in America*.

under the current system. They have been proven to be successful with people already drugged, but their best use is to help people from being put on the neuroleptics in the first place.

Drug Free Hospitals

Psychiatric inpatients should be given the option of no drugs. In 2010, at the urging of patient organizations, the Norwegian parliament mandated patients be allowed to choose a drug-free psychiatric hospital. As a result, the private Hurdalsjøen Recovery Center was opened and operated with extreme success.⁹⁴ Unfortunately, more recently the Norwegian government decided not to continue financially supporting private hospitals, forcing its closure.⁹⁵ Drug free hospitals should be made generally available for inpatients who choose not to take the drugs.

Open Dialogue

The Open Dialogue approach, as set forth above, can also achieve remarkable results in the 80% recovery range.⁹⁶ There are Seven Principles of the Open Dialogue Approach:

1. Immediate help
2. Social network perspective
3. Flexibility and mobility
4. Responsibility
5. Psychological continuity
6. Tolerance of uncertainty
7. Dialogue (& polyphony).⁹⁷

As stated on the Developing Open Dialogue website:

The principles and values of Open Dialogue are simple. People are met in crisis within 24 hours of contact and daily until the crisis is resolved. Hospitalisation is avoided and its consequential stigma, preferring to meet in the homes of those seeking their services. They avoid the use of anti-psychotic medication wherever possible. All those who have something to say are invited including the networks of the person and mental health services. The latter are integrated into a comprehensive service and the same

⁹⁴ Whitaker, Robert. (8 Dec 2019). "[Medication-Free Treatment in Norway: A Private Hospital Takes Center Stage.](#)" *Mad in America*.

⁹⁵ Whitaker, Robert. (11 Jan 2023). "[A Revolution Wobbles: Will Norway's 'Medication-Free' Hospital Survive? Politics, Mainstream Psychiatry May Shutter Lake Hurdal Recovery Center.](#)" *Mad in America*.

⁹⁶ Seikkula, Jaakko, et al. (2006). "[Five-Year Experience of First-Episode Nonaffective Psychosis in Open-Dialogue Approach: Treatment Principles, Follow-Up Outcomes, and Two Case Studies.](#)" *Psychotherapy Research* 16(2): 214–228.

⁹⁷ Olson, Mary; Seikkula, Jaakko; & Ziedonis, Douglas. (2014). "[The Key Elements of Dialogic Practice in Open Dialogue.](#)" Worcester, MA: University of Massachusetts Medical School.

Open Dialogue team work with the client and their social network throughout the life of the problem. In addition people are offered other therapies as required e.g. employment support, individual therapy, occupational therapy etc.⁹⁸

Open Dialogue, or the dialogic approach as it is sometimes called, with variations, is being deployed as an alternative to the traditional psychiatric drug and coercion system around the world.⁹⁹ It needs to become part of the mainstream system as it has in Lapland, where it reduced schizophrenia diagnoses by 90% because they were getting people through what they were going through and their lives back on track before the six months of symptoms required for a schizophrenia diagnosis to properly be made.¹⁰⁰ This was possible because the Open Dialogue Approach was the first and preferred treatment.

Hearing Voices Network

Hearing Voices Groups bring together people who hear voices, in peer-supported group meetings that seek to help those with similar experiences explore the nature of their voices, meanings and ultimately, acceptance. Hearing Voices Groups have grown in popularity in no small part because suppressing voices using medication and other interventions are often ineffective or worse. Hearing Voices groups ask not what is wrong with you, but what happened to you? The *WHO Guidance* endorses the Hearing Voices Network.¹⁰¹

The Hearing Voices Movement began in the Netherlands in the late 1980s. It now has national networks in 30 countries. Some groups are co-founded by professionals and closely aligned with mental health services while others are initiated independently by voice hearers. Due to the independent nature of these groups, it is challenging to research outcomes. In spite of limited research, some reported outcomes include: decrease in hospital admissions, voice frequency and use of medication, increase in support that is often otherwise unavailable and better understanding of voice experiences.¹⁰² Most importantly, the participants value Hearing Voices groups and they should be encouraged and supported.

⁹⁸ Developing Open Dialogue. [“Open Dialogue Finland”](#) (web page). Accessed 18 Sep 2023.

⁹⁹ Mosse, David, et al. (2023). [“Introduction: Open Dialogue Around the World – Implementation, Outcomes, Experiences and Perspectives.”](#) *Frontiers in Psychology* 13.

¹⁰⁰ Seikkula, Jaakko, et al. (2006). [“Five-Year Experience of First-Episode Non-affective Psychosis in Open-Dialogue Approach: Treatment Principles, Follow-Up Outcomes, and Two Case Studies.”](#) *Psychotherapy Research* 16(2): 214–228.

¹⁰¹ World Health Organization. (9 Jun 2021). [Guidance on Community Mental Health Services: Promoting Person-Centered and Rights-Based Approaches](#). Guidance and Technical Packages on Community Mental Health. Geneva: World Health Organization. See also the [Hearing Voices Network](#) website.

¹⁰² Branitsky, Alison. (2017). [“Commentary: Assessing the Impact and Effectiveness of Hearing Voices Network Self-Help Groups.”](#) *Frontiers in Psychology* 8; Beavan, Vanessa; de Jager, Adele; & dos Santos, Bianca. (2017). [“Do Peer-Support Groups for Voice-Hearers Work? A Small Scale Study of Hearing Voices Network Support Groups in Australia.”](#) *Psychosis* 9(1): 57–66.

Minimal costs are involved, usually only rent for a weekly meeting space and a possible fee for the facilitator, if even that. **The very low cost Hearing Voices Network approach should be encouraged and facilitated.**

Warmlines

Warmlines are different than crisis/suicide lines, also called "hot lines," which often betray callers by having the police dispatched to haul them off to the psychiatric hospital in handcuffs even though they advertise themselves as confidential and/or anonymous.¹⁰³ This betrayal went national with the rollout of the 988 line in the United States, which is often linked with mental health crisis response programs, such as Crisis Now.¹⁰⁴ The rationale for the betrayal is they only call for the apprehension of people who are at risk of suicide so they can be incarcerated safely in a psychiatric ward. Not only does this make people unwilling to call the hotline, but as set forth above, increases suicides.

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

"Standalone peer-run warm lines are garnering national attention as a part of states' responses since they are cost effective, highly utilized and are the most accessible way for people, regardless of age, gender, sexual orientation, race, ethnicity, geography, insurance/no insurance and financial circumstances to get support and prevent emergency department, 911 and involuntary hospital stays."¹⁰⁵ Forty states have warmlines.¹⁰⁶

Emotional CPR (eCPR)

Emotional CPR ([eCPR](#)) is an educational program designed to teach people to assist others through an emotional crisis¹⁰⁷ by three simple steps:

¹⁰³ Chapter 10 of the comprehensive and authoritative book on forced psychiatric interventions, *Your Consent is Not Required: The Rise in Psychiatric Detentions, Forced Treatment, and Abusive Guardianships* (2023) by investigative reporter Rob Wipond, documents the tracing of promised confidential and/or anonymous calls and dispatching of police to take people into custody.

¹⁰⁴ National Association of State Mental Health Program Directors (NASMHP). "[Crisis Now: Transforming Crisis Services](#)" (website). Accessed 18 Sep 2023.

¹⁰⁵ From a presentation by Cherene Caraco, Warm Lines, part of her series of [webinars on Peer Run Crisis Alternatives](#), presented by the Café TA Center, Tallahassee, FL.

¹⁰⁶ [warmlines.org](#) maintains a directory of known warmlines in the U.S.

¹⁰⁷ The terrific book *Heartbeats of Hope: the Empowerment Way to Recover Your Life* (2018) by psychiatric survivor and psychiatrist Daniel Fisher includes a description eCPR and its development.

C = Connecting
P = emPowering, and
R = Revitalizing

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

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

Non-Police Community Response Teams

It is being recognized more and more that the police should not be involved in responding to what are termed mental health crises. So many of these police encounters end in tragedy in the United States with the police shooting and killing people for whom they were asked to check on. Mobile Crisis Teams are meant to address the problem of police being first responders, but they are set up to psychiatrically incarcerate people which, as set forth above, is counterproductive and cause people to avoid contact with the system no matter what problems they may be having. Instead, non-coercive non-police community response teams should be utilized.

Non-Police Community Response Teams

- An alternative to 911, police intervention and mobile crisis
- Diversion from involuntary commitment and incarceration
- Various models exist – for example:
 - co-responders which include a peer supporter and clinician
 - completely peer staffed team
 - a peer supporter and paramedic
- Receiving national attention due to the racial injustices and use of police force when responding to people experiencing mental health crisis

108

Open Dialogue teams could be viewed as community response teams that continue the engagement with the person and the person's close community. They are often used in situations where mobile crisis teams would be deployed, but with the outstanding outcomes set forth above.

Psychotherapy

Psychotherapy is often overlooked, or even dismissed, as an effective approach for people diagnosed with serious mental illness, but much of what works in the approaches discussed above could be considered psychotherapy in a broad sense, and good psychotherapy is provided in a way that is consistent with these voluntary, relationship-based approaches. As set forth above, Dr. Mosher testified as a qualified expert witness in the *Myers* case, that "in the field of psychiatry, it is the therapeutic relationship which is the single most important thing."¹⁰⁹

Many patients desire psychotherapy and it has been shown to be very effective.¹¹⁰ The 1966–1971 Michigan Psychotherapy Project found that psychotherapy was significantly more effective than neuroleptic treatment for people diagnosed with schizophrenia.¹¹¹

¹⁰⁸ [“Peer Run Crisis Alternatives: Community Response Teams”](#) (video) by Cherene Caraco, 16 Jun 2021, from the [CAFE TAC Peer-Run Crisis Alternatives Webinar Series](#). These are really worth watching.

¹⁰⁹ [In the Matter of F.M. Transcript of proceedings \(March 5 and March 10, 2003\)](#), p. 177. Anchorage Superior Court, Case No. 3AN-02-00277 CI; See also Duncan, Barry L. (2015). [“The Person of the Therapist: One Therapist’s Journey to Relationship.”](#) In Kirk J. Schneider, J. Fraser Pierson, & James F. T. Bugental (eds.), *The Handbook of Humanistic Psychology: Theory, Research, and Practice*, 2nd ed., pp. 457–472. Thousand Oaks, CA: Sage Publications.

¹¹⁰ Gøtzsche, Peter C. (22 Dec 2022). [“Psychotherapy: Less Expensive and Better Than Pills, it’s What the Patients Want But Don’t Get.”](#) *Mad in America*; Irwin, Matt. (Jan 2004). [“Treatment of Schizophrenia Without Neuroleptics: Psychosocial Interventions Versus Neuroleptic Treatment.”](#) *Ethical Human Sciences and Services* 6(2): 99–110.

¹¹¹ Karon, Bertram P.; & VandenBos, Gary R. (1972). [“The Consequences of Psychotherapy for Schizophrenic Patients.”](#) *Psychotherapy: Theory, Research & Practice* 9(2): 111-119; Karon, Bertram P.; & VandenBos, Gary R. (1981). [Psychotherapy of Schizophrenia: The Treatment of Choice](#). New York: Roman &

Studies with long-term follow-up show that psychotherapy has an enduring effect that outperforms psychiatric drugs.¹¹²

Other Person-Centered and Rights-Based Approaches

In addition to the programs described above endorsed by the [WHO Guidelines](#), a number of other effective, humane, person-centered and rights-based programs are identified.¹¹³ Similarly, the [Compendium Report: Good Practices In The Council Of Europe To Promote Voluntary Measures In Mental Health](#) (Good Practices Compendium), was published to assist member States by developing a compendium of good practices to promote voluntary measures in mental healthcare, both at a preventive level and in situations of crisis, by focusing on examples in Council of Europe countries.¹¹⁴

One of programs described in the [WHO Guidelines](#) is the Friendship Bench program in Zimbabwe:

The name Friendship Bench derives from the shona term, chigaro chekupanamazano, which translates literally as, “bench to sit on to exchange ideas”. It provides a short-term form of problem-solving therapy to people with common mental health conditions, known in shona as kufungisisa, which translates literally as “thinking too much.” The free service is linked to the local primary health care centre and is usually delivered outside the centre on a wooden bench. People can self-refer or be referred by schools, police stations or the primary care clinic.

This seems somewhat similar to the tōjisha-kenkyū program in Japan, which roughly translates as “the science of the self” or “self-supported research”, where people with disabilities and/or mental illness learn to study their own experiences.¹¹⁵

Both of these are examples of a community developing solutions that work for them. There should be room in the mental health system to support approaches the people

Littlefield; Morrison, Anthony P, et al. (2014). [“Cognitive Therapy for People With Schizophrenia Spectrum Disorders Not Taking Antipsychotic Drugs: A Single-Blind Randomised Controlled Trial.”](#) *The Lancet* 383(9926): 1395–1403.

¹¹² Cuijpers, Pim, et al. (2013). [“Does Cognitive Behaviour Therapy Have an Enduring Effect That is Superior to Keeping Patients on Continuation Pharmacotherapy? A Meta-Analysis.”](#) *BMJ Open* 3(4): e002542; Shedler, Jonathan. (2010). [“The Efficacy of Psychodynamic Psychotherapy.”](#) *American Psychologist* 65(2): 98-109; Bighelli, Irene, et al. (2021). [“Psychosocial and Psychological Interventions for Relapse Prevention in Schizophrenia: A Systematic Review and Network Meta-Analysis.”](#) *The Lancet Psychiatry* 8(11): 969–980.

¹¹³ World Health Organization. (9 Jun 2021). [Guidance on Community Mental Health Services: Promoting Person-Centered and Rights-Based Approaches](#). Guidance and Technical Packages on Community Mental Health. Geneva: World Health Organization.

¹¹⁴ Gooding, Piers. (2021). [Compendium Report: Good Practices in the Council of Europe to Promote Voluntary Measures in Mental Health](#). Report commissioned by the Committee on Bioethics, Council of Europe.

¹¹⁵ Ayaya, Satsuki; & Kitanaka, Junko (12 Jun 2023). [“Tōjisha-Kenkyū: Japan’s Radical Alternative to Psychiatric Diagnosis.”](#) *Aeon*.

themselves develop and want to implement. When a community comes up with a solution they want to pursue, there is “buy-in” which succeeds because the community makes it succeed. Such programs are not necessarily susceptible to being replicated because the buy-in is such a critical component. This does not diminish its effectiveness for that community.

An example is [Ionia](#) in Alaska.¹¹⁶ Five refugee couples from the psychiatric system on the East Coast settled in Kasilof after trying out a number of other locales. They pooled their individually meager assets to purchase land. Starting out in yurts the first winter, they then built cabins with wood stoves. They have a macrobiotic diet, growing as much of their own food as they can, and gathering other food such as seaweed. They have a community meeting every day to work out conflicts and they consider their simple but hard, close to the earth work to be therapy. These couples, at least one of which in each was written off as hopelessly mentally ill, have created a life that works for them. A whole generation of their children grew up there and there is a blossoming third generation. The point is not that Ionia is a model program that should be replicated, but an example of people finding their own solutions.

One of the programs identified by the [Good Practices Compendium](#) is **TANDEMplus** in Belgium, a mobile crisis service involving interdisciplinary teams that support people during and shortly after a mental health crisis. The crisis teams help a person to (re)activate her/his local support network, including connecting to both formal and informal sources of support. Emphasis is placed on the person defining the kind of support she/he would like to receive.

Another program identified by the [Good Practices Compendium](#) is "**Citizen Psychiatry**," in the French City of Lille. "Over the past three decades, the city of Lille has progressively developed a program of ‘citizen psychiatry’ in which mental health services’ aim to avoid resorting to traditional hospitalisation, and instead ‘integrate the entire health system’ into the city, via a network involving all interested partners: service users, carers, families and elected representatives. Within this broad approach to mental health services, there are several specific practices detailed in the report."

Another is the **Trieste, Italy model** "described as an ‘open door—no restraint’ initiative which aims to ‘de-hospitalise’ responses to mental health across the city of Trieste. The core of the program involves a network of ‘Community Mental Health Centres’ with relatively few beds, one general hospital psychiatric unit, a network of supported housing facilities, and several social enterprises/cooperative businesses."

Healing Homes operated by the Family Care Foundation in Gothenburg, Sweden,¹¹⁷ backed by over twenty years of experience, places people who have been failed by

¹¹⁶ [Ionia](#). (website). Accessed 18 Sep 2023.

¹¹⁷ [Family Care Foundation \(Familjevårdsstiftelsen\)](#). (website). Accessed 18 Sep 2023. See also Håkansson, Carina. (5 Feb 2012). "[In Gothenburg, Ordinary Homes Serve as Havens for Healing.](#)" *Mad in America*.

traditional psychiatry with host families — predominately farm families in the Swedish countryside — as a start for a whole new life journey without psychiatric drugs. Host families are chosen not for any psychiatric expertise, but for their compassion, stability, and desire to give back. People live with these families for upwards of a year or two and become an integral part of a functioning family system.

Staff members offer clients intensive psychotherapy and provide host families with intensive supervision. The Family Care Foundation eschews the use of diagnosis, works within a framework of striving to help people come safely off psychiatric drugs, and provides their services, which operate within the context of the Swedish national health service, for free. There is a movie, *Healing Homes*, by Daniel Mackler, now a free download, about this program that has been translated into 20 languages and viewed over 66,000 times.¹¹⁸ Like Soteria Houses and Peer Respite, Healing Homes provide a home or home-like environment with the expectation people can get through their experiences and come out the other side able to have meaning, purpose and connection in their lives.

Healing Homes is similar to the more well-known city of Geel in Belgium, which has a centuries-long tradition of taking people into their homes and making them part of their families.

Warfighter Advance is another example of a community fashioning a solution.¹¹⁹ In this case, the community are people who have been deployed to wars overseas and come home with psychiatric diagnoses, put on psychiatric drugs and told there is something wrong with their brain and they essentially have no future. Warfighter Advance changes the trajectory of the warfighter's post-deployment life, so that rather than an existence characterized by an endless cycle of mental illness diagnoses, drugs, medical appointments and disappointments, the warfighter has a life characterized by pride, productivity, healthy relationships, continued service, and advocacy for the same outcomes for their fellow service members. Warfighter Advance eschews psychiatric drugs and force, instead encouraging informed consent. It has outstanding results in helping traumatized veterans live fulfilling lives. This program and two of its participants are featured in the award winning documentary film, *Medicating Normal*.¹²⁰

¹¹⁸ Mackler, Daniel (2011). *“Healing Homes: Recovery From Psychosis Without Medication”* (documentary). 1h20m.

¹¹⁹ *Warfighter Advance*. (website). Accessed 18 Sep 2023.

¹²⁰ Cunningham, Lynn; & Ractliffe, Wendy. (2020). *“Medicating Normal”* (documentary). 1h 16m: Periscope Moving Pictures.

V. ACKNOWLEDGMENTS

The authors give great thanks to Melissa S. Green for editing and formatting assistance and to Susan Musante, LPCC, for her input. Melissa was the publication specialist at the University of Alaska Anchorage's Justice Center for 29 years. Among many other things, Susan was the founding director of Soteria-Alaska and thus has personal experience successfully implementing the types of programs recommended in this Report.

VI. AUTHORS

James B. (Jim) Gottstein, Esq.

[James B. \(Jim\) Gottstein, Esq.](#), author of *The Zyprexa Papers* (2021) is an Alaskan lawyer who in 1982, at the age twenty-nine, experienced a manic episode as a result of sleep deprivation and was held at the Alaska Psychiatric Institute (API) for 30 days. He was told he would never practice law again and the best he could hope for was to minimize his hospitalizations by taking one or more neuroleptics for the rest of his life. Instead, with one other brief hospitalization in 1985, Mr. Gottstein learned how to manage his life to avoid getting into trouble again.

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

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

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

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

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

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

See [Multifaceted Grassroots Efforts To Bring About Meaningful Change To Alaska's Mental Health Program](#) (2012).

Peter C. Gøtzsche, MD

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

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

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

Gøtzsche has published over 100 papers in "the big five" (*BMJ*, *Lancet*, *JAMA*, *Annals of Internal Medicine* and *New England Journal of Medicine*) and his scientific works have been cited over 190,000 times (his H-index is 91 according to Web of Science, June 2022, which means that 91 papers have been cited at least 91 times). Gøtzsche is the author of several books. The ones most relevant for psychiatry are:

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

Gøtzsche has given numerous interviews, one of which — about organised crime in the drug industry — has been seen [by half a million](#) on YouTube. Gøtzsche was in The Daily Show in New York on 16 Sept 2014 where he played the role of Deep Throat revealing secrets about big pharma. A documentary film about Peter's reform work, [Diagnosing Psychiatry](#), appeared in 2017, and another one is in the making, [The honest professor and the fall of the Cochrane empire](#).

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

David Cohen, PhD

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

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

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

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

Chuck Ruby, PhD

Chuck Ruby, author of [Smoke and Mirrors: How You Are Being Fooled About Mental Illness - An Insider's Warning to Consumers](#), is a licensed psychologist in private practice in southern Maryland. He is the Executive Director of the International Society for Ethical Psychology and Psychiatry (ISEPP), a non-profit research and public education organization that rejects the traditional medical notion of "mental illness" and calls for humane ways of helping people who suffer from significant life distress. Dr. Ruby was trained in clinical psychology at the Florida State University, earning his Ph.D. in 1995. He is also a retired U.S. Air Force Lieutenant Colonel who served in counterespionage, counterintelligence, and criminal investigative assignments across the globe.

Faith J. Myers

Faith J. Myers is the author of the book *Going Crazy in Alaska: A History of Alaska's Treatment of Psychiatric Patients* (2020). For approximately 5 years, from 1999 to 2003, Faith was in and out of acute care psychiatric facilities or units and at times, homeless. She is the Myers in *Myers v. Alaska Psychiatric Institute*, declaring Alaska's forced drugging regime unconstitutional.

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

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From: [Jim Gottstein](mailto:Jim.Gottstein)
To: jones.david@joneslawfirm.net
Cc: [David Russell](mailto:David.Russell); jim.gottstein@psychrights.org
Subject: David Russell
Date: Thursday, May 2, 2024 9:08:03 PM

Dear Mr. Jones,

I am the president and CEO of the [Law Project for Psychiatric Rights \(PsychRights\)](#) and a board member of [MindFreedom, International](#). Your client, David Russell has contacted us because of his concern, terror really, over being electroshocked against his will. We are willing and able to assist in defending against this barbaric proposal.

PsychRights and the Committee for Truth in Psychiatry submitted what I think is a pretty good overview of the evidence against electroshock in our [submission to the FDA opposing reclassification of electroshock machines](#) in March of 2016.

As you should know, the United Nations has concluded Electroshock can constitute torture in violation of International Law. See, UN Human Rights Council. (19 June 2020). [“Mental Health and Human Rights: Resolution 43/13 Adopted 19 June 2020.”](#) A/HRC/RES/43/13. Geneva: United Nations; UN Human Rights Council. (20 Mar 2020). [Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment: Report of the Special Rapporteur.](#) A/HRC/43/49. Geneva: United Nations; Méndez, Juan E. (4 Mar 2013). [“Statement By Mr. Juan E Méndez, Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 22nd Session of the Human Rights Council of the United Nations.”](#) Geneva: United Nations. See also the related [Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Juan E. Méndez](#) (2013), A/HRC/22/53. Geneva: United Nations.

I see the Electroshock Petition was filed on April 24th and the hearing set for May 6th. This is not a sufficient period to prepare a defense and it seems necessary for you to obtain a continuance if the Electroshock Petition is not withdrawn or dismissed as we have asked of Dr. Morgan.

Mr. Russell informs me he has directed you to provide me with information about his case. I would like the entire court file, which I believe is Case No. 85-PR-24-46, but initially I need to see the Electroshock Petition. You may e-

mail it to me at this address, or if you are concerned about e-mail not being secure enough, upload it to [REDACTED]

Since the hearing is scheduled for this coming Monday, I need it today (your time), Friday, May 3rd.

I look forward to working with you on this matter.

James B. (Jim) Gottstein, Esq.
President/CEO



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The Law Project for Psychiatric Rights is a public interest law firm whose mission is to mount a strategic litigation campaign against forced psychiatric drugging and electroshock. We are further dedicated to exposing the truth about these drugs and the courts being misled into ordering people to be drugged and subjected to other brain and body damaging interventions against their will. Due to the massive psychiatric drugging of children and youth, PsychRights has made attacking this problem a priority. Children are virtually always forced to take these drugs because it is the adults in their lives who are making the decision. This is a national tragedy of immense proportions. PsychRights is seeking sufficient funding to increase its impact. See, [Getting to the Next Level](#).

Comments by Professor John Read on May 6, 2024, Dr. Schak Electroconvulsive Therapy Testimony¹

Background and Qualifications.

I have been a Professor of Clinical Psychology at the University of East London, England, since April 2016. I previously held the same position at the University of Liverpool, England; Auckland University, New Zealand; and Swinburne University of Technology, Melbourne, Australia. At the Universities of Liverpool and Auckland I was also Director of the Postgraduate Training Programmes in Clinical Psychology.

I graduated from the University of Wales with an honours degree in Psychology, before attaining my M.A and Ph.D in Clinical Psychology at the University of Cincinnati.

Prior to returning to work in academia I worked for thirteen years as a Clinical Psychologist and manager of mental health services, in the United States, England, and New Zealand, predominantly with patients at the extreme end of the spectrum of psychiatric disturbance, e.g., those experiencing psychosis or severe depression and suicidality.

I have over 230 research publications (Google Scholar), which have been cited over 25,000 times. I have published over 50 book chapters and have edited or authored five books. I have given over 65 invited plenary/keynote addresses at psychiatric conferences in 17 countries. A list of my publications authored in the previous 10 years is attached hereto as Appendix A.

Since 2009 I have been the Editor of the international, peer-reviewed, scientific journal 'Psychosis: Psychological, Social and Integrative Approaches'. I am also currently the Chairperson of the International Institute for Psychiatric Drug Withdrawal.

In 2010 I received the New Zealand Psychological Society's Hunter Award (awarded only every three years) for 'excellence in scholarship, research and professional achievement.'

Since 2010, I have published four reviews of the research literature on the efficacy and safety¹⁻³ and mechanisms of action,⁴ of electroconvulsive therapy [ECT] (sometimes referred to as 'electroshock therapy' or 'shock therapy') in peer-reviewed journals. The most recent of these was a 40-page review in 2019,³ with Professor Irving Kirsch, Associate Director of Placebo Studies at Harvard Medical School.

I am also the lead researcher on two independent audits of the administration and monitoring of ECT in England's National Health Service,^{5,6} and was a member of the research team that conducted audits on the accuracy of ECT patient information leaflets in England⁷ and the rest of the UK.⁸

In 2018 I was invited by the Institute of Psychiatry, London, to propose the motion on ECT in the 57th 'Maudsley Debate', and was first author on the summary of the debate published in the British Medical Journal.⁹

¹ *In the Matter of the Civil Commitment of David Austin Russell*, Respondent, Case No 85-PR-24-46, State Of Minnesota, County Of Winona, Third Judicial District.

In 2021 I wrote, by invitation, a summary of the ECT research literature for *Psychiatric Times*, a medical trade publication distributed monthly to approximately 50,000 psychiatrists, primarily in the United States.¹⁰ I have also published several summaries of the ECT research for the popular media, including *Psychology Today* and *Aeon*.

In 2023, two of my ECT papers^{6,9} were cited in the joint World Health Organisation/United Nations report 'Mental health, human rights and legislation: guidance and practice'¹¹ (p.58)

In the early 1970s I witnessed ECT first-hand as a psychiatric nursing aide at a Bronx psychiatric hospital. I was assigned the role of sitting with people as they recovered consciousness and orientation during the postictal state following a seizure, which can last from a few minutes to several hours.

I have previously provided expert deposition testimony in three cases: *Michelle Himes et al. v. Somatics, LLC*, USDC for the Central District of California, Case No. 2-17CV-06686-RGK-JCX; *Thelen v. Somatics, et al.*, USDC for the Middle District of Florida, Case No. 8:20-cv-01724; and *Diane O'Neil v. Somatics, LLC*, USDC for the District of New Hampshire, Case No., 1:20-cv-00175-PB. I also testified at trial in *Thelen v. Somatics, et al.*, USDC for the Middle District of Florida, Case No. 8:20-cv-01724 on May 31, 2023, after which the jury found Somatics failed to warn about the risks associated with its ECT devices.

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8. Read, J. et al. (2023). An independent audit of Electroconvulsive Therapy patient information leaflets in Northern Ireland, Scotland and Wales. *Psychology and Psychotherapy: Theory, Research and Practice*, 96, 885-901.
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Comments on Testimony

P 9 'Schizoaffective disorder, among other diagnoses, but that would be the primary one for which we are treating here' and p 14. 'It is a well-documented treatment for mental illness, including primary psychotic disorders such as schizoaffective disorder.'

Schizoaffective Disorder is not listed as a target diagnosis for ECT anywhere I know of and not in the Mayo Clinic's own document:

Electroconvulsive therapy (ECT) can greatly and rapidly improve severe symptoms of several mental health conditions, including:

Severe depression, particularly when other symptoms are present, including a break from reality (psychosis), a strong desire to attempt suicide or failure to thrive.

Treatment-resistant depression, a severe depression that doesn't get better with medicines or other treatments.

Severe mania, a state of intense euphoria, agitation or hyperactivity that occurs as part of bipolar disorder. Other signs of mania include impulsive or risky behavior, substance misuse, and psychosis.

Catatonia, which features a lack of movement, fast or strange movements, a lack of speech, and other symptoms. It's related to schizophrenia and certain other mental health conditions. In some cases, a medical illness causes catatonia.

Agitation and aggression in people with dementia, which can be hard to treat, negatively affect quality of life, and injure and distress others.

<https://www.mayoclinic.org/tests-procedures/electroconvulsive-therapy/about/pac-20393894>

P 11 ‘... a well-documented treatment for primary psychotic disorders’

There is no meaningful evidence that ECT is effective for people diagnosed with psychosis or ‘schizophrenia.’ A recent commentary on Cochrane reviews (widely regarded as the most objective and comprehensive reviews) reported that ‘What is common in all versions of these Cochrane reviews is that in spite of seven decades of clinical use of ECT for people with schizophrenia, there still is a lack of strong and adequate evidence regarding its effectiveness.’¹

A subsequent, 2023, randomized, double blind, placebo-controlled trial of ECT with people diagnosed with schizophrenia who had not responded to medication ‘found no evidence that ECT is better than Sham -ECT’.² The only other two such studies this century had also found no difference.

(And no placebo controlled trials for ‘schizo-affective disorder’)

1. Shokraneh, F. et al. (2019). Electroconvulsive Therapy for people with schizophrenia: Updating a Cochrane systematic review for two decades. *British Medical Journal*, 26, <https://www.bmj.com/content/364/bmj.k5233/rr-8>
2. Melzer-Ribeiro, D. et al. (2023). Randomized, double-blind, sham-controlled trial to evaluate the efficacy and tolerability of ECT in patients with clozapine-resistant schizophrenia. *Schizophrenia Research*, doi.org/10.1016/j.schres.2023.11.009

P 13.

Q. Has Mayo Clinic determined if ECT is medically necessary?

A. Yes, we have. And that is due to the lack of response to antipsychotic medication.

No evidence that psychological therapy has been offered /tried:

Mayo Clinic document:

‘ECT may be a good treatment when you can't tolerate medicines or you haven't found relief from other forms of therapy.’

<https://www.mayoclinic.org/tests-procedures/electroconvulsive-therapy/about/pac-20393894>

and on p 22: ‘he's asked for therapy in the hospital, like individual psychotherapy,’ but no evidence he was offered/given it.

p 16. 'I'm not able to give percentages. ECT is generally more effective than medication. We know that from -- historically ECT was used much more frequently and earlier on for treatment of a primary psychotic disorder. Now it's become relatively less common because we have so many antipsychotic medications. So I just don't have an ideal reference to give percentages. But the effectiveness is usually quite beneficial to patients

with primary psychotic disorders more so than medication. I'm comfortable saying that today.'

Can't give %s because there are few/no studies comparing ECT to antipsychotics. Most studies are of the two together.

Ali SA, Mathur N, Malhotra AK, Braga RJ. Electroconvulsive Therapy and Schizophrenia: A Systematic Review. *Mol Neuropsychiatry*. 2019 Apr;5(2):75-83. doi: 10.1159/000497376.

Pp 16/17.

Q. Are there any potential side effects associated with ECT treatment?

A. Yeah. Most common are going to be body aches, possible memory loss around the time of treatment -- so that's within the days to a week of treatment but generally not long-term memories from childhood or events prior to hospitalization -- are going to be the most common from the ECT. (emphasis added)

This is inaccurate and inconsistent with the relevant research

Memory Loss and Brain Damage: In the 1940s and 1950s autopsies repeatedly provided evidence of brain damage, including necrosis (cell death) following ECT. An early review of autopsies, in the esteemed British medical journal, the *Lancet*,¹ observed that 'Recognition of what occurs in the brain during the course of shock treatment may well make us pause before adding injury to insult too promiscuously in the course of shock treatment. Though the method has been used widely in the treatment of psychiatric disorders, it has not been without its opponents who look with horror on its use and who regard it as an insult to the nervous system.' The reviewer noted other possible explanations for the brain damage, such as old age, before concluding 'that more studies are necessary concerning the problem in question, and that security in the application of shock treatment is ill-founded'. A subsequent review,² of the first 20 years of autopsies and other forms of brain investigations, concluded, after considering the possibility of pre-existing lesions, that: 'damage to the brain sometimes reversible but often irreversible, occurred in the course of electric shock treatment.'

It was originally argued that ECT worked because it causes brain damage. In 1941, the internationally renowned American psychiatrist, Dr Walter Freeman, wrote, in a paper about 'various shock methods of therapy': 'The greater the damage, the more likely the remission of psychotic symptoms. . . . Maybe it will be shown that a mentally ill patient can think more clearly and more constructively with less brain in actual operation.'³ Freeman's paper was entitled 'Brain Damaging Therapeutics'.

In 1942, another US psychiatrist explained: 'There have to be organic changes or organic disturbances in the physiology of the brain for the cure to take place. I think the disturbance in memory is probably an integral part of the recovery process. I think that it may be true that these people have for the time being at any rate more intelligence than they can handle and that the reduction in intelligence is an important factor in the curative process. . . . Some of the very best cures that one gets are in those individuals whom one reduces almost to amentia.'⁴

In 1974, Professor Karl Pribram, head of Stanford University's Neuropsychology Institute, wrote: 'I'd rather have a small lobotomy than a series of electroconvulsive shock. . . . I just know what the brain looks like after a series of shock – and it's not very pleasant to look at.'⁵

Today, it is accepted by almost all concerned, that some degree of memory loss occurs for most patients. Recent studies have found memory impairment in 61% of adults, and 68% and 69% of adolescents, after ECT.^{6,7}

There is not a consensus, however, on exactly how many patients recover the memory loss over time, and how many go on to suffer persistent or permanent memory loss.

An example of researchers arguing that few or no patients suffer persistent memory loss is a 2010 meta-analysis⁸ which argued that 'Cognitive abnormalities associated with ECT are mainly limited to the first 3 days posttreatment.' This paper is of questionable merit. It entirely excludes retrograde amnesia (see below), the cognitive dysfunction that most other researchers agree is the most pervasive and persistent adverse effect of ECT. Such bias might be explained, in part, by the second author (DM) receiving payments from Mecta, a manufacturer of ECT machines.

A 2004 New Zealand Government report, however, had concluded that 'ECT may permanently affect memory' and bemoaned the 'slowness in acceptance by some professional groups that such outcomes are real and significant in people's lives.'⁹ A U.S. psychiatry textbook states that 'All patients should be informed that permanent memory loss may occur.'¹⁰ The American Psychiatric Association has acknowledged that 'evidence has shown that ECT can result in persistent or permanent memory loss.'¹¹ Somatics, a manufacturer of ECT machines includes 'permanent memory loss' in its list of adverse effects.¹²

In 2023, a joint report by the World Health Organisation and the United Nations confirmed that: 'People being offered ECT should also be made aware of all its risks and potential short- and long-term harmful effects, such as memory loss and brain damage'.¹³ (p. 58).

A 2003 review of studies of self-reported memory loss, at least six months post-ECT, found a range of patients reporting memory loss from 51% to 79%, with an average of 70%.¹⁴ The same review found that the range for 'persistent or permanent memory loss' was 29–55%; with an average of 38%. The memory loss caused by ECT can be categorised into two broad types. Anterograde amnesia is difficulty retaining new information. Retrograde amnesia is the loss of memories of past events, known as 'autobiographical memories.' There is a consensus that ECT can cause both types of memory loss to some extent. There is less agreement about the severity and duration of the two types of cognitive damage.

One review, which acknowledged that 'both anterograde and retrograde memory impairment are common', found that retrograde amnesia is a consequence of electrochemical dysfunction of the limbic-diencephalic subcortical areas involved in information retrieval, while in anterograde amnesia the medial temporal lobe is most affected.¹⁵

The tests routinely used in clinical practice and research studies are not able to detect many of the cognitive deficits suffered by ECT patients. A review published in the clinical journal of the Royal College of Psychiatrists in the UK¹⁶ concluded that 'Claims that ECT does not have permanent adverse effects on memory and cognitive ability have been based on extremely gross measures of mental function such as the Mini-Mental State Examination and other dementia screening scales. But if ECT had produced wholesale dementia on a scale gross enough to be detected by these tests, it would have been abandoned decades ago'. Therefore, many of the studies cited next are probably underestimates of the prevalence of memory impairment.

Anterograde amnesia: Almost everyone receiving ECT suffers anterograde amnesia, the inability to retain new information. An American Psychiatric Association report notes that as a result ‘returning to work, making important financial or personal decisions, or driving may need to be restricted.’¹⁰

For many the ability to retain new information returns over a period of a few weeks. For an undetermined number of patients this anterograde amnesia has been identified several months or years after ECT, for example, eight years¹⁷ and ten years.¹⁸ Both these studies used control groups to rule out the possibility that the amnesia had been caused by other factors, such as medication, age, diagnosis or depression.

In the largest study, of 418 UK patients’ long-term experiences of ECT, ‘Inability to remember new information’ (anterograde amnesia) was reported by 204 (49%), with 121 (29%) describing this inability as ‘permanent’. Thus, of those who reported anterograde amnesia it was permanent for 59% (121/204). Of the 418 participants, most (332; 79%) had received ECT at least three years ago and 280 (67%) at least six years ago.¹⁹

A 2019 review reported that ‘Recent meta-analyses suggest the most prominent deficits are on measures of attentional/executive control (i.e., tests measuring cognitive flexibility, inhibitory control, and processing speed) and auditory verbal learning/recall (i.e., unstructured list learning), a memory task that is also strongly correlated with executive functioning.’²⁰

Retrograde amnesia: Three facts are generally accepted: (a) retrograde amnesia occurs to some extent in almost all ECT recipients; (b) memory of events closest to the treatment are most affected; and (c) some improvement occurs over time for some patients.^{11,15}

The APA report¹¹ acknowledges: ‘In some patients the recovery from retrograde amnesia will be incomplete, and evidence has shown that ECT can result in persistent or permanent memory loss.’ A subsequent review of the research confirmed that ‘ECT can cause persistent or permanent memory loss, especially autobiographical memory.’²¹

The first large-scale prospective study of cognitive outcomes, in 2007,²² found that six months after ECT, autobiographical memory was significantly worse ($p < .0001$) than pre-ECT levels. Furthermore, 12.4% were deemed to have suffered ‘marked and persistent retrograde amnesia.’

In an earlier study, in which ECT recipients performed worse than non-recipients on ability to recall 1960s celebrities and childhood memories, the average time since ECT was 8.4 years.¹⁷

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17. Freeman, C. et al. (1980). ECT: Patients who complain. *British Journal of Psychiatry*, 137, 17-25.
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19. Pedler, M. (2001). *Shock Treatment A survey of people's experiences of Electro-Convulsive Therapy*. London: Mind
20. Mosti, C., Brook, M. (2019). The cognitive effects of Electroconvulsive Therapy: a critical review. *Psychiatric Annals*, 49, 152-6.
21. Singhai, A. (2011). ECT and its place in the management of depression. *Progress in Neurology and Psychiatry*, 15, 1-26.
22. 33. Sackeim H. et al. (2007). The cognitive effects of ECT in community settings. *Neuropsychopharmacology*, 32, 244–54.

P 25 The memory loss is around the time of treatment. So one might forget like what happened the day before or the details of what transpired over the days before the treatment, but we would not be expecting there to be brain damage in a way that one would not remember past events.

See Retrograde amnesia above , and:

Does the memory loss constitute brain damage? There is no consensus amongst ECT researchers on whether the well documented anterograde and retrograde amnesia memory

induced by ECT should be thought of as 'brain damage.' On the one hand it can be argued that 'marked,' 'persistent' and 'permanent' damage to the cognitive functioning of the brain is, by definition, damage to the brain. Others highlight the fact that not all brain scan or imaging studies show clear signs of damage.

Early autopsies,^{1,2} and early theories about how ECT works,^{3,4} were clear that ECT can cause significant brain damage, and named it as such. While some claim that early studies are not relevant because today's ECT is so different, a constant fact, from 1938 to today, is that sufficient electricity has been administered to the brain to cause a seizure.

While scanning and imaging studies have produced inconsistent results, some computerised tomography (CT) scans have found frontal lobe atrophy following ECT.^{5,6} An MRI study found that the number of ECTs administered correlates with reduced grey matter density.⁷ Marked deactivation in several cortical regions have also been found.⁸

My own review of more than 100 imaging studies (with Dr Roar Fosse of the University of Oslo)⁹ concluded that 'the temporarily improved scores on depression instruments following ECT reflect the combination of frontal and temporal lobe functional impairments and activation of the hypothalamic-pituitary-adrenal axis (HPA axis) and the mesocorticolimbic dopamine system. These effects as well as other detailed changes observed in structures such as the hippocampus appear consistent with those typically seen after severe stress-exposure and/or brain trauma.'

ECT can cause repetitive intracranial mild traumatic brain injury which is not easily captured on standard brain scans. The neuropathology of repetitive high field strength electricity on brain tissue involves compounding microstructural damages only visible under microscope with proper staining technique. Cellular, microvascular, neuronal, voltage-gated ion channel damage is invisible on standard brain scans.⁸⁻¹¹

Bennet Omalu, MPH, a neuropathologist who identified chronic traumatic encephalopathy in National Football League players, stated that, where they exist, functional injuries resulting from ECT must be considered as both repetitive brain injury and repetitive electrical trauma.¹²

Although it is generally agreed that the electricity has a causal role in the brain damage, an Editorial of the American Journal of Neuroradiology notes that 'A number of experimental animal and clinical studies imaging studies confirm the idea that seizures by themselves cause brain damage.'¹³

The ECT manufacturer, Somatics, includes 'permanent brain damage' in its list of risks from ECT.¹⁴

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Dated: October 31, 2024

/s/ John Read, PhD
John Read, PhD

Appendix A

Professor JOHN READ: CURRICULUM VITAE 2014 - September 2024

Articles in Peer-reviewed Journals

READ, J. (2024). Major adverse cardiac events and mortality associated with electroconvulsive therapy: Correcting and updating a 2019 meta-analysis. *Ethical Human Psychology and Psychiatry*, doi.org/10.1891/EHPP-2024-0003

READ, J., DAVIES, J. (2024). Incidence of antidepressant withdrawal symptoms. *Lancet Psychiatry*, 11, S2215-0366(24)00273-6.

READ, J. (2024). Warning: Medical records about ECT-induced memory impairment matter. *Journal of Affective Disorders*, 360, 137-138.

MONCRIEFF, J., READ, J., HOROWITZ, M. (2024). The nature and impact of antidepressant withdrawal symptoms and proposal of the Discriminatory Antidepressant Withdrawal Symptoms Scale (DAWSS). *Journal of Affective Disorders Reports*, 100765.

READ, J. (2024). Warning: High incidence of cognitive impairment from electroconvulsive therapy with adolescents. *Journal of Affective Disorders*, 346, 230-231.

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