Repeal Mental Health Laws
Documenting and challenging forced psychiatric treatment

Report on forced psychiatry and psychiatric abuse against African Americans as intersectional discrimination based on race and disability

Summary

This report addresses the role of the mental health system as a system for social control that exists in parallel to the criminal justice system, is governed by minimal guarantees of due process, legitimizes discrimination based on disability and gives free rein to racial prejudice. African Americans and other people of color – including children – bear a disproportionate impact of this system in the United States. In particular they experience its most cruel and callous treatment, the disproportionate application of restrictive measures such as inpatient hospitalization, restraint and seclusion (solitary confinement), the combined impact of coercive mental health and criminal justice systems, the application of dehumanizing diagnostic classifications, and the invoking of control systems of any kind for behavior of lower intensity than is the case for most whites.

We ask the Committee to condemn the violence inflicted on African Americans by public mental health systems, and by private mental health providers operating with legal authorization, as intersectional discrimination based on race and disability that violates Article 5(b) of the International Convention on the Elimination of All Forms of Racial Discrimination. Forced medication in particular is an act of disability-based violence that can amount to ill-treatment or torture, as is also the suffering inflicted by indefinite detention in the mental health system.

Instead of a discriminatory system of social control, we need supports and services that are accountable to communities of color and particularly to people of color with lived experience of trauma, mental health problems and psychiatric oppression. Known alternatives to be investigated for inclusion in a menu of choices available to communities and individuals include Soteria, Open Dialogue, Family Group Conferencing, Intentional Peer Support, WRAP (Wellness Recovery Action Plan), Personal Ombud (PO) and Personal Board of Directors. We ask the Committee to build on the approach of the Convention on the Rights of Persons with Disabilities in setting out standards for the abolition of forced psychiatry and the development of supports that respect the person's will and preferences, and to make recommendations to the United States aimed at eradicating coercive measures in the mental health system as a problem of intersecting discrimination based on race and disability.

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I. Organizations submitting this report

Organizations submitting this report are the Campaign to Repeal Mental Health Laws, M.O.M.S. – Movement Of Mothers and others Standing Together, Center for the Human Rights of Users and Survivors of Psychiatry (CHRUSP), Law Project for Psychiatric Rights (PsychRights), Victorious Black Women, MindFreedom International (MFI), World Network of Users and Survivors of Psychiatry (WNUSP) and International Disability Alliance (IDA). These organizations include individuals with lived experience of the violations described in this report, and have substantial knowledge of human rights violations in the mental health system. Detailed information about these organizations is supplied in Appendix IV. Special thanks to law student intern Tifanei Nikol Ressl-Moyers for research assistance.

II. Statement of the issue under Article 5 of ICERD

This report addresses the role of the mental health system as a system for social control that exists in parallel to the criminal justice system, is governed by minimal guarantees of due process, legitimizes discrimination based on disability and gives free rein to racial prejudice. African Americans and other people of color – including children – bear a disproportionate impact of this system in the United States. In particular they experience its most cruel and callous treatment[1] (see also sections III and IV and Appendix I), the disproportionate application of restrictive measures such as inpatient hospitalization,[2] restraint and seclusion (solitary confinement),[3] the combined impact of coercive mental health and criminal justice systems,[4] the application of dehumanizing diagnostic classifications,[5] and the invoking of control systems of any kind for behavior of lower intensity than is the case for most whites (see sections III and IV and Appendix I).

In the State of Colorado, the most recent yearly report for FY 2013 documents consistently that African Americans are disproportionately subjected to a wide range of coercive and restrictive measures, including 72-hour holds, certifications, instances of seclusion and restraint, extended seclusion and restraint, and involuntary medication. While African Americans are only 4% of Colorado's population, they represent 8% of these measures overall, 11% of seclusion and restraint, and over 11% of extended seclusion, extended restraint and involuntary medication.[6]

A study of a New York City forensic psychiatric institution (psychiatric commitment resulting from criminal proceedings) found that African Americans comprised 56% of the inmates and represented 65% of the seclusion (solitary confinement) episodes, although they make up only 25% of the city's population.[7]

We ask the Committee to condemn the violence inflicted on African Americans by public mental health systems, and by private mental health providers operating with legal authorization, as intersectional discrimination based on race and disability[8] that violates Article 5(b) of the International Convention on the Elimination of All Forms of Racial Discrimination. Forced medication in particular is an act of disability-based violence that can amount to ill-treatment or torture, as is also the suffering inflicted by indefinite detention in the mental health system.[9]

Instead of a discriminatory system of social control, we need supports and services that are accountable to communities of color and particularly to people of color with lived experience of trauma, mental health problems and psychiatric oppression. Known alternatives to be investigated for inclusion in a menu of choices available to communities and individuals include Soteria,[10] Open Dialogue,[11] Family Group Conferencing,[12] Intentional Peer Support,[13] WRAP (Wellness Recovery Action Plan),[14] Personal Ombud (PO)[15] and Personal Board of Directors. (Please see Annexes II and III for descriptions of the Beyond Soteria project, and a description of the Personal Board.) We ask the Committee to build on the

approach of the Convention on the Rights of Persons with Disabilities in setting out standards for the abolition of forced psychiatry and the development of supports that respect the person's will and preferences, and to make recommendations to the United States aimed at eradicating coercive measures in the mental health system as a problem of intersecting discrimination based on race and disability.

III. Story of Cynthia Fisher and Siddharta Fisher

My name is Cynthia Fisher and I am the mother of Siddharta Fisher, age 37. We live in Vancouver, WA. Our story is one of deep heartbreak and outrage at what has and is transpiring in the U.S. mental health system.

U.S. news media would never cover our story from our viewpoint, and so many others who have experienced similar stories of outrage and injustices. However, a Canadian Journalist, Rob Wipond, felt it needed to be told. A link to our story, "From Compliance to Activism; A Mother's Story" can be found on the M.O.M.S. webpage at MentalHealthRightsYES.org.

Siddharta, at age 12, was the Washington State Intermediate Chess Champion for Elementary School, and also at age 12, took the Scholastic Aptitude Test (SAT) for high school seniors preparing to go to college. He was presented an award from John Hopkins University for scoring in the top 25% of college bound high school seniors.

Not surprising, during his pre-teen and teen years he experienced several severe traumas; including two extremely harmful and violent racist acts. By age 16, with no trauma informed care accessible, he began suffering a break in reality, which among other symptoms, expressed itself as psychosis. At age 17, that psychosis, was diagnosed and labeled as schizophrenia and he was given a prescription for a psychotic drug that was 1200% of the pharmaceutical drug company's recommendation for his age.

The impact of this overdose of the unapproved FDA (U.S. Food and Drug Administration) drug on my son was devastating. He began very serious self-harming acts such as burning himself, threatening to jump out of a second story window, and other confusing and self-destructive behavior. As his parents, we were led to believe these acts were simply part of his diagnosed illness. It was only many years later, that the truth was uncovered.

Following the overdosing, within 8 months, after stopping and starting the psychotic drug, over and over again in an attempt to relieve his torment and agony, he experienced a medical crisis and made a desperate attempt to get someone to call 911. This act was criminalized and was the beginning of a 19 year vicious cycle of being drugged and criminalized, jailed or forced hospitalized, released into the community without real treatment, and criminalized and drugged again. These treatments have caused a significant decline in his cognitive functioning; a loss of his love of music, and dancing, as well as made him an insulin dependent diabetic; dependent on high blood pressure medication and caused a critically enlarged growth on his thyroid gland.

In December 2013, Siddharta was finally released to go to Cowlitz Garden Adult Family Home. This was arranged by his guardian, after 2 years of confinement at Western State Mental Hospital. She basically "disappeared" him so that none of his family or friends knew where he was for more than 30 days, including his first Christmas in freedom in over 2 years. He was confined to the grounds and unable to make or receive calls. He was the only African American there. When she was exposed in court January 3, 2014,with potentially having to reveal his whereabouts, Siddharta was framed that night, by the adult family home, who then had him removed by local police, and transported to the Peace Health Hospital in Kelso, Washington. There he was locked in the isolation unit of their psychiatric ward for the next 30 plus days. I wrote endless emails after finding his whereabouts, trying to persuade the hospital he was unjustly confined, and shared his agony of being caged like an animal,

and he didn't even know what he had done wrong. The police report, which was completely ignored by the guardian, the adult family home and the court, proved my son was innocent and should NOT have been rehospitalized. The hospital banned me from seeing my son after I respectfully but strongly accused them of racism in one of my emails. I was told by 3 security personnel, who met me, upon my next arrival to visit my son, that the staff felt uncomfortable because I had accused them of racism and therefore they needed to escort me out of the hospital and I was now banned from the hospital and seeing my son. From that local hospital, he was unjustly returned to be once again confined at Western State Hospital in late January, 2014.

His current treatment team at Western State Hospital, has actually advocated for his release, contrary to his past teams. Thus, Siddharta has been approved for discharge again, since February 2014, but he continues to be denied housing over and over in his hometown, Vancouver, Washington, USA, due to his so-called criminal record.

Without an address to be officially discharged to, he CANNOT be discharged, however, because he does not meet the requirements for being involuntarily institutionalized, I am able to take him home "to visit" for 5 days and then he must return to the place he most wants to leave.

The apartment where I live, and also every other apartment we have applied for, refuse to rent to him because of his criminal record. Even though the ADA (Americans with Disabilities) states that if the criminal record is caused by the mental illness then accommodations should be made. And again, his criminal record is not only related to his mental illness, but so much of it was caused by the "psychiatric drug treatment side effects."

This ADA law is violated over and over again in our city. Vancouver has a large homeless population and a severe housing shortage and even with that they still turn down people with mental illness even when they have openings. Clearly that is one of the reasons we have a higher, population of people with mental illness in our jail, than other counties our size.

Siddharta has said over and over again, the one thing he wants most is to be FREE!

Luckily his guardian resigned, and if the court follows through as promised he should be restored his full citizenship on Monday July 6, 2014. We are awaiting to hear the response of one more apartment application, which we think and hope and pray will say yes and he will be able to stay home and be Free! Please check in or subscribe to our newsletter on the M.O.M.S. website to keep updated MentalHealthRightsYES.org.

IV. African American Chronology of Genocide and Eugenics in America – the Chameleon may change its colors, but the canary in the coal mine is Black….
Vigilance is necessary to identify the ever changing camouflaged intent of eugenics.
By Cynthia Fisher

Below is a brief chronological chameleon-like history that spans more than a century of racist medical/psychiatric practices and programs, sacrificing children and youth and adults' health, futures and lives for the purpose of eugenics of the African American race in America.

These practices targeted African Americans and poor people for socially and government created problems, including racist oppression, poverty and state-sponsored economic inequality, and overt and covert physical violence. Just as the U.S. practices of eugenics change identity overtime to silence the public outrage and camouflage its purpose; ***like the chameleon***, its underlying essence remains the same. In this case, the essence or purpose is to destroy communities, families and individuals of African American descent; vigilance is necessary to identify the ever changing camouflaged intent of eugenics.

The eugenics of the African American race, IS the canary in the coal mine for the American people.

The canary in a coal mine is an advanced warning of some danger. The metaphor originates from the times when coal miners used to carry a caged yellow canary down into the mines while at work; if at any time the lethal invisible methane or carbon monoxide began to be released in the underground, the canary would die before the levels of the gas reached those hazardous to the miners, and they would escape.

And what is the danger, it is that the majority of Americans are now a surplus people.

'The fundamentally inhumane contradiction of the American economy is that it doesn't need American workers anymore - of any color.' (Ong, Aihwa. 2006. Neoliberalism As Exception: Mutations in Citizenship and Sovereignty (Durham and London: Duke University Press, 2006.http://www.truth-out.org/news/item/24138-econocide-over-the-rhine)

Here's the issue: We now have masses of people who will no longer find employment due to our economy. (The New Problem With No Name
Mon, Aug 06, 2012 by Charles Derber
http://cognoscenti.wbur.org/2012/08/06/surplus-people-charles-derber)
It is now driven by outsourcing, new technology, and a merciless global corporate strategy.

We are becoming more of a police state as this impoverished low-wage and no-wage class is seen as potentially explosive and must be held in check . . .
Managing and controlling the new class of dispossessed is the new paradigm of policing and incarceration" (Long-Scott, Ethel. 2008. "Justice - It's in the Details." The Black Commentatorhttp://blackcommentator.com/269/269_cover_obama_race_speech_analysis_ed_bd.html (March).

And I, Cynthia Fisher, would add, controlling includes not just the eugenics of the African American, but now, the eugenics of the surplus American People.

1779 Negritude
Benjamin Rush, MD (1746-¬1813), signer of the Declaration of Independence, Dean of the Medical School at the University of Pennsylvania and the "Father of American Psychiatry argued that "Negroes" suffered from a skin condition which he labelled "negritude" (akin to leprosy) and that the only cure was for them to become white. While there was no indication that he ever treated African-Americans for this "disease", he argued against intermarriage between races to ensure that negritude would not be spread further."(http://drvitelli.typepad.com/providentia/2012/02/the-benjamin-rush-prescription-part-2.html)

1851 Drapetomania, or the disease causing Negroes to run away
American physician Samuel A. Cartwright in 1851 "The cause in the most of cases, that induces the negro to run away from service, is as much a disease of the mind as any other species of mental alienation, and much more curable, as a general rule. (De Bow's Review Southern and Western States Volume XI, New Orleans, 1851 AMS Press, Inc. New York, 1967 http://www.pbs.org/wgbh/aia/part4/4h3106t.html)

1851 Dysaesthesia aethiopica

Dysaesthesia aethiopica was another alleged and accepted mental illness described by American physician Samuel A. Cartwright in 1851, which proposed a theory for the cause of laziness among slaves; (De Bow's Review Southern and Western States Volume XI, New

Orleans, 1851 AMS Press, Inc. New York, 1967
http://www.pbs.org/wgbh/aia/part4/4h3106t.html)
Treatment was severe beatings.

1902-1974 Legal Sterilization
Hundreds of thousands of legal sterilizations were medically justified in the American states, actually preceding the German mass sterilization and murder of over 100,000 so called "mental defectives".

The leaders in the German Sterilization movement, such as Marie Kop state **repeatedly that their legislation was formulated only after careful study of the California experiment**…" She correctly observed, "the legal sterilization of mental incompetents originated in the United States."

Between 1905 and 1922, thirty bills permitting the sterilization of institutionalized persons were passed in 18 states…The widespread sterilization of inmates of mental institutions and facilities for the developmentally disabled undoubtedly effected blacks disproportionately, if only because of the higher representation among the poor who flooded these institutions (The War Against Children of Color by Peter Breggin, M.D. Updated paperback published in 1998, p.156)

In North Carolina alone, by the end of 1960's more that 60% of the people sterilized under North Carolina's Eugenics laws were black, of those, 99% were female. (Lutz Kaelber, Associate Professor of Sociology, University of Vermont, Eugenics: Compulsory Sterilization in 50 American States)

In 1974 Judge Gerhard A. Gesell concluded that between 110,000 and 150,000 low income women had been sterilized annually just over the last few years under federally funded programs. He wrote, "The dividing line between family planning and eugenics is murky." (The War Against Children of Color by Peter Breggin, M.D. Updated paperback published in 1998, p.157)

Late1960s Psychosurgery (Lobotomy)
Vernon Mark, William Sweet and Frank Ervin suggested that urban violence, which most African-Americans perceived as a reaction to oppression, poverty and state-sponsored economic and physical violence against us, was actually due to "brain dysfunction, " and recommended the use of psychosurgery to prevent outbreaks of violence..

Drs. Alvin Poussaint and Peter Breggin were two outspoken opponents of the updated "Drapetomania" theory, along with hundreds of psychiatric survivors who took to the streets to protest psychosurgery abuses. ." (The War Against Children of Color by Peter Breggin, M.D. Updated paperback published in 1998, p.157)

1970's Psychosurgery: Operating on Young Black Children
O. J. Andy, Director of neurosurgery at the University of Mississippi, was publishing reports on multiple surgical interventions into the brains of approximately 30 to 40 children, aged five to twelve, who were diagnosed as aggressive and hyperactive…most of the children were housed in a segregated Black institution for the developmentally disabled. (The War Against Children of Color by Peter Breggin, M.D. Updated paperback published in 1998, p.115-116)

1980's and early 1990's Violence initiative: Drug experiments on oppressed African American Communities
In 1980's and early 1990's, the Violence initiative was exposed. The purported medical purpose was to screen, identify, and drug children who were considered genetically prone to violence. Leading NIMH (National Institute of Mental Health) psychiatrist who proposed the

initiative, Dr. Frederick Goodwin compared inner city youth to monkeys in the jungle that only desire to kill each other, have sex and reproduce. (See *The War Against Children*, Peter Breggin, 1994, St. Martin's New York)

1995 The Texas Medication Algorithm (flow chart) Project (TMAP)
George Bush was governor of Texas, when T-MAP was developed in 1995 in a collaborative effort between the pharmaceutical industry, prominent University of Texas psychiatrists and state officials in the department of mental health, and the Texas prisons. During his 2000 presidential campaign, Gov. Bush boasted of his support for the project and the fact that the legislation he passed expanded Medicaid coverage of psychotropic drugs. (Report on TMAP by whistleblower Allen Jones, Revised edition, posted on psychrights.org, January 20, 2004, http://psychrights.org/Drugs/AllenJonesTMAPJanuary20.pdf)

TMAP is essentially a series of drug "flow charts" with a recommended drug "treatment" plan for each psychiatric disorder. The charts say, for example, that a child with ADHD should be started on one type of drug, and then if that fails, add another type of drug, and if that fails add others drugs—and if all those treatments fail, try electroshock. Of course, the recommended drugs also happen to be those manufactured by the pharmaceutical companies that developed TMAP. (http://www.cchrint.org/issues/psycho-pharmaceutical-front-groups/tmap/). No other alternatives to drugs were ever recommended for treatment.

To make clear which drugs the government would pay for, some states issued complex medication algorithms based on T-MAP — detailed 'decision trees' that spelled out precisely what a psychiatrist seeking government reimbursement should prescribe when confronted with certain symptoms." Ben Wallace-Wells, "The Bitter Pill," Rolling Stone, 28 Jan. 2009, http://www.rollingstone.com/politics/story/25569107/bitter_pill.)

1995 Eugenics, the Canary and the Drugs recommended by T-Map
The drugs recommended in TMAP include **Risperdal**, **Paxil**, Zyprexa, Seroquel, Geodon, Depakote, Zoloft, Celexa, Wellbutrin, Zyban, Remeron, Serzone, Effexor, Buspar, Adderall, and Prozac, all manufactured by the above companies. (http://psychrights.org/Drugs/AllenJonesTMAPJanuary20.pdf.)
Risperdal May cause sexual dysfunction, decreased libido, impaired performance, gynecomastia, reduced fertility, galactorrhea, menstrual irregularities

Paxil Depression Medications May Reduce Male Fertility

Risperdone Theoretically, women taking risperidone may be less likely to become pregnant than those taking olanzapine, for example. (Psychopharmacology: Antipsychotic Medications and Fertility) Glenn W. Currier, M.D., M.P.H.; George M. Simpson, M.D. Psychiatric Services 1998; doi:

Paxil As many as half of all men taking the antidepressant medication paroxetine (trade names Seroxat, Paxil) may have increased sperm DNA fragmentation — a predictor of compromised fertility.(NewYork-Presbyterian/Weill Cornell Study Shows Abnormal Sperm DNA Fragmentation in Half of Men Taking an SSRI)

Antidepressants have become some of the most commonly prescribed medications in the US, especially SSRIs (selective serotonin reuptake inhibitors). These are prescribed not just by psychiatrists, but also by internists, neurologists, family practitioners, cardiologists and gastroenterologists for depression and anxiety.

Paxil is an antidepressant, A recently discovered, little-known side effect of SSRIs is **their significant impact on men's fertility**. SSRIs have been found to cut a man's sperm count as well as the normal shape and motility of their sperm **by 50 percent**. This effect can

become evident by the first month after treatment and begins to have a major impact after just three months on an SSRI.

Specifically, scientists have found SSRIs cause the sperm to be abnormally shaped and unable to swim properly, which is believed to be a direct result of the medication on the sperm itself. These changes in shape and function of sperm, added to the drop in overall sperm count, can push men into the "infertile" range while he is taking the SSRI. (NewYork-Presbyterian/Weill Cornell Study Shows Abnormal Sperm DNA Fragmentation in Half of Men Taking an SSRI NEW YORK (Jun 11, 2009))

2002 The New Freedom Commission on Mental Health

The New Freedom Commission on Mental Health was established by U.S. President George W. Bush in April 2002 to conduct a comprehensive study of the U.S. mental health service delivery system and make recommendations based on its findings. The commission has been touted as part of his commitment to eliminate inequality for Americans with disabilities.

Under the auspices of George W. Bush, TMAP has been exported under the umbrella of the NFC (New Freedom Commission) to at least 48 States. (http://www.thecommonsenseshow.com/2012/10/06/government-sponsored-mind-control-in-america-the-teen-screen-scam/)

According to the BMJ report on the New Freedom Commission report, Bush planned to screen the whole US population for mental illness', including 52 million children in school and 6 million adults working in the schools. (Jeanne Lenzer, British Medical Journal, Vol 328, pp1458, June 19, 2004)

2000 Prescribing Psychotropic Medication to Preschoolers and Youth

A study on 2-4 year olds comparing Medicaid and HMO (Health Maintenance Organization) populations, found a 300% increase in psychotropic drug use in 2-4 year old children. (Medicaid is government health insurance provided to individuals and families with low income and resources, while HMOs are a form of private insurance.) (Zito, J.,et al. (2/23/00 Trends in the prescribing of psychotropic medications to preschoolers. Journal of the American Medical Association, 238; 1025-1030)

2000 Psychotropic Practice Patterns for Youth

"The new research found steep increases in the use of most classes of medicines, including antipsychotic drugs for youth. Such powerful medications, normally meant to treat schizophrenia, were increasingly being prescribed to children on Medicaid, possibly as a way to restrain difficult children. Neuroleptics were less likely to be prescribed for the HMO youth. Children of color make up over half of the Medicaid budget but only 1/3 of the general population." (Zito, J., et al, (1/13/03) Psychotropic Practice Patterns for youth A 10 Year Perspective. Archives of Pediatric & Adolescent Medicine, 157:17-25)

2004 NAACP Legislative priority for the 109th Congress

PROTECT CHILDREN FROM OVER-MEDICATION: Each year, African American boys, are much more likely to have these behavior-and mind-altering drugs prescribed for them. Each year, eight million children, or 10% of the school age children, are prescribed drugs, such as Ritalin, for learning and attention difficulties. Children of color, especially African American boys, are much more likely to have these behavior-and mind-altering drugs prescribed for them. ***In fact, a recent study in the state of New York showed that 'minority boys' are 11 times more likely to be on mind-altering medicines than in the general student body.*** (www.naacp.org/inc/docs/washington/109/109_legislative_priorities.pdf)

The drugs damage the nervous system, the metabolic system, trigger hyperglycemia, acute weight gain, diabetes, cardiac arrest, cognitive impairment, and are linked to insulin suppression in children. (http://www.ahrp.org/cms/content/view/112/28)

2005-2006 Hazardous effect of Mental Health Treatment in Schools Prescribing Drugs for ADHD

From the executive summary of the report **Psychiatric Adverse Events Associated with Drug treatment of ADHD** by Kate Gelperin, M.D., M.P.H., Medical Epidemiologist and Kate Phelan, R.Ph., Safety Evaluator, The DDRE ADHD Psychiatric Review Team, Division of Drug Risk Evaluation (DDRE), Office of Drug Safety (ODS):

The executive summary of this report, which reviewed FDA AERS (Adverse Event Reporting System of the U.S. Food and Drug Administration) safety database, refers to ADHD (Attention Deficit and Hyperactivity Disorder) drugs that cause aggression, violence, mania, hallucinations, suicidal thoughts and behavior.

In children under the age of 10, other signs and symptoms of mania, hallucinations, both visual and tactile, involving insects, snakes, and worms were identified ***after introducing the drug, but stopped after stopping the drug.***

Numerous reports of aggression or violent behavior during drug treatment were received.

A striking 80 to 90% of patients identified **had no prior history** of similar events.
20% of cases were considered life-threatening or required hospitalization. Some cases resulted in the incarceration of the juveniles.

The majority of the reported cases of aggression were predominantly male
Stopping the drugs **can cause** aggression; violence; mania, hallucinations, suicide thoughts.

2006 **Covert** New Programs Same purpose (under the guise of socio-emotional development, mental health screening, early prevention, and treatment)

Such powerful medications, normally meant to treat schizophrenia, were increasingly being prescribed to children on Medicaid, possibly as a way to restrain difficult children. Neuroleptics were less likely to be prescribed for the HMO youth. ." (Zito, J., et al, (1/13/03) Psychotropic Practice Patterns for Youth A 10 Year Perspective. Archives of Pediatric & Adolescent Medicine, 157:17-25)

State Early Childhood Comprehensive System (SECCS)
"SECCS funds grants for states to develop **mental health early intervention services targeted to infants, toddlers, preschool, and school-aged children."** These are the grants that are steering states to establish **universal infant mental health screening**. . (see EdWatch Federal Funding for Universal Mental Health screening #3 June 19, 2006 www.edwatch.org)

Foundations for Learning Grants ($1,000,000)
"This is a mental health program funded through No Child Left Behind for children ages **birth through age seven.** It provides mental health, among other services, in order to deliver services to eligible children and their families that foster eligible children's emotional, behavioral, and social development. These services are based on such ridiculously vague eligibility criteria, as the child has been exposed to violence or the child has been removed from child care, Head Start, or preschool for behavioral reasons or is at risk of being so removed; or the child has been exposed to parental depression or other mental illness…". (see EdWatch Federal Funding for Universal Mental Health Screening # 3 June 19, 2006 www.edwatch.org)

Violence Prevention Grants Safe Schools/Healthy Students ($75,710,000)
"These grants involve mental health screening programs for both infants and TeenScreen with all of their lack of scientific merit and invasiveness. In addition, they use a program

funded under the NCLB (No Child Left Behind) Safe and Drug Free Schools Program that labels children as potentially violent and or mentally unstable **based on attitudes, values and beliefs.** It is called Early Warning, Timely Response. Among the purported warning signs of violence is intolerance for others and prejudicial attitudes. The US Department of Education website for this program states:

> All children have likes and dislikes. However, an intense prejudice toward others based on racial, ethnic, religious, language, gender, sexual orientation, ability, and physical appearance when coupled with other factors may lead to violent assaults against those who are perceived to be different.

Given the multiple problems with the mental health screening and psychiatric drug treatment for children already mentioned, as well as the politically correct thought control aspects of this program, we urge its further reduction and preferably its elimination." (see EdWatch Federal Funding for Universal Mental Health Screening # 5 June 19, 2006 www.edwatch.org)

Mental Health Integration in Schools ($4,900,000)
"This is yet another vehicle for mental health screening to be implemented in schools. Due to government and private insurance reimbursement patterns, treatment almost always means with psychotropic medications, very few of which are actually approved for children and every groups of which is under the FDAs most serious black box warnings for serious if not fatal side effects."
The President has recommended eliminating this program and we heartily concur with that assessment. (see EdWatch Federal Funding for Universal Mental Health Screening # 6 June 19, 2006 www.edwatch.org)

Teen Screening: "DEPRESSION" TEEN SCREENING

Psychiatrists and psychologists advised that the worsening state of our youth provided justification for "mandatory, universal behavioral" or "mental illness" screening. The tool promoted was Teen screen testing. With this license to inspect every child from pre-school to college and university, they fraudulently claimed they could identify those "at risk" of becoming unstable, anti-social and even violent. With a referral to their local doctor, the recommended treatment was almost always anti-depressant drugs.

As later discussed, these drugs cause or increase violent and suicidal behavior. The "teen screen" and other "depression screening" programs were thereby potential causes of greatly increased youth suicides when drugs were prescribed to supposedly "at risk" children.

TeenScreen wrongly identified 84% of teens as suicidal
TeenScreen's extremely high false positive rate makes the test virtually useless as a diagnostic instrument. One study, completed by the creators of the test themselves, found an 82% false positive rate, meaning that if 100 adolescents scored in the diagnosable range, 82 of them would be flagged as having some mental illness without having any real problems. http://www.mindfreedom.org/campaign/usa/zyprexa-teenscreen

After much controversy and an 84% false reading for at risk of suicide Teen Screen finally closed it doors in November of 20012. But only after thousands of teens were falsely labeled and many treated with psychiatric drugs.

"DEPRESSION" TEEN SCREENING
Unreliable, Invasive and Dangerous
In January, 2013 TeenScreen claimed over 2800 active sites in 47 US states and 10 nations, including 50 sites in the United Kingdom, three each in India and Canada, and one

each in Columbia, Scotland, the United Arab Emirates, New Zealand, Australia, Malaysia, Germany, and Brazil. It is not known at this time whether TeenScreen in nations outside the US will also shut down.
http://www.bmj.com/content/345/bmj.e8100

Foster Children: The Psychiatric Drugging of America's Foster Children

In 2012, more than half of the children entering foster care in the U.S. were children of color. **Twenty-six percent of the children in foster care are African American**, double the percent of African American children in the population in America. (http://www.childrensrights.org/issues-resources/foster-care/facts-about-foster-care/)

The most vulnerable among us are the littlest victims. Young children, torn from their birth families through various, often unspeakable tragedies. These children end up in state supervised foster care and too often are passed from hand to hand, house to house. There were approximately 662,000 children in foster care in the United States in 2010.

Now there is a Government Accounting Office (GAO) report confirming that foster children in five states — Florida, Massachusetts, Michigan, Oregon and Texas — are receiving shocking amounts of psychiatric drugs. In the words of ABC News, they are \"being prescribed psychiatric medications at doses higher than the maximum levels approved by the Food and Drug Administration (FDA) in these five states alone. And hundreds of foster children received five or more psychiatric drugs at the same time despite absolutely no evidence supporting the simultaneous use or safety of this number of psychiatric drugs taken together." **The ABC News report shows one 7-year-old holding a bag filled with 13 psychiatric medications that she had taken. (**Dr. Peter Breggin, reform psychiatrist, with coauthor Ginger Ross Breggin, The Psychiatric Drugging of America's Foster Children, in Huffington Post …Posted: 12/22/11 03:22 PM ET http://www.huffingtonpost.com/dr-peter-breggin/foster-children_b_1149805.html)

2011 Elderly Medical board allows over-drugging of elderly patients

Elders with dementia are often drugged indiscriminately with antipsychotic drugs in hospitals and long-term care settings. Despite sometimes-fatal side effects and a lack of efficacy, the drugs remain the treatment of choice for patients who present behavioral challenges resulting from their inability to communicate their needs. The drugs are frequently used as chemical restraints, designed to subdue patients for staff convenience, despite proven non-drug options.

Right now, more than 25,000 nursing home residents are being drugged with antipsychotic drugs. A 2011 federal report found that 83 percent of atypical antipsychotics prescriptions in nursing homes are for uses not approved by the FDA, and that more than half did not meet Medicare reimbursement criteria. As a result, Medicare paid more than $116 million in erroneous claims in a six-month period.

By Anthony Chicotel, Special to the San Jose Mercury News Posted: 01/08/2013 12:01:00 PM PST0 Comments Updated: 01/08/2013 07:18:08 PM PST
http://www.mercurynews.com/ci_22328287/anthony-chicotel-medical-board-allows-over-drugging-elderly (Anthony Chicotel is staff attorney for California Advocates for Nursing Home Reform. He wrote this for this newspaper.)

2013-2014 Murphy Bill – federal legislation proposed to expand biomedical coercive approach to mental health
Legislation was introduced in Congress by Representative Tim Murphy (http://murphy.house.gov/uploads/Section%20By%20Section%20Detailed%20Summary%20of%20HR3717.pdf), falsely linking "mental illness" with violence, to de-fund peer-run and

trauma-informed programs and legal rights advocacy, reduce privacy protections, incentivize states to implement outpatient commitment (compulsory treatment in the community), and to comprehensively require a biomedical coercive approach throughout U.S. mental health policy and programs, while eliminating any programs outside that model. The bill has 94 cosponsors to date. A rival bill introduced by Democrats (http://barber.house.gov/sites/barber.house.gov/files/2014.05.06%20Summary_StrengtheningMentalHealthinOurCommunitiesAct.pdf) removes the most controversial provisions, but would nevertheless expand mental health screening and medication of youngsters and the link between mental health and criminal justice systems. Congressional leaders are reportedly negotiating a compromise between the two bills.

An expansion of outpatient commitment passed into law separately as an amendment to another bill on April 1, 2014, Public Law 113-93 § 224.

Washington — December 12, 2013 — Today, Congressman Tim Murphy introduced legislation that, if passed, would reverse some of the advances of the last 30 years in mental health services and supports. It would exchange low-cost services that have good outcomes for higher-cost yet ineffective interventions, according to the National Coalition for Mental Health Recovery (NCMHR), a coalition of 32 statewide organizations and others representing individuals with mental illnesses; the National Disability Rights Network (NDRN), the non-profit membership organization for the federally mandated Protection and Advocacy (P&A) Systems and Client Assistance Programs (CAP) for individuals with disabilities; and the Bazelon Center for Mental Health Law, a national non-profit legal advocacy organization. …

"This proposal targets the rights of individuals with mental illnesses and restructures federal funding to heavily encourage the use of force and coercion. It also would reduce privacy protections and rights advocacy," said NDRN executive director Curt Decker….

Among the problematic provisions of Rep. Murphy's bill is the establishment of a grants program to expand involuntary outpatient commitment (IOC), under which someone with a serious mental illness is court-mandated to follow a specific treatment plan, usually requiring medication. Yet the facts show that involuntary outpatient commitment is not effective, involves high costs with minimal returns, is not likely to reduce violence, and that there are more effective alternatives.

"Force and coercion drive people away from treatment," said Jean Campbell, Ph.D., one of the nation's leading mental health researchers. "In 1989, 47% of Californians with mental illnesses who participated in a consumer research project reported that they avoided treatment for fear of involuntary treatment; that increased to 55% for those who had been committed in the past." (Dr. Campbell was one of the two researchers.[i])

Rep. Murphy's bill is based on a false connection between mental illness and violence. Study after study shows that no such connection exists. In fact, individuals with mental illnesses are actually 11 times more likely to be *victims* of violence than the general public.

Rep. Murphy's bill also attacks the federally mandated Protection and Advocacy programs, which, together with the Client Assistance Programs, are the largest provider of legally based advocacy services to people with disabilities in the United States….
(http://www.bazelon.org/News-Publications/Press-Releases/12-12-13-Murphy-PR.aspx)

Thus in summary:

Modern-day psychiatry has not left behind its legacy of racism. The public mental health system in the U.S. functions as a regime of control and repression, targeting African Americans and other people of color disproportionately for coercive and intrusive interventions such as electroshock treatment, medication with high doses of mind-altering drugs, commitment to institutions, and the use of restraints and solitary confinement. The

controversial label of schizophrenia is applied disproportionately to people of African descent in both the U.S. and the United Kingdom. The federal government has repeatedly targeted communities of color for mental health system initiatives aimed at identifying individuals who are thought likely to engage in violent behavior, and applying medical measures of control. Currently, federal policy to target individuals labeled with mental illness as well as individuals convicted of crimes as the populations uniquely subjected to gun control legislation is perpetuating the stereotype that mental health problems equate with violence, which continues to impact disproportionately on people of color.

V. Mental health system, criminal justice system and violence profiling

The mental health system as a system of social control is intricately linked to racism, due to the power that has been given to psychiatrists to mark individuals for exclusion, segregation, confinement and intrusive alteration of mind and body, based on diagnostic labels that give a scientific veneer to prejudices about a person's character and behavior.[16] The standard of "danger to self or others" that is applied to mental health commitments[17] gives free rein to prejudice by inviting psychiatrists and courts to predict future violent behavior. This system discriminates de jure based on disability, and de facto based on both race and disability.

African American children have been the target of several official attempts by the psychiatric profession to find biological causes for violence and to pre-emptively "treat" those perceived to be at risk of becoming violent, by means of intrusive interventions with mind-altering drugs.[18] African American children continue to be channeled into special education classes based on psychiatric diagnoses,[19] where they are given inferior education and subjected to intensive behavior monitoring that feeds the school to prison pipeline. At the present time, attempts to paint all people labeled with mental illness as violence-prone focus on publicized cases of white male shooters, but the restrictive laws and policies that have already been enacted or are being considered in response to such incidents[20] will have a disproportionate racial impact as well as discriminating based on disability, since they represent an intensification of the existing system of commitment and forced treatment.

As Michelle Alexander demonstrates in her influential work "The New Jim Crow: Mass Incarceration in the Age of Colorblindness" (2010), criminal justice and law enforcement policies enacted with racist motivations, combined with an official policy of colorblindness in these same systems and in the courts that enforce them, has resulted in a new manifestation of racial caste in the United States. In particular, the so-called War Against Drugs criminalized low-level drug dealing by African Americans to a much greater extent than the same behavior by whites. As a result, African American men are overwhelmingly subjected to control by the criminal justice system – not only long periods of incarceration, but also probation and parole – and suffer lifelong consequences including legalized discrimination in housing and employment; in some states they lose the right to vote. Yet at the same time, politicians, mental health professionals and the media are increasingly calling for a mental health response to the problem of mass incarceration,[21] ignoring its racial character and painting it as a problem that large numbers of people who experience serious distress or have been labeled with diagnoses can be found in prisons. In fact, an understanding of the extent to which trauma contributes to mental distress, considered a good practice by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA),[22] suggests that the social conditions that affect a person's likelihood of going to prison also increase the likelihood that this person will have had numerous traumatic experiences that affect them in ways that psychiatry classifies as mental illness. In effect, trauma, poverty and race are both criminalized and psychiatrized.

It is especially ironic that the mental health system is being asked to solve the problems of the prison system, given that the primary if not the only treatment offered, or forced against a person's will, consists of psychotropic drugs[23] – some of which are also sold on the street, and all of which can alter the structure and function of the brain and result in withdrawal

symptoms.[24] The war "against" drugs is replaced by the war "with" drugs; but in both cases the real target is the same. As a system of social control, the mental health system absorbs members of society whose economic activity is not needed and suppresses the search for social answers to social problems. It also punishes those who transgress unwritten rules and are inconvenient for mainstream society.

VI. African American users and survivors of mental health services

Many circumstances impinge on the lives of African Americans who find themselves forced into the mental health system or who use mental health services. They are often dealing with inter-generational trauma and historical, collective trauma including the impact of successive racial caste systems beginning with slavery.[25] Inequality of educational opportunities, poverty, foster care and prison systems contribute to ongoing challenges. Despite this, they struggle for well-being and self-sufficiency in their own lives and to uplift others. Family, peer support and mentoring,[26] and simply reaching out from one human being to another, looking beyond the person's current situation and not giving up on any human being, are strengths that African American users and survivors of the mental health system bring to the table.

Yvette McShan, founder of Victorious Black Women, describes her work and the positive encounter that transformed her own life:

> We all have hopes and dreams. Victorious Black Women wants you to know, whatever your dream is, if you're willing to do the work, if you love yourself, not only you're a voice in society, you're your own voice first. I'm my best example because I believe in me and I know what I have experienced and I know what other people have experienced because they're like me. They don't see me as a provider, they see me as an associate, or someone easy to talk to that really cares, I'm not looking down on you. I'm offering hope not only to you but to myself too.
>
> A provider saw something in me and spoke into my life, and that really changed my life. I promise you I felt like an animal and he taught me no you're not. He found out what I like and what I do. Now I see he's a good therapist, because I have some education and I learned what he was doing; I do some of it myself. At that time I thought of myself as an animal because I acted like that - throwing feces over that concrete wall. Looking back I don't think I was out of my mind, I was acting like that in the environment I was in, in isolation. Isolation is no good for any human being, not being by yourself without anything. I don't know if there was a bible in there - if not for my spirituality I don't know what would have happened. That man saw something in me. He gave other people medication but he didn't give me medication, he gave me candy. I'm not on drugs today and he played a major part in that.

VII. Convention on the Rights of Persons with Disabilities and a new approach to the human rights of persons with psychosocial disabilities

People of any race or ethnicity can be affected by mental distress and altered reality, or can feel or act different from others for unknown reasons. These experiences have been stigmatized throughout history and across most cultures, though they are sometimes recognized as having positive value for the person and the community (e.g. to become a healer, such as the sangomas in South Africa). The medical model of mental illness has not been an improvement, but only a re-iteration of disability-based discrimination. Thanks to the Convention on the Rights of Persons with Disabilities, there a new approach has come into international human rights law that recognizes practices such as forced treatment, confinement in psychiatric institutions, and deprivation of legal capacity as violations of the person's right to be treated equally as others.[27] Instead of removing a person's legal

capacity to make decisions when the person is in a state of great distress or altered reality, the CRPD calls for support to be provided for the person's decision-making.[28]

VIII. Recommendations

We urge the Committee on the Elimination of Racial Discrimination to adopt the standards that have been introduced by the CRPD, and to recommend the following:

- The United States should prohibit mental health commitment and forced treatment, so as to end the social control function that has been given to the mental health system, which has a discriminatory impact on people of color.

- The United States should transfer resources from research and services based on a medical model of mental illness, to research, development and expansion of alternatives that fully respect the person's autonomy, choices, dignity and privacy, that are culturally competent, trauma-informed and capable of meeting diverse needs of people experiencing serious distress or altered realities, and including aid in withdrawing from psychiatric drugs.

- In order to implement the shift from a medical model to person-directed services, consultations should be carried out, in a manner accountable to communities and to people with lived experience and their trusted family members and supporters, to learn about alternatives such as Soteria, Open Dialogue, Family Group Conferencing, Intentional Peer Support, WRAP, Personal Ombud and Personal Board models, and create a menu of such services from which individuals and communities can choose.

- The United States should support community-based peacemaking and restorative justice programs to reduce violence and create constructive solutions, and to promote community-building based on racial justice and equity along with justice and equity from a disability perspective.

Annex I: Stories of Dominique Jamerson, Alfonsia Allen and Byron Thompson, as documented by Cynthia Fisher

As part of my advocacy, I have digital tape interviews of African Americans who are currently locked in Western State hospital from 2 years to 10 years. Each one has given me their permission to publish their stories, based on their interviews here. Here are three stories.

21 year old Domique Jamerson's crime was wearing a black hoodie, talking to himself and, walking while Black, on the streets of Seattle on January 24, 2012. He was profiled by two Seattle Police who said Dominique looked like a suspect they were looking for who had just stabbed a man 12 times within the hour. Two and a half years later he is still locked up, never allowed to go to trial to prove his innocence, nor has anyone brought forth the police DNA test of his clothes that was negative.

He has been kept locked up, first in jail, then pronounced incompetent to stand trial; and then locked up in maximum security ward of Western State Hospital's forensic hospital, given maximum doses of psychiatric drugs, (even though he had only been on a psychiatric drug once in his life, when he was 6 years old;) by January 2013,one year later, it was determined he could not be made competent, transferred from the forensic(criminal) side to the civil side, where life behind bars was still cruel inhumane and degrading, but not as much so as on the forensic side.

He had been involuntarily committed for about 1 year and a half when we did a call into Prosecuting Attorney, Daniel Satterberg's Office of Seattle, to Free Dominique. Finally in October, 2013, Dominique was scheduled for discharge. The only delay was that the prosecutor's office needed to be given a 30 day notice of his proposed discharge, in case they decided to pursue the charges again. Finally, just 3 days before Dominique's dream of freedom would be realized and the worse nightmare of his life ended; 3 days before the family was planning to celebrate his release; the pros attorney's office sent police to his hospital room to handcuff and transport him to the jail. There he would be tried for the charge he was originally profiled for. He was given a million dollar bail. Dominique was devastated and confused, but did not resist.

Unbelievably he was brought before the court and also scheduled for several court hearings that were postponed, but never brought to trial…Why? Because he was once again determined to be incompetent to stand trial and recommitted once again back to the forensic side to be made competent.

From January 2012 to now, the hospital charged Over ONE HALF MILLION DOLLARS to Medicare…so it seems as if the new form of slavery for African Americans besides prison slavery, is that instead of pickin' cotton, they are forced to poppin' pills. Dominique says the medication is destroying him.

****

Alfonsia Allen has been confined at Western State Hospital for over 10 years. He had pled guilty by reason of insanity. His maximum sentence date has already passed, but he is being kept imprisoned by a corrupt court. He is also pursuing a lawsuit because he was given eye drops that blinded him for 6 months. He has an excellent non-violent history while confined and is able to often solve conflict among patients more effectively than staff.

****

Byron Thompson pleaded not guilty by reason of insanity. He entered the hospital in the physical shape of a football player at around 232 pounds almost 6 years ago. He is now down to 400 pounds after reaching 432 pounds due to the medication he is on. His kidneys have been destroyed and he will die if he is not put on dialysis. He refuses to go out for dialysis, because he has experienced extreme humiliation and degrading treatment. For instances he must be handcuffed when being transported off ground and the staff refused to remove the handcuffs even for him to go to the bathroom. He has had to ride around with

feces on him, until he returned to the hospital. He also experienced a serious accident and must have knee surgery, because he was forced to climb into a van with handcuffs on and slipped and twisted his knee.

Annex II: Beyond Soteria, by Cynthia Fisher

Soteria is our inspiration!

Beyond Soteria is our next step… supporting people living in the community and in community, while withdrawing from psychiatric drugs.

The Soteria Experiment proved that young adults experiencing their first psychosis could be successfully treated in a family like supported home setting, with little or no drugs. The key was acceptance, being with, and believing in the possibility of real recovery for the person. Thus Soteria is our Inspiration!

Today, our communities, jails and hospitals are filled with individuals who have experienced psychosis or other intense emotions and have been placed on psychiatric drugs. Many have experienced these drugs as harmful and preventing recovery. People, experiencing devastating health and emotional effects from these drugs, are often criminalized or committed for drug-induced behavior, which can include, confusion, aggressiveness, violence, mania, homicidal and suicidal tendencies. People who try to withdraw from these drugs may find they experience severe addiction withdrawal symptoms and debilitating illnesses that endanger their own lives, and can lead to acts that endanger their loved ones and their community.

One of our nation's leading psychiatric drug withdrawal experts, Dr. Peter Breggin, states the greatest mental health need in our nation today, is drug withdrawal programs. However, even he cites the dangers inherent in drug withdrawal that can cause severe reactions and will not treat anyone who does not have a strong long term support system to help them through the process.

Most supported housing and public housing decline applications of people with mental illness who have extensive criminal records. They do not factor in that every psychiatric drug has side-effects that often does induce bizarre unusual behavior, aggressiveness, violence and even murderous and suicidal tendencies, and these acts are often criminalized. Also most supported housing, and private and public housing, definitely do not embrace the fact that the violent or aggressive behavior that can be exhibited when a person attempts to slowly go off these drugs, can often be attributed to the excruciating debilitating withdrawal effects. Instead the blame is placed on the person, and it is believed that the symptoms of the illness are not withdrawal induced, but returned due to the medication being stopped. Therefore most supported housing will not, and others cannot, legally support or tolerate desires or attempts to withdrawal from these potent addictive drugs. For some the choice often feels like no real choice at all; remain on drugs that feel like they are destroying your mind, body and Soul, or lose your housing and become homeless.

Often even families are overwhelmed with the support needed to withdrawal a loved one from psychiatric drugs and keep everyone safe.

The Soteria Model, for today's individuals, who often have been heavily drugged for years, as well as institutionalized and traumatized, is not enough; IT DOES NOT ADDRESS THE INCREASED DANGER OF LONG TERM DRUGGING AND TRAUMATIZATION.

And so we are embarking on a project we are calling Beyond Soteria! The core values of acceptance of the person where they are, being with, and believing in their resilience to recover, like the original Soteria model, are still at the center of our Beyond Soteria project.

What we have added is:
A model that includes two (preferably side by side) neighborhood co-op houses and a Peace Team!

(Although realistically you may need to start with one house and a neighborhood peace team)

One house of 5 people are peers (persons with lived experience of trauma, mental health issues or being psychiatrized) and allies who are passionate about life and bring their gifts and talents to share to support the healing and integration of the person in the second house, into the community, as well as the healing and integration and education of the community back into wholeness and integration. They will be known as the Peace Team. As a Peace Team (the peace team will also include neighborhood members who do not live in the co-op house) they will bring gifts such as a passion for permaculture gardening, knitting, music, arts, mindfulness, bicycling and bicycle repair, healthy eating and living, natural building, entrepreneurship, as well as advocacy work, such as helping to craft and educate the **community on a Community Bill of Rights etc.** They will initially participate in a 3-hour weekly 6-week training, which will include de-escalation techniques, being with, restorative circles, and on-going trainings such as Non-violent Communication. They will also often lead ongoing trainings, house meetings, and community gatherings and be a part of the evolution of this model. Key to this model is that the coop house members and other neighborhood members will be trained as neighborhood Peace Team members and specialize in non-violent de-escalation. In essence they are the crisis response team for the core house and the neighborhood crisis team for certain types of crisis, and community builders. Of course what type of crisis for the neighborhood and other important details will be defined as the group comes together and strengths and weaknesses are assessed and training determined.

The other house of 3 includes a person who has explored their options carefully and has thoughtfully made the decision to try and live a drug free life. Professional support, as well as the help of people with lived experience and knowledge of the withdrawal, as consultant/s will be critical to supporting this individual. The other two housemates living in the second house are of the same mindset as the other supporters in the house of 5, but have made a commitment to be the closest supporters, living with the person in recovery and withdrawal. It is possible that a rotation schedule might work as well with the other 5.

These houses are co-op and will not have any licensing requirements. Every effort will be made to befriend and educate the neighbors, city council, the community police and build a sense of collaboration and support. Ideally the houses would be purchased by investors, who may just be looking for a good investment in property, and to whom we would pay rent and have a long term lease. The housing investment would be solid, and separate from the project.

Because they are co-op, there is no paid staff, and volunteer co-op housemates would each pay approximately $400 in rent. It is hoped that the rent would be uniformly subsidized, by donations to lower the rental rates, but would be self-sustaining from the beginning by the expected rent income.

Annex III: The Board as Recovery Model, by Cynthia Fisher

Somewhere I read about a recovery model (I believe it was in Canada, but I could not find it on the web, so I am sharing it to the best of my memory) that supported a person by helping them develop a personal board of directors. The director of the board would be from the person's friends, family, allies, or from an organization like a church, or civic organization. The prospective director and the person in recovery would meet, perhaps weekly for a period of time, to share dreams, goals, and challenges. If they mutually arrive at a place where both feel this could be an empowering relationship then the director commits to be in that role for 1 year. The CEO is the person in recovery.

The director's priority is to support the CEO in seeking out other board members, from the community, based on the choice or recovery vision of the CEO. This could be from the CEO's personal or professional circle of relationships or through other circles, including the director's circle of professional or personal relationship. Board members can also be sought according to passions, for example if the CEO has a passion to expand their cooking skills, then perhaps finding someone who loves to cook would be the ideal board member. The prospective board member's priority is to share dreams, goals, strengths, and challenges with the CEO over a period of a few weekly meetings. If they mutually arrive at a place where both feel this could be an empowering relationship then the board member(s) commits to be in that role for 1 year.

Once the director and CEO have chosen the board then you all are a team, and the 1-year commitment begins! The team is made up of a group of specially equipped individuals (including the CEO) who each bring a unique and important viewpoint to the table.

The Team then decides how many times a month they will meet. The goal is to be a support of the CEO in the areas that they most feel inspired to, according to the needs, goals, and dreams of the CEO. The director is key to building a relationship between the team, and time spent developing a bond between the team is as important as the time spent Soulstorming and creating opportunities for the needs, goals and dreams of the CEO to be fulfilled.

Examples of gifts and talents the board member might bring to the table are a passion for permaculture gardening, knitting, music, arts, mindfulness, yoga, massage, bicycling and bicycle repair, healthy eating and living, natural building, entrepreneurship, advocacy work. They may help secure housing, spend an hour a week just being with the CEO, offering a listening ear, playing the guitar with or for the CEO.

It is to be expected that over the year, as the team becomes a community that some conflicts will arrive and some form of restorative circle/justice will be practiced; not only to meet the current need, but as a model for resolving conflicts based through power sharing, not power over.

At the end of the year, the commitment period is ended. Collectively and individually, each team member can reflect on the value and the growth of that year. Perhaps a new director has already been selected for the coming year or perhaps the CEO has elected to become a board member for another CEO.

Annex IV: Information about submitting organizations

The **Campaign to Repeal Mental Health Laws** is working for the repeal of mental health laws in the United States and Canada that allow people to be deprived of their liberty, drugged, restrained, electroshocked and otherwise treated against their will in the name of "psychiatric help." The United Nations has called on countries to abolish such laws to comply with human rights obligations and has said that forced psychiatric treatment/interventions can amount to torture. The purpose of the campaign is to educate the public about all forms of forced psychiatric treatment/interventions and, most importantly, to take action to eradicate laws that allow these human rights violations to occur.
repealingmentalhealthlaws@gmail.com
http://repealmentalhealthlaws.org

M.O.M.S. the **M**ovement **O**f **M**others-and others **S**tanding-up-together: We are Mothers, Fathers, Survivors and Allies who have felt deep grief, heartbreak, and outrage at the treatment of our loved ones or ourselves, within the mental health system. We are dedicated to shining a light on our broken mental health system and Creating Communities and Neighborhoods where Hearts Can Heal.
Cynthia Fisher
cindipacha@gmail.com
www.mentalhealthrightsyes.org

The **Center for the Human Rights of Users and Survivors of Psychiatry (CHRUSP)** provides strategic leadership in human rights advocacy, implementation and monitoring relevant to people experiencing madness, mental health problems or trauma. In particular, CHRUSP works for full legal capacity for all, an end to forced drugging, forced electroshock and psychiatric incarceration, and for support that respects individual integrity and free will.
Tina Minkowitz, Esq.
tminkowitz@earthlink.net
www.chrusp.org

The **Law Project for Psychiatric Rights (PsychRights)** is a public interest law firm whose mission is to mount a strategic litigation campaign against forced psychiatric drugging and electroshock in the United States. The public mental health system is creating a huge class of chronic mental patients through forcing them to take ineffective, yet extremely harmful drugs. Currently, due to the massive growth in psychiatric drugging of children and youth and the current targeting of them for even more psychiatric drugging, 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 an unfolding national tragedy of immense proportions. As part of its mission, PsychRights is 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.
James B. (Jim) Gottstein, Esq.
jim.gottstein@psychrights.org
www.psychrights.org

The **Victorious Black Women** and Women of Color take a stand for those who are misunderstood, disenfranchised, marginalized, discriminated against and overlooked by being a voice for mental health and substance abuse consumers in communities of California. The Victorious Black Women are dedicated to enlightening, educating and informing all members of society to treat all consumers with mental health, substance abuse challenges; Whether Ex/Cons, TAY (transition age youth), Veterans, Older Adult, Gay, lesbian, bisexual, and transgender with dignity and respect. The Women of Victorious Black Women choose to encourage awareness and understanding about those affected by mental health, substance abuse, homelessness challenges in order to reduce disparities, barriers, stigma and discrimination that exist and prevail in the African American and Women of Color community.
Yvette McShan
victoriousblackwomen@yahoo.com

MindFreedom International (MFI) is an independent coalition rooted in a global movement to change the mental health system. The majority of MindFreedom's membership, board and staff identify themselves as psychiatric survivors. However, membership is open to everyone who supports MFI's human rights goals. Advocates, mental health professionals, family members, and the general public are all valued members and leaders in the MindFreedom community, and MFI is one of the few

mental health advocacy groups that does not accept money from government, drug companies, mental health systems or religious groups.
Celia Brown, President of MindFreedom International
office@mindfreedom.org
www.MindFreedom.org

The **World Network of Users and Survivors of Psychiatry (WNUSP)** is an international organisation of users and survivors of psychiatry, advocating for human rights of users and survivors, and representing users and survivors worldwide.[1] The organisation has expertise on the rights of children and adults with psychosocial disabilities, including on the latest human rights standards set by the CRPD, which it played a leading role in drafting and negotiating. WNUSP is a member organisation of IDA and has special consultative status with ECOSOC. WNUSP supports its members to advocate before UN treaty bodies, and has provided expertise to UN bodies including the Special Rapporteur on Torture, the Subcommittee on Prevention of Torture and the Committee on the Rights of Persons with Disabilities. WNUSP is currently engaged with processes for review of the Standard Minimum Rules on the Treatment of Prisoners and for the development of an instrument on the rights of older persons.
Jolijn Santegoeds and Salam Gomez, chairs
www.wnusp.net

The **International Disability Alliance (IDA)** is the international network of global and regional organisations of persons with disabilities (DPOs), currently comprising eight global and four regional DPOs. Each IDA member represents a large number of national DPOs from around the globe, covering the whole range of disability constituencies. IDA's mission is to advance the human rights of persons with disabilities as a united voice of DPOs utilising the CRPD and other human rights instruments, and to promote the effective implementation of the CRPD, as well as compliance within the UN system and across the treaty bodies.
Victoria Lee
vlee@ida-secretariat.org
www.internationaldisabilityalliance.org

[1] In its statutes, "users and survivors of psychiatry" are self-defined as people who have experienced madness and/or mental health problems, or who have used or survived mental health services.

[1] A FY 2013 report by the State of Colorado showed that, "like blacks, Hispanics are more likely to be subject to the most punitive conditions while in care. About 30 percent of the people put into seclusion and restraint last year were Hispanic." Colorado Moves Away from Seclusion, Restraint in Mental Health Crisis Cases, Inequities Remain, by Kristin Jones, June 11, 2014, available at: http://inewsnetwork.org/2014/06/11/colorado-moves-away-from-seclusion-restraint-in-mental-health-crisis-cases-inequities-remain/.

[2] African Americans are more often coerced into treatment and hospitalization, are hospitalized as inpatients disproportionately to whites, are more often subjected to restraints and seclusion, and receive diagnoses that lead them to be considered as "severely mentally ill." Julian Chun-Chung Chow, Kim Jaffee, Lonnie Snowden, Racial/Ethnic Disparities in the Use of Mental Health Services in Poverty Areas, Am J Public Health. 2003 May; 93(5): 792–797; David T. Takeuchi, Mang-King Cheung, Coercive and voluntary referrals: How ethnic minority adults get into mental health treatment; Arnold Barnes, Race, Schizophrenia and Admission to State Psychiatric Hospitals, Administration and Policy in Mental Health and Mental Health Services Research Vol. 31, No. 3 (2004); Lonnie R. Snowden, Julia F. Hastings, Jennifer Alvidrez, Overrepresentation of Black Americans in Psychiatric Inpatient Care, Psychiatric Services, Vol. 60 No. 6 (2009).

[3] Two-Year Trends in the Use of Seclusion and Restraint Among Psychiatrically Hospitalized Youths, Abigail Donovan, B.S.; Robert Plant, Ph.D.; Allyson Peller, M.P.H.; Lesley Siegel, M.D.; Andrés Martin, M.D., M.P.H., Psychiatric Services 2003; doi: 10.1176/appi.ps.54.7.987; Armando Barragán, Jr, Seclusion and Mechanical Restraints Among Ethnic Minorities: Understudied and Needed Area of Research, Mental Health Law & Policy Journal Vol. 1 99-125 (2012); Paul J Toriello, Stephen J Leierer, Joseph E Keferl, The Impact of Race on the Use of Physical Restraint on Adolescent Males with Behavioral Disabilities: An Initial Study, Journal of Applied Rehabilitation Counseling Vol. 34 No. 4 (Winter 2003).

[4] African Americans are especially over-represented in forensic psychiatric settings, i.e. those that are part of the criminal justice system. Michael Rembis, The New Asylums, in Disability Incarcerated, ed. Liat Ben-Moshe, Chris Chapman & Alison C. Carey (2014) (citing Patricia E. Erickson and Steven K. Erickson, Crime, Punishment, and Mental Illness: Law and the Behavioral Sciences in Conflict [2008]).

[5] Schizophrenia, a highly controversial and stigmatizing diagnosis once more closely associated with gender bias and stereotypically passive resistance, and applied to white women, has shifted since civil rights movement protests to be consistently applied disproportionately to African American men, and to be seen as linked with violence. Christopher Lane, "How Schizophrenia Became a Black Disease: An Interview with Jonathan Metzl [author of The Protest Psychosis (2010)]," Psychology Today, http://www.psychologytoday.com/blog/side-effects/201005/how-schizophrenia-became-black-disease-interview-jonathan-metzl; Caroline Helwick, "Schizophrenia May Be Overdiagnosed in Black Patients," Medscape Medical News, 31 July 2012 (citing study by Lawson et al. in Arch Gen Psychiatry. 2012;69:593-600).

[6] A Profile of the State of Colorado's Care and Treatment of People with Mental Illness: Title 27, Article 65 (C.R.S. 27-65-101 et seq.) A Report from the Colorado Department of Human Services Office of Behavioral Health for Fiscal Year 2013 (July 1, 2012 – June 30, 2013), available at: http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheadername1=Content-Disposition&blobheadername2=Content-Type&blobheadervalue1=inline%3B+filename%3D%22FY13+27-65+Report.pdf%22&blobheadervalue2=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251987077069&ssbinary=true; see also http://inewsnetwork.org/2014/06/11/colorado-moves-away-from-seclusion-restraint-in-mental-health-crisis-cases-inequities-remain/.

[7] Tracy Benford Price, MD, Bruce David, DO, JD, and David Otis, PhD, The Use of Restraint and Seclusion in Different Racial Groups in an Inpatient Forensic Setting, J Am Acad Psychiatry Law 32:163–8, 2004.

[8] Committee on the Elimination of Racial Discrimination, General Comment No. 32 (2009) paragraph 7.

[9] See Committee on the Rights of Persons with Disabilities, General Comment No. 1, CRPD/C/GC/1 (2014), paragraph 38; Report of the Special Rapporteur on Torture Manfred Nowak (2008), A/63/175, paragraphs 38, 40, 41, 44, 47, 61-65; Report of Special Rapporteur on Torture Juan E. Méndez, A/HRC/22/53 (2013), paragraphs 85(e), 89. See also Tina Minkowitz, The United Nations Convention on the Rights of Persons with Disabilities and the Right to be Free from Nonconsensual Psychiatric Interventions, Syracuse Journal of Intl L & Commerce Vol. 34 No. 2 (2007), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1481512.

[10] http://www.amazon.com/Soteria-Deliverance-Loren-R-Mosher/dp/1413465234; http://www.pathwaysvermont.org/?q=soteria.
[11] http://www.dialogicpractice.net.
[12] http://punkertje.waarbenjij.nu/reisverslag/4567654/presentation-text-on-eindhoven-model-cosp.
[13] http://www.intentionalpeersupport.org.
[14] http://www.mentalhealthrecovery.com/wrap/.
[15] http://www.po-skane.org/ombudsman-for-psychiatric-patients-30.php.
[16] Peter R. Breggin and Ginger Ross Breggin, The War Against Children of Color (1998).
[17] Pursuant to the Supreme Court case O'Connor v. Donaldson, 422 U.S. 563 (1975), which held that it is unconstitutional to "confine, without more, a nondangerous individual who is capable of surviving safely in freedom," a standard of danger to self or others is generally applied in commitment hearings, and has been enacted into some statutes. See for example California Welfare and Institutions Code § 5150; NY Mental Hygiene Law § 9.37.
[18] See footnote 4.
[19] Wanda J. Blanchett, Disproportionate Representation of African American Students in Special Education: Acknowledging the Role of White Privilege and Racism, Educational Researcher, August 2006 Vol. 35 No. 6.
[20] This began over a decade ago, with organizations advocating more coercive measures in the mental health system, particularly the Treatment Advocacy Center, articulating a strategy to utilize such incidents to promote outpatient commitment, i.e. court-ordered treatment in the community. TAC has been involved at the state level in numerous instances of such legislation, including in New York State's "Assisted Outpatient Treatment" law, Mental Hygiene Law § 9.60. A 2005 study by New York Lawyers for the Public Interest found highly disproportionate use against African Americans (46% of AOT orders compared with 16% of population) and slightly so against Hispanics (21% compared with 15% of the population); available at: https://www.prisonlegalnews.org/media/publications/ny_lawyers_for_the_public_interest_implementation_of_kendra's_law_2005.pdf. Current NYS Office of Mental Health statistics show that since 1999, 20% of AOT orders have been issued against African Americans compared with 14.7% of the population, while use is rising against Hispanics with 30% of AOT orders compared with 16.8% of the population. On April 1, 2014, the federal government through Public Law 113-93 § 224 established a program to provide 50 grants to local mental health systems for the implementation of such outpatient commitment programs.
[21] See for example "Laura's Law can help decriminalize mental illness," http://www.sfexaminer.com/sanfrancisco/lauras-law-can-help-decriminalize-mental-illness/Content?oid=2842119; rebutted by "'Laura's Law' a looming disaster for mentally ill," http://www.sfexaminer.com/sanfrancisco/lauras-law-a-looming-disaster-for-mentally-ill/Content?oid=2816140.
[22] Trauma and Justice, Substance Abuse and Mental Health Services Administration, http://www.samhsa.gov/traumajustice/traumadefinition/approach.aspx.
[23] Robert Whitaker, Anatomy of an Epidemic (2010).
[24] Id; Peter R. Breggin, Brain Disabling Treatments in Psychiatry: Drugs, Electroshock, and the Psychopharmaceutical Complex (2007). See also Center for the Human Rights of Users and Survivors of Psychiatry, Victorious Black Women, Law Project for Psychiatric Rights, MindFreedom International, Intentional Peer Support, Campaign to Repeal Mental Health Laws, World Network of Users and Survivors of Psychiatry, and International Disability Alliance, Joint Submission to Human Rights Committee for its review of the United States in October 2013 on nonconsensual psychiatric medication, Section II: Harm caused by nonconsensual medication with neuroleptics – research and subjective evidence, available at: https://dk-media.s3.amazonaws.com/AA/AG/chrusp-biz/downloads/283810/CHRUSPUSICCPRshadowreportFINAL.pdf.
[25] See http://historicaltrauma.com; http://gainscenter.samhsa.gov/cms-assets/documents/93078-842830.historical-trauma.pdf.
[26] "Focus on the Alternatives Conference: An Interview with Yvonne Smith," Recovering Together, December 2004 Vol. 2004-2, http://www.consumerstar.org/resources/pdf/recoveringtogether/Recovering%20Together%20Dec%2004.pdf; Katherine Brown, "Oakland: Former addict helps others through Victorious Black Women program," San Jose Mercury News 23 February 2013, http://www.mercurynews.com/ci_22654840/oakland-former-addict-helps-others-through-victorious-black.
[27] CRPD Articles 3, 12, 13, 14, 15, 17 and 25(d). Committee on the Rights of Persons with Disabilities, General Comment No. 1 on Article 12, Equal recognition before the law, CRPD/C/GC/1

(advance unedited version), especially paragraphs 8, 11-13, 22-24, 36-38. Regarding prohibition of mental health detention, see also Concluding Observations on El Salvador, CRPD/C/SLV/CO/1 paragraph 32; Concluding Observations on Austria, CRPD/C/AUT/CO/1 paragraphs 29-31; Concluding Observations on Australia, CRPD/C/AUS/CO/1 paragraphs 29-34; Concluding Observations on Sweden, CRPD/C/SWE/CO/1 paragraphs 35-36. See also Affidavit of Attorney Tina Minkowitz, https://dk-media.s3.amazonaws.com/AA/AG/chrusp-biz/downloads/289371/RohrerAffidavit.pdf.

[28] CRPD Article 12.3, CRPD General Comment No. 1 paragraphs 14-17.