

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23

Systematic violations of patients' rights and safety: Forced medication of a cohort of 30 patients in Alaska

Gail Tasch,¹ Peter C Gøtzsche²

¹ S8661 Dogwood Road Eau Claire, WI 54701, USA

² Institute for Scientific Freedom, Copenhagen, Denmark

Correspondence:

pcg@scientificfreedom.dk

Orchid: 0000-0002-2108-7016

First author:

gailtasch@aol.com

24 **Abstract**

25

26 We assessed the records for 30 consecutive petitions for mental health commitment in which an
27 involuntary medication order was requested from Anchorage, Alaska. In 29 cases, the
28 commitment petition was granted. One patient requested a jury trial and the jury found in her
29 favor. The forced medication order was granted in 27 of the 30 cases. In 26 cases, in violation of
30 previous Supreme Court rulings, the patients' desires, fears, wishes and experiences were totally
31 ignored even when the patients were afraid that the drugs used for psychosis might kill them or
32 when they had experienced serious harms such as tardive dyskinesia. The ethical and legal
33 imperative of offering a less intrusive treatment was ignored. Benzodiazepines were not offered.
34 Psychotherapy was not offered or mentioned in fifteen of the 30 cases. The providers claimed it
35 does not work, even though that statement is blatantly false. The legal procedures can best be
36 characterized as a sham where the patients are defenseless. The power imbalance and abuse were
37 extreme and several of the psychiatrists who argued for forced treatment obtained court orders
38 for administering drugs and dosages that were dangerous. Forced medication should be
39 abandoned.

40

41

42 Keywords: antipsychotics; forced treatment; patient rights

43

44

45 **Introduction**

46 Involuntary civil commitment in the United States is a legal intervention. A judge or someone in
47 a judicial capacity may order that a person with symptoms of a serious mental disorder who
48 presents a danger to self or others can be confined to a psychiatric hospital or receive supervised
49 outpatient treatment. Standards and procedures for commitment are provided by state law in
50 every state. Involuntary commitment and involuntary medication proceedings must comport with
51 due process protections under state and federal law.

52 In the State of Alaska, the Law Project for Psychiatric Rights (PsychRights) pursued a
53 strategic litigation campaign against forced psychiatric drugging through its founder, James B.
54 (Jim) Gottstein, Esq., and won two Alaska Supreme Court cases ruling Alaska's forced drugging
55 regime unconstitutional.

56 The first case was *Myers versus Alaska Psychiatric Institute* (1). In that case, the Alaska
57 Supreme Court held that in order to be forced to take psychiatric medication against their will,
58 the court had to find by clear and convincing evidence that (1) the patient does not have the
59 capacity to give or withhold informed consent; (2) it is in the patient's best interest to take
60 medication, which means that the benefits outweigh the harms; and (3) there is no less intrusive
61 alternative available.

62 The second case was *Bigley versus Alaska Psychiatric Institute* (2). The court held that forced
63 drugging petitions must include the "Myers factors" which are (1) an explanation of the patient's
64 diagnosis and prognosis, and the symptoms with and without medication; (2) information about
65 the proposed medication, its purpose and method of administration, possible harms
66 (euphemistically called side effects) and benefits; (3) review of the patient's history including
67 medication history and previous harms; (4) an explanation of interactions with other drugs
68 including over-the-counter drugs, street drugs and alcohol; and (5) information about alternative
69 treatments and risks along with benefits.

70 On June 1, 2016, Peter C Gøtzsche testified in an involuntary medication proceeding under
71 Alaska Statutes 47.30.839 held in Anchorage, Alaska, and in connection with that reviewed four
72 AS 47.30.839 petitions. All four petitions were strikingly similar and failed to provide the
73 information required in the *Bigley* case.

74 We therefore wished to investigate more formally if the legal predicates for the involuntary
75 administration of psychotropic medication orders were uniformly lacking. We assembled two
76 cohorts of 30 patients, one from Anchorage, Alaska and one from Copenhagen, Denmark.

77 This report describes our experience from Alaska. The results from the Danish cohort have
78 been published (3,4).

80 **Methods and materials**

81
82 We asked the court to provide its files for 30 consecutive AS 47.30.839 petitions from
83 Anchorage with January 1, 2016 as the planned starting date. In Alaska, such files are normally
84 confidential and to obtain them, Gottstein submitted a request that access be granted for our
85 research while preserving confidentiality. It turned out to be very difficult to get access to such
86 cases with objections from both the hospital and the Alaska Public Defender Agency, which
87 represent almost all of the psychiatric patients against whom AS 47.30.839 petitions are filed.
88 They objected to providing us with the files. It required two trips to the Alaska Supreme Court
89 and over four years to be granted access to redacted files of these proceedings. Because of the

90 delay, the start date for the files was changed to the most recent files as of the date access was
91 granted.

92 When the cases took place, the commitment hearings were held mostly by Zoom due to the
93 Covid-19 pandemic. In the court room or by Zoom, the judge, the prosecuting attorney
94 representing the State of Alaska and Alaska Psychiatric Institute and a public defender
95 representing the patient were present.

96 The patients themselves were not always present, but they had the choice of either being in
97 the court room or attending the court hearing via Zoom.

98 The hearings had two parts. The first was whether the patient required mental health
99 commitment. The second was whether a medication petition for involuntary drug administration
100 should be granted.

101 Based on the written material available to us, we noted the judge's ruling and evaluated if,
102 based on the criteria from the *Myers* and *Bigley* cases, the petitions, hearings, and decisions
103 complied with the following requirements:

- 104
- 105 1 Information was provided that documented that the patient could not provide informed
106 consent;
 - 107 2 The information about the psychiatric drugs the patient took or would be forced to take was
108 accurate;
 - 109 3 A less intrusive alternative was available;
 - 110 4 The combination of drugs the patient took was safe;
 - 111 5 The arguments for using force were reasonable and documented;
 - 112 6 The patients' rights were respected; and
 - 113 7 There were striking similarities from case to case considering that the patients were different.
- 114

115 **Results**

116

117 We were able to obtain access to 30 consecutive cases, which were heard in court between
118 January 3, 2018 and August 19, 2020. We reviewed the cases to see whether or not there was
119 compliance with the Alaska cases *Myers versus Alaska Psychiatric Institute* and *Bigley versus*
120 *Alaska Psychiatric Institute*.

121 In all 30 cases there was a Notice of 30-day Commitment Hearing document which outlined the
122 patient's rights such as having representation by counsel, call experts, and the ability to appeal an
123 involuntary commitment. In the following, we describe the results according to our seven
124 requirements.

126 *1 Information was provided that documented that the patient could not provide informed consent*

127

128 We reviewed the cases as to whether the issue of informed consent was addressed at the time of
129 the hearings for mental health commitment and medication orders. Under AS47.30.839(g), the
130 requirement is that the patient does not have the capacity to give or withhold informed consent in
131 order for the medication petition be granted. Informed consent is crucial because it is important
132 to determine whether or not the patient is able to make an informed choice about making
133 healthcare decisions. Consent also protects the patients against assault and battery in the form of
134 unwanted medical interventions. Psychiatric medications have the potential for severe adverse
135 effects. Informed consent is important for protecting the legal rights of the patients and also helps

136 guide the ethical practice of medicine. A high standard of informed consent can safeguard the
137 patients' rights to autonomy and self-determination in respect to the individual.

138 For all the requirements to be fully met, there would have to be evidence that the patient did
139 not have capacity to give or withhold informed consent. In 29 of the 30 cases, the commitment
140 petition was granted. One case went to a jury trial and the jury found in favor of the patient.

141 AS 47.30.839(d) requires a Court Visitor be appointed to make recommendations to the
142 court. The Court Visitor prepares a report and testifies in the hearings as to whether they believe
143 the individual has capacity for informed consent in regard to taking medications.

144 In 27 cases (90%), the medication order was granted. For this to happen there would have
145 had to be discussion about whether the individual could give or withhold informed consent.
146 However, in 16 of the records (53%), there was no mention throughout the hearings regarding
147 competency of the individual even though the judge sometimes made it clear that the hearing
148 was held to determine the capacity of the individual and even though the Court Visitors were
149 expected to mention this. In three of the cases, the patients were already deemed incompetent to
150 stand trial and in one case the patient had a guardian.

151 In one case, there was an initial denial of the medication petition order because the judge was
152 concerned about the testifying doctor. The court indicated that "the doctor was confused about
153 whether or not the patient can give informed consent or not," and the judge did not grant the
154 medication petition citing the *Myers* case. However, the medication order was granted at a
155 second hearing two weeks later because the judge felt confident in the Court Visitor who
156 testified that the patient was not competent. The patient said he felt "knocked out" when he took
157 medication and declined medications but there was testimony that the patient was improved with
158 medications.

159 In another case, the patient herself testified at the hearing and said that she was competent to
160 refuse medications. She preferred therapy, enjoyed the groups at the hospital but the judge
161 granted the medication order. The psychiatrist testified that she was disorganized in her thinking,
162 was not eating, and said she was unable to care for herself.

163 In a third case, the patient was deaf and blind, and his parents were guardians. The parents
164 were no longer able to care for the patient and the only real option for placement was the Helen
165 Keller Institute in New York. The judge was very concerned that the drugs would sedate the
166 patient so much he would not be able to participate in the placement interview, thereby rendering
167 the patient unable to be placed at the institute. The judge said, "I don't have confidence in the
168 doctor" and felt that the drugs were used in a way where the doctor would "give him this or that"
169 in a capricious or arbitrary manner. Nonetheless the medication petition was granted.

170 Two patients expressed in court that they had a "right to refuse medication." One patient
171 agreed to take medication but only at lower doses. The Court Visitor testified that the patient had
172 the ability to consent to treatment and was therefore competent to make the decision. The
173 treating psychiatrist disagreed, and the medication petition was granted.

174

175 *2 The information about the psychiatric drugs the patient took or would be forced to take was*
176 *accurate*

177

178 There was much discussion about which medications the psychiatrist intended to use, and in all
179 cases, several drugs were proposed, usually a combination of a psychosis drug and a so-called
180 mood stabilizer (which usually means lithium or an antiepileptic), sometimes adding a
181 depression drug.

182 There was little concern about the harms. In only three cases, did the judge reject the
183 polypharmacy (see below).

184 Typically, during the medication petition part of the hearing, the prescriber would describe
185 the planned medications and their side effects, often mentioning the risk of a permanent
186 neurologic disorder - tardive dyskinesia - and the rare possibility of neuroleptic malignant
187 syndrome.

188 However, there was no contrary testimony to what the provider - a psychiatrist, physician
189 assistant or nurse practitioner – recommended except for cross-examination by the public
190 defender. While the public defenders all seemed to care about their clients, they had little to say
191 to oppose the state attorney and they never presented an opposing psychiatrist or other expert
192 witness. The only “proof” that the medication was in the person’s best interest was the
193 unopposed opinion from the treating psychiatrist.

194 Thus, with a few exceptions, the hospital was able to direct their psychiatric practice in the
195 manner they saw fit. There was no way to determine if what the providers argued regarding
196 treatment was accurate, but some of the judges were experienced and used their own knowledge
197 in some of the cases, e.g. questioning the need for so much medication and even at times the
198 dose of medications. One judge thought that the patient was not psychotic, although the provider
199 said so.

200 The patients’ experience with previous drug treatment was never taken into consideration
201 even though it was extensive and although many expressed their opinions.

202 There was never any discussion about what types of drugs the patients preferred. The patients
203 commented on the harms of the drugs, and one noted that she did not want lithium because it
204 made her "shake physically" and she did not feel well on it.

205 One patient mentioned that Lamictal (lamotrigine) had helped him in the past, but the treating
206 doctor did not want to use it. He said he would rather use an antipsychotic medication and the
207 patient was started on Geodon (ziprasidone) 40 mg b.i.d., which is double the starting dose
208 recommended by the FDA (5).

209 In another case, the treating psychiatrist said the patient did not have any side effects from the
210 medication, but the court visitor testified that she had tardive dyskinesia. The psychiatrist
211 became defensive and said, "She will experience neurological damage if she is not treated," and
212 the medication order was granted. The patient had involuntary mouth movements from years of
213 Thorazine (chlorpromazine) treatment. The patient's public defender argued that she suffered
214 from a developmental disability and not a mental illness. It was suggested that she could get a
215 reduced amount of medication due to her history of intellectual disability, but no concessions
216 were made by her provider.

217 One patient was vehemently objecting to medication and noted that she had side effects that
218 made her hands cramp. She requested a psychotherapist and said her son would pay for it. The
219 provider argued that "There would be no therapeutic benefit from therapy." The patient objected
220 to medication because it "takes my feelings away," but the provider said: "I will give you
221 medications that get your feelings back," which is blatantly wrong as all psychiatric drugs
222 remove or dampen feelings. The patient said, "The medication will give me a heart attack and
223 liver disease." She had been on Depakote (valproate), and the FDA warns that the drug can cause
224 fatal heart blocks and fatal hepatotoxicity (6). The provider requested two psychosis medications.
225 In the medication petition hearing, the public defender quoted the *Myers* case, arguing that the
226 patient should have the least intrusive treatment and should not be given two medications. The
227 judge ordered that only one medication, Depakote should be given. The psychiatrist wanted to

228 prescribe Depakote as he said it was the only medication that treated her bipolar disorder, but the
229 judge order was that she would be treated with i.m. olanzapine if she refused to take Depakote
230 and Ativan (lorazepam).

231 One patient experienced tremor from Haldol (haloperidol), a well-known harm of the drug,
232 particularly at overdosage (7). The public defender requested limiting the dose to 30 mg orally
233 daily. The provider, a nurse practitioner, requested up to 100 mg orally on a daily basis, which is
234 an extreme dose. The recommended doses go up to 6 mg daily for moderate symptoms and 15
235 mg for severe symptoms. During that medication petition hearing, the prosecuting attorney for
236 the Alaska Psychiatric Institute said that there was an instruction from the Alaska Supreme Court
237 that courts should not micromanage petitions for medications. He also argued that 100 mg of
238 Haldol was the medical standard of care, but the judge limited the dose to 30 mg.

239 In some instances, the medication amounts were duplicate; for instance, one individual was
240 on oral Abilify (aripiprazole) 30 mg daily in addition to an injectable Abilify dose of 882 mg on
241 a monthly basis. Generally, there is no need for oral and injectable medication of the same drug.

242 It was assumed that all the patients required medication. There was no discussion of the
243 patients possibly doing better without medication or on reduced doses. All the treating
244 psychiatrists said that the benefits outweighed the risks of the medications.

245

246 *3 A less intrusive alternative was available*

247

248 Consideration of alternative and less intrusive treatments along with the risks and benefits was a
249 requirement from the *Myers* case. There weren't really any alternatives offered while, in other
250 areas of world, there are programs such as Open Dialogue in Europe and a facility called
251 "Alternative to Meds" in Arizona. Benzodiazepines are much less toxic than antipsychotics but
252 this option was not mentioned in any of the 30 cases.

253 In 15 cases, alternatives to drugs were mentioned such as psychotherapy or occupational
254 therapy, but in every single case, the provider opined that it would not be helpful, even when the
255 judge had asked if the patient could benefit from talk-based therapy.

256 The underlying assumptions were that all drugs are good and that all combinations of drugs
257 are good. The dangers of the psychiatric medications were minimized and the plan was in all 30
258 cases to have the patients take medication, live in an assisted living facility or hospital without
259 any thought of what could be done to improve their functional capacity and lives. For some, the
260 heavy drugging regimen would render them incapable of getting employed or sustaining
261 relationships.

262

263 *4 The combination of drugs the patient took was safe*

264

265 It was presumed that the medications only had positive effects and that side effects were
266 uncommon. All the providers recommended at least two medications, sometimes three or four.
267 There was no discussion about possible drug-drug interactions even though commonly
268 prescribed drugs, e.g. proton pump inhibitors can reduce clearance of other drugs, which could
269 result in overdoses of psychiatric drugs.

270 It was not considered if substance abuse contributed to the patients' symptoms, although
271 some of the patients had significant substance abuse histories and there was no discussion about
272 possible drug-drug interactions with these substances.

273

274 *5 The arguments for using force were reasonable and documented*

275
276 The providers testified that emergency medication was needed at times and this was always
277 requested, with no opposing testimony as to the requirements or documentation.
278 In 14 cases there was some reference to force being used. Several individuals were held down
279 by the staff in order that they be injected. One psychiatrist testified that if a patient refused oral
280 medications, he would be held down and injected. At times, the patients were threatened with
281 injections but they acquiesced and agreed to the oral medication rather than receiving the
282 injection.

283
284 *6 The patients' rights were respected*

285
286 The patients' rights were not respected and their thoughts, plans and wishes were never
287 considered. One patient did not wish to take medications and the public defender made this clear
288 in the closing argument in court and argued he may benefit from increased psychosocial support.

289 One patient did not want to take Haldol because it made him to groggy and "took away his
290 feelings." He told the doctor that Haldol calms him down in small doses and he agreed to low
291 doses. The patient's son requested Haldol not be used because it exacerbated his anger. The son
292 noted that Haldol also caused lethargy and muscle cramps.

293 One patient stated that "they labelled me as schizophrenic but they can't prove it." She
294 wanted to stay at the facility and prove to them that she did not need medication. She was
295 probably going to be at the Alaska Psychiatric Institute for a year. The judge questioned whether
296 or not she was psychotic. She herself testified and explained her side effects. Two antipsychotics
297 were requested but only one was granted.

298 One patient wanted to see how she did without medications and prove to the providers that
299 she could do well without medications. The possibility of a trial without medication that this
300 patient requested was not considered.

301 Some of the patients had reduced cognition secondary to the mental health disorder or
302 medication. Eight patients said that they did not need medication and eleven other patients
303 objected to the medication due to its harms. One said, "I've been drugged out of my mind." One
304 patient declined medication because she believed she was a psychiatrist. All patients had a
305 medication order granted by the court.

306
307 *7 There were striking similarities from case to case considering that the patients were different*

308
309 All the patients were presumed to have a mental health disorder. There was no consideration as
310 to the possibility that the person's symptoms were secondary to their history of substance abuse
311 or other condition. Many of them seemed to be experiencing withdrawal symptoms after they
312 had stopped medication, sometimes abruptly, with subsequent development of psychosis, but
313 these symptoms were always thought to be part of their primary psychiatric disorder. There was
314 no documentation that any of the patients were warned about the possibility of severe withdrawal
315 symptoms if the psychiatric medications were abruptly discontinued.

316
317 **Discussion**

318

319 The patients' human rights were systematically violated and the precedents stemming from the
320 *Myers and Bigley* Supreme Court cases in Alaska were consistently ignored.

321 The psychiatrists got away with the argument that, in their opinion, it was in the patients' best
322 interests to be forcefully treated with a psychosis drug. This argument is invalid, and a healthcare
323 professional cannot be excused for not knowing about the science or for ignoring it. Psychosis
324 drugs do not have any specific effects against psychosis and it is therefore misleading to call
325 them antipsychotics. They work the same way in patients, human volunteers, and animals,
326 basically by knocking people down (8) so that they cannot function, which is why their original
327 name, major tranquilizers, was more appropriate.

328 It is well-known that placebo-controlled trials of psychosis drugs are highly flawed. One of
329 the reasons is that patients recruited for the trials were already in treatment with such a drug
330 before randomization (9,p.44). Psychosis pills can cause psychosis, known as supersensitivity
331 psychosis or oppositional tolerance, even during continued treatment (8p.45,10). The drugs
332 decrease dopamine levels, and the number of dopamine receptors goes up to compensate for this.
333 If the drugs are suddenly stopped, the response can very well be a withdrawal psychosis. The
334 trials therefore only show what happens when patients randomized to placebo get harmed by a
335 cold turkey.

336 Another important bias is the lack of effective blinding because of the drugs' conspicuous
337 harms. When atropine is added to the placebo to mimic some of the harms of depression pills,
338 the effect is markedly smaller than in usual placebo-controlled trials (11).

339 Virtually all of these trials are carried out by the drug industry, and a third important bias is
340 serious manipulation with the data analysis or outright fraud (9,12).

341 Despite these formidable biases, the effect reported in the placebo-controlled trials of recent
342 drugs submitted to the FDA was only 6 points on the Positive and Negative Syndrome Scale
343 (13), whereas the minimally clinically relevant effect corresponds to about 15 points on this scale
344 (14).

345 The huge CATIE trial, financed by the US National Institute of Mental Health is also telling
346 of the poor effect of the drugs (15). It randomised 1493 "real world" patients with schizophrenia
347 to olanzapine, quetiapine, risperidone, or ziprasidone, or to an old drug, perphenazine, marketed
348 in 1957. The primary outcome was a very reasonable one, time to discontinuation for any reason,
349 which reflects both the benefits and the harms of the drugs. After 18 months, only 26% of the
350 patients were still on the randomized drug, and perphenazine was not worse than the newer drugs
351 and did not produce more extrapyramidal harms than these agents, even though this is usually
352 claimed (9).

353 The final blow to the argument that it is in the patients' best interest to be treated with
354 psychosis drugs is that both randomized trials with long-term follow-up and carefully conducted
355 observational studies comparing treated with untreated patients have shown that more patients
356 get rehospitalized and end up on disability pension when they receive psychosis drugs (9,16-18)
357 (this research is summarised in ref. 9).

358 In addition to ignoring the *Myers* requirements, the court violated the principles laid down in
359 the United Nations Convention on the Rights of Persons with Disabilities (19). The Convention
360 has specified that member states must immediately begin taking steps towards the realization of
361 the patients' human rights by developing laws and policies to replace regimes of substitute
362 decision-making by supported decision-making, which respects the person's autonomy, will, and
363 preferences (19). The convention has been ratified by virtually all countries except the United
364 States, but this cannot be an excuse for not living up to it. We have an obvious ethical obligation

365 to respect the patients and involve them in our decisions, and this ethical imperative cannot be
366 suspended. Being psychotic does not mean that the patients are incapacitated as regards their
367 views on and experiences from being treated with psychiatric drugs (19).

368 Polypharmacy of patients with psychosis was very common but it increases their risk of
369 dying markedly. It is particularly bad medicine to try to force two psychosis drugs on a patient,
370 as psychosis drugs double the risk of dying (9p.47,20) and as this harm is clearly dose related
371 (21-25). Antiepileptics also increase the risk of dying, e.g. they double the risk of suicide (26).

372 There are no randomized trials that show that polypharmacy leads to better outcomes than
373 treatment with just one drug or with psychotherapy. In addition, very little is known about
374 interactions between the medications. Polypharmacy can be considered an off label or
375 experimental treatment that should not be used, particularly not involuntarily.

376 The argument that the patients' brains will be damaged if they are not treated with psychosis
377 drugs, which was used in the court, is also commonly seen in textbooks (9). but it is totally
378 wrong. Psychosis pills can cause irreversible brain damage (9,27,28), and it has never been
379 shown that the psychosis per se can cause brain damage. One type of brain damage is tardive
380 dyskinesia, which psychiatrists very often ignore. Among 58 consecutively admitted patients
381 with acute psychosis, 48 of whom were treated for at least one week with psychosis drugs, the
382 researchers found 10 patients with tardive dyskinesia, but the psychiatrists only made this
383 diagnosis in one of them (29). It took psychiatry 20 years to recognise tardive dyskinesia as an
384 iatrogenic illness (30), even though it is one of the worst harms of psychosis drugs and affects
385 about 4-5% of patients every year (31), which means that most patients in long-term treatment
386 will develop it.

387 The internationally established principle, confirmed also in the *Myers* case, of offering a less
388 intrusive treatment was totally ignored. Benzodiazepines are far less dangerous than psychosis
389 pills and even seem to work better for acutely disturbed patients (32), but they were never
390 offered.

391 Psychotherapy was not offered either and in all 15 cases where this issue was raised, the
392 providers claimed it does not work. This is totally wrong (9,33-38). A systematic review of seven
393 trials showed that cognitive behavioral therapy can reduce the risk of developing psychosis by
394 50% (34), which is a huge effect.

395 It was not until 2014 that the first trial of psychotherapy in people with schizophrenia who
396 were not on psychosis drugs was published (36). All the patients had declined to be treated with
397 such drugs. The effect size was 0.46 compared to treatment as usual, about the same as that seen
398 in seriously flawed trials comparing psychosis pills with placebo, which is a median of 0.44 (39).
399 These and other results, e.g. those obtained with the Open Dialogue approach in Lapland (9,40).
400 compared to treatment as usual (41), means that psychotherapy is far better than pills,
401 particularly in the long run, as psychotherapy can help the patients live more normal lives while
402 psychosis pills do the opposite (9,17,18,40,41).

403 Psychotherapy for schizophrenia even seems to be cost-effective. According to a NICE
404 guideline from 2012, a systematic review of the economic evidence showed that cognitive
405 behavioral therapy improved clinical outcomes at no additional cost, and economic modelling
406 suggested that it might result in cost savings because of fewer hospital admissions (37,38).

407

408 Comparison between Alaska and Denmark

409

410 There were striking similarities between the human rights violations in Alaska and Denmark.
411 Gøtzsche's review of 30 consecutive cases from the Danish Psychiatric Appeals Board showed
412 that not in a single case was clear and convincing evidence presented that the proposed treatment
413 was in the patient's best interest (3,4).

414 According to Danish law, forced medication should be with drugs with the fewest possible
415 adverse effects, but this condition was violated in 29 cases (97%). In 7 cases (23%), where the
416 Appeals Board disagreed with an earlier decision made by the Psychiatric Patients' Complaint
417 Board and resolved that the conditions for forced treatment with a psychosis drug had not been
418 met, the issues were formal and minor, and the Appeals Board argued nonetheless that force was
419 justified because the patient was insane and that the prospect of cure or a significant and decisive
420 improvement in the condition would otherwise be significantly impaired.

421 As noted above, both arguments are invalid. Like in Alaska, the Appeals Board seemed
422 mainly to have a cosmetic function, rubber stamping what the psychiatrists' wanted and focusing
423 on uncontroversial issues it could easily check and not on what was best for the patients. In both
424 countries, the outcome was a foregone conclusion, and the patients' desires, fears, wishes, and
425 experiences were totally ignored. Supported decision making was never an issue and there were
426 no plans to improve the patients' ability to function and to help them lead a full and purposeful
427 life.

428 The patients' reactions were also very similar. Several patients expressed fear of dying
429 because of the forced treatment. These very valid concerns were ignored or cited as proof the
430 person was delusional, even though one patient said: "my father died because of intoxication
431 with psychiatric drugs" (4). Some patients have seen fellow patients suddenly drop dead because
432 of the psychosis pills forced upon them, and some have even died themselves shortly afterwards
433 (42).

434 Several patients, both in Alaska and Denmark had clear signs of tardive dyskinesia, which
435 were discounted by the psychiatrists who ascribed the side effects to their illness even though
436 schizophrenia cannot cause tardive dyskinesia. The psychiatrists recommended continued
437 treatment with psychosis drugs despite the serious harms they had caused.

438 Neither in Alaska nor in Denmark was the issue of withdrawal symptoms ever brought up
439 even though some of the patients in both countries suffered from them, which seemed to have led
440 to lack of control, aggression and sometimes to a withdrawal psychosis. The psychiatrists never
441 considered that the patients' symptoms were due to drug withdrawal.

442 Akathisia was also ignored even though this drug harm is dangerous, as it increases the risk
443 of suicide and violence, including homicide (9,12). An expert confirmed our suspicion that a
444 patient had developed akathisia on aripiprazole; but on the same page this expert – a high-
445 ranking member of the board of the Danish Psychiatric Association – recommended forced
446 treatment with this drug even though it had been stopped because of the akathisia (4). This is
447 serious medical malpractice.

448 The patients or their disease were blamed for virtually everything untoward that happened.
449 We did not see a single admission that it was the psychiatrist or other staff who had escalated a
450 situation by their insistence that the patients be treated with drugs they could not tolerate or did
451 not want or with other forced measures. We found several clear examples that it was the
452 impending use of force that made the patients aggressive (4). In five of the Danish cases, the
453 explicit purpose of forced treatment was not to benefit the patients but to prevent them from
454 disturbing the staff and other patients.

455 In Denmark, we had reservations about the psychiatrists' diagnoses of delusions in nine cases
456 (4). For example, when a patient rejected olanzapine totally, this was called a persecutory
457 delusion; another patient who became "hotheaded and difficult to communicate with" as soon as
458 an antipsychotic was mentioned, was called "paranoid and conspiratorial about how we rally
459 against him". One patient with clear signs of tardive dyskinesia was said to have psychotic
460 misconceptions about the "postulated side effects;" when a patient mentioned that she was
461 served meat even though she was a vegetarian, this was interpreted as a delusion; and a patient
462 who wanted to complain about being subjected to forced medication was also called delusional.

463 The disconnect between the views of the psychiatrists and their patients was vast. In all 21
464 cases in Denmark where there was information about the effects of previous drugs, the
465 psychiatrists stated that psychosis drugs had had a good effect whereas *none* of the patients
466 shared this view (4). Seven patients asked for a psychologist, but this seemed not to have been
467 granted. Even when the patients had explained that they could not tolerate the drugs, they were
468 forced upon them to "preserve their health." One patient noted that her medication caused
469 psychosis, but to treat the psychosis, the dose kept getting increased and she became
470 overmedicated and unable to manage her life. Another patient noted that one definition of
471 madness is administering poison and expecting your victim to heal.

472 In Alaska, one patient felt "near death" while taking drugs but her psychiatrist said, "She is
473 improved on medications." She reported constipation, jerking muscles and inability to urinate
474 and declined medications: "Let me stay here long enough to prove that I don't need medication."
475 Even the judge questioned if she was psychotic. She testified herself, but the judge did not
476 respect her wishes but allowed treatment with one psychosis drug, olanzapine, one of the worst
477 psychosis drugs (9), instead of the requested two drugs, the other being quetiapine.

478 The approach in both countries was to focus on heavy medication instead of recovery, which
479 meant that many patients would need to live permanently under assisted housing conditions with
480 no real future. A Danish patient who had become lethargic while receiving three psychosis drugs
481 simultaneously would rather go to jail than be given drugs. And an Alaskan patient said, "I have
482 more rights in jail than here" (in the Alaska Psychiatric Institute) and that, "You can get in and
483 out faster when you are in jail."

484 The legal procedures in both countries can best be characterized as a sham where the patients
485 are defenseless. The power imbalance and abuse we found were extreme and several of the
486 psychiatrists who argued for forced treatment obtained court orders for administering drugs and
487 dosages that were dangerous. In the US, it has been documented that psychiatrists, with the full
488 understanding and tacit permission of trial judges, regularly lie in court to obtain involuntary
489 commitment and forced medication orders (12,43). Mendacious information is routinely included
490 in petitions and testimony also in Alaska. Gottstein's book, *The Zyprexa Papers*, details this with
491 some particularity regarding the forced drugging proceedings against Bill Bigley (44).

492 In Norway, the Ombudsman concluded in December 2018 that the Psychiatry Act had been
493 violated in a specific case because the randomized trials showed that the probability of achieving
494 the intended improvement was low (45).

495

496 **Conclusions**

497

498 The systematic violation of the rights of psychiatric patients and the discrimination against them
499 is a global problem and the harms inflicted on the patients is immense. Forced medication must
500 be abandoned.

501
502 **Acknowledgment**
503
504 We thank Jim Gottstein for his invaluable help with getting access to documents.
505
506 **Funding**
507
508 The study was not funded.
509
510 **Contribution of each author**
511
512 PCG wrote the protocol for the study; GT interpreted the raw data; and both authors contributed
513 to writing the manuscript.
514
515 **Data sharing**
516
517 The anonymised raw data can be obtained from the authors.
518
519 **References**
520
521 1 *Myers v. Alaska Psychiatric Institute*, 138 P3d 238 (Alaska 2006),
522
523 2 *Bigley v. Alaska Psychiatric Institute*, 208 P.3d 168 (Alaska 2009).
524
525 3 Gøtzsche PC, Vinther S, Sørensen A. Forced medication in psychiatry: Patients' rights and the
526 law not respected by Appeals Board in Denmark. *Clin Neuropsychiatry*. 2019;16:229-33.
527
528 4 Gøtzsche PC, Sørensen A. Systematic violations of patients' rights and safety: Forced
529 medication of a cohort of 30 patients. *Ind J Med Ethics*. 2020;Oct-Dec;5(4) NS: 312-8.
530
531 5 [FDA package insert for Geodon](#). Accessed 7 July 2022.
532
533 6 [FDA package insert for Depakote](#). Accessed 7 July 2022.
534
535 7 [FDA package insert for Haldol](#). Accessed 7 July 2022.
536
537 8 Moncrieff J. *The bitterest pills*. Basingstoke: Palgrave Macmillan; 2013.
538
539 9 Gøtzsche PC. *Critical psychiatry textbook*. Copenhagen: Institute for Scientific Freedom; 2022.
540
541 10 Moncrieff J. Does antipsychotic withdrawal provoke psychosis? Review of the literature on
542 rapid onset psychosis (supersensitivity psychosis) and withdrawal-related relapse. *Acta*
543 *Psychiatrica Scandinavica*. 2006;114:3-13.
544
545 11 Moncrieff J, Wessely S, Hardy R. Active placebos versus antidepressants for depression.
546 *Cochrane Database Syst Rev*. 2004;1:CD003012.

- 547
548 12 Gøtzsche PC. *Deadly psychiatry and organised denial*. Copenhagen: People's Press; 2015.
549
550 13 Khin NA, Chen YF, Yang Y, et al. Exploratory analyses of efficacy data from schizophrenia
551 trials in support of new drug applications submitted to the US Food and Drug Administration. *J*
552 *Clin Psychiatry*. 2012;73:856-64.
553
554 14 Leucht S, Kane JM, Etschel E, et al. Linking the PANSS, BPRS, and CGI: clinical
555 implications. *Neuropsychopharmacology*. 2006;31:2318-25.
556
557 15 Manschreck TC, Boshes RA. The CATIE schizophrenia trial: results, impact, controversy.
558 *Harv Rev Psychiatry*. 2007;15:245-58.
559
560 16 Wunderink L, Nieboer RM, Wiersma D, et al. Recovery in remitted first-episode psychosis at
561 7 years of follow-up of an early dose reduction/discontinuation or maintenance treatment
562 strategy: long-term follow-up of a 2-year randomized clinical trial. *JAMA Psychiatry*.
563 2013;70:913-20.
564
565 17 Whitaker R. *Mad in America: bad science, bad medicine, and the enduring mistreatment of*
566 *the mentally ill*. Cambridge: Perseus Books Group; 2002.
567
568 18 Whitaker R. *Anatomy of an epidemic, 2nd edition*. New York: Broadway Paperbacks; 2015.
569
570 19 [United Nations Convention on the Rights of Persons with Disabilities: General comment No.](#)
571 [1](#). 2014; May 19.
572
573 20 [FDA package insert for Zyprexa \(olanzapine\)](#). Accessed 5 May 2022.
574
575 21 Joukamaa M, Heliövaara M, Knekt P. Schizophrenia, neuroleptic medication and mortality.
576 *Br J Psychiatry*. 2006;188:122-7.
577
578 22 Tenback D, Pijl B, Smeets H. All-cause mortality and medication risk factors in
579 schizophrenia. *J Clin Psychopharmacol*. 2012;32:31-5.
580
581 23 Waddington JL, Youssef HA, Kinsella A. Mortality in schizophrenia. Antipsychotic
582 polypharmacy and absence of adjunctive anticholinergics over the course of a 10-year
583 prospective study. *Br J Psychiatry*. 1998;173:325-9.
584
585 24 Ray WA, Meredith S, Thapa PB, et al. Antipsychotics and the risk of sudden cardiac death.
586 *Arch Gen Psychiatry*. 2001;58:1161-7.
587
588 25 Ray WA, Chung CP, Murray KT, et al. Atypical antipsychotic drugs and the risk of sudden
589 cardiac death. *N Engl J Med*. 2009;360:225-35.
590
591 26 [FDA package insert for Neurontin \(gabapentin\)](#). Accessed 4 Jan 2020.
592

- 593 27 Ho BC, Andreasen NC, Ziebell S, et al. Long-term antipsychotic treatment and brain
594 volumes: a longitudinal study of first-episode schizophrenia. *Arch Gen Psychiatry*. 2011;68:128-
595 37.
- 596
- 597 28 Andreasen NC, Liu D, Ziebell S, et al. Relapse duration, treatment intensity, and brain tissue
598 loss in schizophrenia: a prospective longitudinal MRI study. *Am J Psychiatry*. 2013;170:609-15.
599
- 600 29 Weiden PJ, Mann JJ, Haas G, et al. Clinical nonrecognition of neuroleptic-induced movement
601 disorders: a cautionary study. *Am J Psychiatry*. 1987;144:1148-53.
602
- 603 30 Breggin PR. *Brain-disabling treatments in psychiatry: drugs, electroshock, and the*
604 *psychopharmaceutical complex*. New York: Springer; 2008.
605
- 606 31 Moncrieff J. Antipsychotic maintenance treatment: time to rethink? *PLoS Med*.
607 2015;12:e1001861.
608
- 609 32 Dold M, Li C, Tardy M, et al. Benzodiazepines for schizophrenia. *Cochrane Database Syst*
610 *Rev*. 2012;11:CD006391.
611
- 612 33 Moritz S, Kerstan A, Veckenstedt R, et al. Further evidence for the efficacy of a
613 metacognitive group training in schizophrenia. *Behav Res Ther*. 2011;49:151-7.
614
- 615 34 Hutton P, Taylor PJ. Cognitive behavioural therapy for psychosis prevention: a systematic
616 review and meta-analysis. *Psychol Med*. 2014;44:449-68.
617
- 618 35 Moritz S, Veckenstedt R, Andreou C, et al. Sustained and “sleeper” effects of group
619 metacognitive training for schizophrenia: a randomized clinical trial. *JAMA Psychiatry*. 2014;71:
620 1103–11.
621
- 622 36 Morrison AP, Turkington D, Pyle M, et al. Cognitive therapy for people with schizophrenia
623 spectrum disorders not taking antipsychotic drugs: a single-blind randomised controlled trial.
624 *Lancet*. 2014;383:1395-403.
625
- 626 37 [Psychosis and schizophrenia in adults: prevention and management](#). Clinical guideline
627 [CG178]. NICE 2014; Feb 12.
628
- 629 38 Freeman D, Freeman J. At last, a promising alternative to antipsychotics for schizophrenia.
630 *The Guardian*. 2014; Mar 7.
631
- 632 39 Leucht S, Cipriani A, Spineli L, et al. Comparative efficacy and tolerability of 15
633 antipsychotic drugs in schizophrenia: a multiple treatments meta-analysis. *Lancet*.
634 2013;382:951–62.
635
- 636 40 Seikkula J, Aaltonen J, Alakare B, et al. Five-year experience of first-episode nonaffective
637 psychosis in open-dialogue approach: Treatment principles, follow-up outcomes, and two case
638 studies. *Psychotherapy Research*. 2006;16:214-28.

- 639
640 41 Svedberg B, Mesterton A, Cullberg J. First-episode non-affective psychosis in a total urban
641 population: a 5-year follow-up. *Soc Psychiatry Psychiatr Epidemiol.* 2001;36:332-7.
642
643 42 Christensen DC. *Dear Luise: a story of power and powerlessness in Denmark's psychiatric*
644 *care system.* Portland: Jorvik Press; 2012.
645
646 43 Gottstein J. [Psychiatry: force of law](#). Psych Rights 2002; Nov.
647
648 44 Gottstein J. *The Zyprexa Papers.* Toronto: Samizdat Health Writer's Co-operative; 2021.
649
650 45 Gøtzsche PC. [Forced drugging with antipsychotics is against the law: decision in Norway.](#)
651 *Mad in America.* 2019; May 4.
652
653 46 Brandt-Christensen M. Mental health law in Denmark. *Int Psychiatry.* 2012 Nov 1;9(4):88-
654 90. PMID: 31508138; PMCID: PMC6735079.
655
656 47 Ogawa R, Echizen H. Drug-drug interaction profiles of proton pump inhibitors. *Clin*
657 *Pharmacokinet.* 2010 Aug;49(8):509-33.