



Psych Rights | Law Project for
Psychiatric Rights

June 15, 2016

Planning Committee
Alaska Mental Health Trust Authority
3745 Community Park Loop, Suite 200
Anchorage, Alaska 99508

Hand Delivered

Dear Trust Planning Committee:

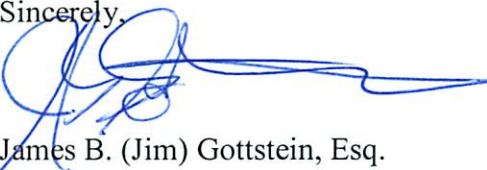
Please find enclosed the June 1, 2016, Affidavit of Peter C. Gøtzsche, MD, detailing (1) the lack of effectiveness and great harm caused by the neuroleptics, misleadingly marketed as "antipsychotics," as well as (2) there being feasible alternatives to both involuntary commitment and forced drugging. These alternatives result in vastly improved lives for people diagnosed with serious mental illness. In other words, beneficiaries of the Trust who are diagnosed with serious mental illness would have vastly improved lives if the neuroleptics were minimized and proven alternative approaches used instead.

Dr. Gøtzsche is an internationally recognized expert on the effectiveness and safety of medications, and through a Trust Small Projects Grant gave a talk in Anchorage on June 2nd. Last year, he published the book, "Deadly psychiatry and organised denial," which I highly recommend. Dr. Gøtzsche has published three other books and more than 70 papers in "the big five" (British Medical Journal, Lancet, Journal of the American Medical Association, Annals of Internal Medicine, and the New England Journal of Medicine). His scientific works have been cited over 15,000 times.

I arranged for Dr. Gøtzsche to testify in a forced drugging hearing on behalf of a patient represented by the Public Defender Agency while he was here. I think it is fair to say he was appalled and termed it a sham at his talk here. As a result, he has agreed to work with me on helping patients avoid the tremendous harm to which they are being subjected through involuntary commitment and forced drugging.

Your beneficiaries have the right to the least restrictive alternative with respect to involuntary commitment and the least intrusive alternative with respect to forced psychiatric drugging. In my view the Trust should make it a high priority to ensure that such alternatives exist.

Sincerely,



James B. (Jim) Gottstein, Esq.

cc: Pater Gøtzsche, MD

Enc.

AFFIDAVIT OF PETER C. GØTZSCHE, MD

THIRD JUDICIAL DISTRICT)
)ss
STATE OF ALASKA)

PETER C. GØTZSCHE, MD, being first sworn under oath hereby deposes and states as follows:

A. Background and Credentials

1. In 1973 I was awarded a Master of Science degree in biology and chemistry from the University of Lund in Sweden. In 1974 I was awarded a Master of Science Degree from the University of Copenhagen in zoology and chemistry. In 1984 I received my Medical Doctor degree from the University of Copenhagen.

2. From April 1, 1975 through March 31, 1977 I was a drug representative and product manager for the Astra Group A/S.

3. I founded the medical department at Astra-Syntex A/S in 1977 and headed it from April 1, 1977, through August 31, 1983.

4. Astra Group A/S and Astra-Syntex A/S are both predecessors of the current drug company AstraZeneca.

5. In 1993 I co-founded the Cochrane Collaboration, now known simply as Cochrane, with Iain Chalmers and others.

6. That same year, I founded the Nordic Cochrane Centre and have headed it ever since, being its Director and Chief Physician.

7. Cochrane is free from financial conflicts of interest and is internationally recognized for its objective analysis of medicines, medical devices and other interventions in healthcare.

8. A large part of my career has involved statistics and research methodology. I am a member of several groups publishing guidelines for good reporting of research and have co-authored CONSORT for randomised trials (www.consort-statement.org), STROBE for observational studies (www.strobe-statement.org), PRISMA for systematic reviews and meta-analyses (www.prisma-statement.org), and SPIRIT for trial protocols (www.spirit-statement.org).

9. I have published more than 70 papers in "the big five" (British Medical Journal, Lancet, Journal of the American Medical Association, Annals of Internal Medicine, and the New England Journal of Medicine) which have been cited over 15,000 times.

10. My book, Rational Diagnosis and Treatment: Evidence-Based Clinical Decision-Making, was published in 2007.

11. My book Mammography Screening: Truth, Lies and Controversy, was published in 2012. This latter book followed up on a previous paper I had written, Is screening for breast cancer with mammography justifiable?,¹ and later papers I authored or co-authored about the benefits and harms not supporting the recommendations for mammography screening.

¹ Lancet 2000;355:129-34.

12. In 2013 I published the book, **Deadly Medicines and Organised Crime: How Big Pharma has Corrupted Healthcare (Deadly Medicines)**, detailing how the drug industry systematically overstates the benefits of medications and understates their harms. Two chapters of **Deadly Medicines** focused on psychiatry and psychiatric drugs, which are the worst in terms of overstating their benefits and understating their harms.

13. In 2015 I published an entire book on psychiatric drugs, **Deadly Psychiatry and Organised Denial (Deadly Psychiatry)**, detailing the lack of solid evidence for clinically meaningful benefits of psychiatric treatments, the immense harm they cause including many unreported suicides and other deaths, and the problems with psychiatric coercion.

14. I am considered an expert on medical research methodology and on evaluating the trustworthiness of research results.

15. I have testified, orally, or in writing, or both, as an expert witness in the following court cases:

- a. 2014: Danish High Court, double homicide attempt on methylphenidate (Ritalin).
- b. 2014: Norwegian High Court, forced treatment with olanzapine (Zyprexa).
- c. 2015: Norwegian High Court, Patient Damage Council, oseltamivir (Tamiflu) for influenza.
- d. 2016: Dutch High Court, double homicide case on paroxetine (Paxil).

**B. Involuntary Commitment and Forcing Psychiatric
Drugs on Patients is Not in Their Best Interests**

16. Psychiatric hospitalization is associated with dramatically worse outcomes for patients with the risk of suicide increased 44 times for people admitted to a psychiatric hospital compared to no psychiatric treatment in the preceding year.²

17. When a patient reacts violently, it is often a result of the violence perpetrated against the person through involuntary psychiatric interventions.

18. Psychiatrists almost always believe that violence is caused by insufficient drug treatment although it is usually caused by the drugs the patients receive.

19. The first generation of drugs developed to treat people diagnosed with schizophrenia such as chlorpromazine (Thorazine), haloperidol (Haldol), trifluoperazine (Stelazine), thioridazine (Mellaril), and fluphenazine (Prolixin) were at first considered chemical lobotomies. They were designated "neuroleptics," meaning "seize the brain." They were also called "major tranquilizers" to distinguish them from the benzodiazepines such as Valium (Valium), known as "minor tranquilizers," which is misleading, as major or minor tranquilization can be obtained with either type of drug; it is simply a matter of dose.

20. The neuroleptics are now commonly called "antipsychotics" due to drug company marketing even though they cannot cure psychosis and though their effects are highly unspecific, namely to sedate people. These drugs are not specific to people

² Hjorthøj CR, et al. *Social Psychiatry and Psychiatric Epidemiology*, 2014;49:1357–65; Gøtzsche PC. *Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015.*

experiencing psychosis; instead they suppress mental functioning so much, that people become less troubled and troubling, often for just a short time until their brains adjust to the drug.

21. Because these drugs block 70-90% of the dopamine transmission to certain receptors in the brain, the brain compensates by growing more dopamine receptors, causing psychotic symptoms if people abruptly withdraw from the drugs. These withdrawal, or "discontinuation" symptoms are almost always misinterpreted as symptoms of mental illness.³

22. These drugs cause serious physical harm, including the often fatal Neuroleptic Malignant Syndrome and akathisia, which increases the risk of both suicide and homicide.⁴

23. The second generation of neuroleptics, such as risperidone (Risperdal), olanzapine (Zyprexa), quetiapine (Seroquel), aripiprazole (Abilify) and ziprasidone (Geodon) started to be introduced in the mid-1990's. These neuroleptics were named "atypical antipsychotics" by drug companies based on their false assertions that they are more effective and less harmful than the first generation of neuroleptics.

24. The drug company financed studies used to obtain regulatory approval of both first and second generation neuroleptics are highly flawed, e.g. because of (a) lack

³ Breggin P. Medication madness. New York: St. Martin's Griffin; 2008.

⁴ Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015; Breggin P. Medication madness. New York: St. Martin's Griffin; 2008.

of adequate blinding, (b) clinically irrelevant outcomes, and (c) using people abruptly withdrawn from other neuroleptics and often experiencing withdrawal psychotic symptoms when they receive placebo in the control group.⁵

25. 80% of people diagnosed with a first psychotic break and given psychological help to get through it without or with minimal neuroleptics (selective use) recover and can go on to lead productive lives.⁶

Outcomes with Selective Use Of Antipsychotics

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

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

⁵ Gøtzsche PC. *Deadly psychiatry and organised denial*. Copenhagen: People's Press; 2015;

⁶ Seikkula, J., "Five-year experience of first-episode nonaffective psychosis in open-dialogue approach," *Psychotherapy Research* 16 (2006): 214-218.

26. In comparison, only 5% of people who are maintained on neuroleptics recover and 40% of people who have been put on neuroleptics and then stop taking them.⁷

27. The only trial that exists where remitted first episode patients were randomized to dose reduction or discontinuation, or to maintenance therapy with antipsychotics, showed that more patients had recovered in the dose reduction/discontinuation group than in the maintenance group after seven years (40% versus 18%).⁸

28. Neuroleptics kill people. For every 100 patients with Alzheimer's disease or dementia there was one additional death, when compared to placebo.⁹ People in the mental health system in the western world diagnosed with serious mental illness like schizophrenia now have about a 20 year reduced life expectancy compared to the general population, most of which is attributable to neuroleptic and other psychiatric drug use.

⁷ M. Harrow and T. Jobe, "Factors involved in Outcome and Recovery in Schizophrenia Patients not on Antipsychotic Medications: A 15-year Multifollow-up Study. *The Journal of Nervous and mental Disease*, 195 (2007): 406-411.

⁸ Wunderink L, Nieboer RM, Wiersma D, et al. Recovery in remitted first-episode psychosis at 7 years of follow-up of an early dose reduction/discontinuation or maintenance treatment strategy: long-term follow-up of a 2-year randomized clinical trial. *JAMA Psychiatry*, 70 (2013):913-20.

⁹ Schneider LS, et al. *JAMA* 2005;294:1934-43.

29. Psychiatric drugs are the third biggest cause of death after heart disease and cancer.¹⁰ These deaths are usually “invisible” for the doctors because people may die from heart problems, suicide and falls even without taking psychiatric drugs.

30. Neuroleptics cripple people. They cause irreversible brain damage in a dose related fashion and dramatically decrease people's prospects of getting back to a normal life; they create dependency, abstinence symptoms if people try to stop and supersensitivity psychosis.¹¹ They are some of the most toxic drugs ever made apart from chemotherapy for cancer.

31. Neuroleptics have killed hundreds of thousands of people and have crippled tens of millions.¹²

32. The primary benefit of neuroleptics being forced on a patient is to make it easier for the staff, not for the patient's benefit.

C. Feasible, Less Restrictive and Less Intrusive Alternatives

33. There are feasible, less restrictive and less intrusive alternatives that provide a much greater probability of recovery without the great risk of harm.

34. Dr. Loren Mosher, the head of the Center for Studies of Schizophrenia from 1968 until 1980 at the National Institute of Mental Health testified in 2003 that in his

¹⁰ Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015.

¹¹ Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015; Breggin P. Medication madness. New York: St. Martin's Griffin; 2008.

¹² Gøtzsche PC. Deadly psychiatry and organised denial. Copenhagen: People's Press; 2015

long career he had never committed anyone because he made it his business to form the kind of relationship that he and the patient can establish an ongoing treatment plan that is acceptable to the both of them.¹³

35. Akershus University Hospital in Norway doesn't have a regime for rapid tranquillisation and has never needed one in the last 20 years.

36. In Trieste, Italy, force is not used at all. The head of psychiatry in Trieste states that coercion has to be completely eliminated, since the employees would otherwise use coercion and not use other approaches that do not require coercion.

37. Enabling force encourages force, or in other words: violence breeds violence; there are feasible non-coercive alternatives.

D. Conclusions

38. In my opinion, which is solidly based on scientific facts, administering a psychotropic medication or medications to a patient against his or her will is not in his or her best interest.

¹³ Transcript of Proceedings, p. 177, in *In the Matter of Faith Myers*, Superior Court in Anchorage, Third Judicial District, State of Alaska, Case No. 3AN-02-00277 CI, cited in J. Gottstein, *Involuntary Commitment and Forced Drugging in the Trial Courts: Rights Violations as a Matter of Course*. 25 Alaska L.Rev51, 76 (2008).

39. In my opinion, there are feasible less intrusive alternatives to administering a psychotropic medication or medications against a patient's will.

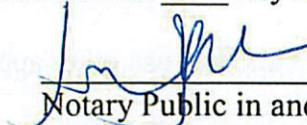
FURTHER YOUR AFFIANT SAYETH NAUGHT.

DATED this 1 day of June 2016.



Peter C. Gøtzsche, MD

SUBSCRIBED AND SWORN TO before me this 1st day of June, 2016.



Notary Public in and for Alaska

My Commission Expires: 01-12-19