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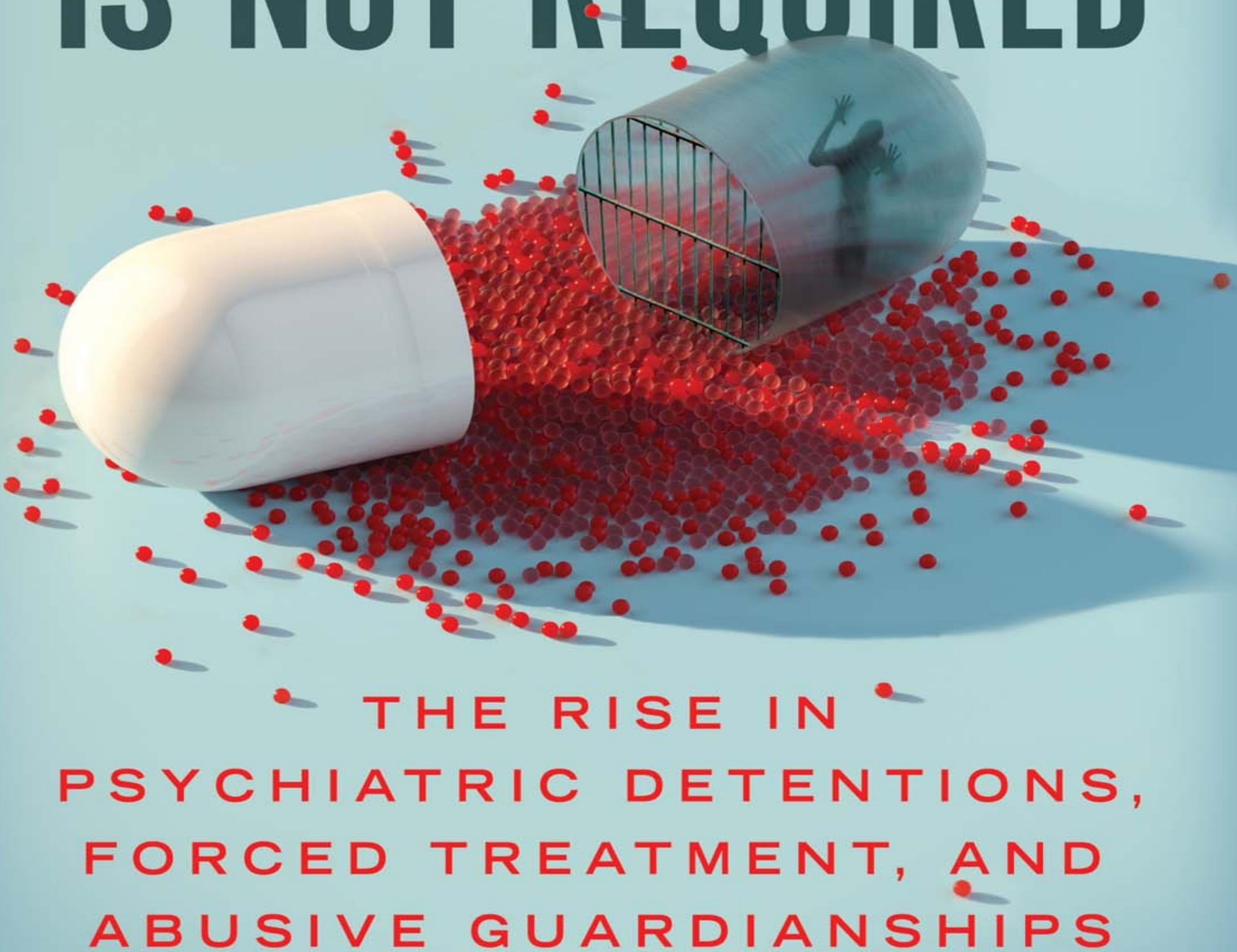
—BRUCE E. LEVINE, PhD, psychologist
and author of *A Profession Without Reason*

YOUR CONSENT IS NOT REQUIRED



THE RISE IN PSYCHIATRIC DETENTIONS, FORCED TREATMENT, AND ABUSIVE GUARDIANSHIPS

ROB WIPOND

PRAISE FOR *YOUR CONSENT IS NOT REQUIRED*

"A hugely important investigation of psychiatry's 'extra-legal' policing of people who have done nothing illegal but who create tension for their families or society . . . A vivid picture of an injustice ignored by the mainstream media."

—Bruce E. Levine, psychologist and author of *A Profession Without Reason* and *Surviving America's Depression Epidemic*

"A timely, well-researched, and comprehensive exposé of one of the least visible epidemics in the US: legalized force, segregation, and—all too often—incapacitation in the name of psychiatric help."

—Peter Stastny MD, psychiatrist, coauthor of *The Lives They Left Behind,* and coeditor of *Alternatives Beyond Psychiatry*

"*Your Consent Is Not Required* examines a problem that gets far too little attention: the detention and forced treatment of people under civil mental health laws. Rob Wipond's exposé is passionate, thoroughly reported, and rigorously reasoned. This book grabbed my attention from the start and never let go."

—John Horgan, columnist for *Scientific American,* author of *Mind-Body Problems,* and director of the Stevens Institute of Technology Center for Science Writings

"In the consumer/survivor/ex-patient movement, for years we've fought against involuntary psychiatric treatments and strived for self-determination and autonomy. Featuring the stories of a wide range of psychiatric survivors, from children and seniors to Black veterans and white medical professionals, *Your Consent Is Not Required* is a vital contribution to discussions of the economics, politics, structural racism, and weak science behind this country's expanding systems of forced psychiatry. And everyone should hear well its warning: *This could happen to you*."

—Celia Brown, board president of MindFreedom International and founder of Surviving Race: The Intersection of Injustice, Disability and

Human Rights

“We exposed many serious, ongoing problems at a major mental health facility in Colorado that ultimately led to the facility being shut down. This groundbreaking book shows that these problems are frighteningly common and nationwide, indeed continent-wide, in scope. Wipond also provides vital information and insights about the risks of involuntary psychiatric detention that everyone should know before voluntarily entering the mental health system.”

—**Tony Kovaleski, Emmy- and duPont Columbia Award–winning chief investigative reporter at ABC Denver7**

“A much-needed investigation that reveals the shocking extent of psychiatric coercion in our society: How well-intentioned 911 callers, suicide hotline volunteers, police and private security guards, school teachers, housing managers, social workers, and others funnel people toward unwanted ‘treatment’ that more often oppresses than helps them.”

—**Dr. Bren LeFrançois, professor at Memorial University School of Social Work and coeditor of *Mad Matters***

“As someone who identifies as a former patient and survivor of involuntary psychiatry, and now works as a lawyer representing people in inpatient psychiatric facilities, many of the experiences shared in this book were, disturbingly, all too familiar. Still, I could not put this book down. From revelations about the true numbers of inpatient beds to stories of psychiatric retaliation against whistleblowers, it’s full of important and sometimes frightening insights, and should be required reading for everyone working in human rights and mental health.”

—**Kathy Flaherty, executive director of Connecticut Legal Rights Project**

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This book is based on notes and recordings of interviews conducted by the author and public statements. Some names have been changed and surnames omitted to protect the privacy of individuals. Stuttered speech, vocal tics, and repeated words have been edited in quoted dialogue for readability.

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INTRODUCTION

THE TIME THE CEILING CAVED IN

Upon retiring to the sunny Okanagan Valley in British Columbia in 1997, my father underwent prostate cancer surgery. His tumor was successfully removed, but the operation rendered him permanently impotent and incontinent. I was visiting my parents and decided to stay longer.

My father was private at all times, and a distant brooder when things weren't going well. The emotional and practical challenges of navigating sexual dysfunction and a lack of bladder control at sixty-five, on the cusp of his golden years, daunted him. The retired life he'd been envisioning after his career as a college professor of computer engineering crumbled, and his feelings of vulnerability took on vast dimensions. Through restless nights, the ineffectiveness of over-the-counter sleep medications increased his anxiety.

In his reticent way, he sometimes opened up to me or my mother. He was worrying about his finances, age, fragility, failures in life, and mortality. He didn't want to eat or get out of bed, and at times actively resisted physical efforts to pull him to his feet. He said he felt like the ceiling of the house was caving in on him and that the furnace was about to blow up. Not unlike the stern father I knew, upon meeting resistance from others, he stubbornly dug in: *The ceiling is caving in. Call the gas company right away.* Never prone to physical violence, suddenly he was saying that he wanted to kill himself, my mother, me.

Considering the circumstances, I didn't find what was happening altogether surprising. I'd been inspired by my father's library of literary classics, and studied philosophy, science and science fiction, theater, yoga, meditation and ancient spiritual practices, and research into unusual states of consciousness. I'd grown a network of similarly reflective, artistic, exploratory friends, among whom it was normal at times to experience emotionally charged or psychologically devastating periods that could last hours, days, weeks, or months. So, when my father's voice trembled with hints of suicide and homicide, I reminded him of his appreciation for Fyodor Dostoevsky's tale of murderous obsession, *Crime and Punishment*.

"Dostoevsky must have spent a lot of time in dark places inside himself," I said, "to portray that character's desperation and violence so well."

"Mm," my father responded. Interested, but wary.

"You're going through a big transition, Dad. These are understandable feelings."

"I don't want to kill you," he said. "I love you, Son."

We weren't able to stay there long, though.

After I returned to work in Victoria, my mother more frequently spoke with my brother, Kevin. She was becoming increasingly distraught, and Kevin flew in for a few days. Eventually, they all agreed to go to the hospital. Dad was admitted, committed under mental health law as a risk to his "own safety or the safety of others," and diagnosed with "major depression with psychotic features."

Kevin and my mother were immediately dismayed, seeing a huge security guard escort Dad to the ward, and then watching as Dad was instantly stripped of all the accoutrements of his life including his comfortable home with lake view, privacy, and independence, and ordered to share a small, barren room with a much younger patient.

* * *

Over the ensuing weeks and months in and out of the psychiatric ward of Kelowna General Hospital, the treating psychiatrists changed often and they gave my father many psychiatric medications in various combinations. He didn't become happier. He became more self-obsessed and less engaged with others, and so clouded, numb, and exhausted from the chemical overload that he could sometimes barely stand.

On phone calls or trips back to the Okanagan, I asked the staff questions that probably revealed my alarm at what the treatments seemed to be doing. One nurse said, "Your father is very, very ill," with a mixture of fear and admonishment, as if she could see him more clearly than I could. A psychiatrist said my father had a biochemical imbalance, like diabetes or a broken leg but in his brain. There were no lab tests to confirm this, though. “That’s why it can be difficult to find the optimal combination of medications,” the psychiatrist said.

My mother was a real-life version of the all-purpose, cooking, cleaning, working woman on 1950s television shows who held family households together with enthusiastic warmth and martyr-like love. I’d never seen her have a depressed day. “We trust the doctors, Rob,” she said. “That’s just the way your father and I grew up.”

My brother and I both researched the prescriptions. According to its official label, one drug was a sedative recommended for occasional emergency interventions only, because it was highly addictive. The second was primarily for tranquilizing people experiencing hallucinations, and its toxicity could victimize nearly every organ, nerve, and metabolic process, and cause permanent movement disorders. The third medication came with a warning that it increased the likelihood of suicide. My brother expressed concern when the fourth medication suddenly replaced the third, because the drug’s manufacturer had issued warnings that the two were potentially lethal if prescribed too soon after one another. The psychiatrist said, “You can’t believe everything you read on the internet.”

We started wondering if Dad might be better off with no drugs at all. Could he just remain safe in the hospital while working through his feelings? “Hospitals are for treating illnesses,” his latest psychiatrist said. He proposed ECT—electroconvulsive therapy—electrical shocks directed into the brain that induced grand mal epileptic seizures. The psychiatrist said it was very effective for “treatment-resistant” depression, and that it had merely gotten a bad reputation due to misrepresentations in sensationalist movies.

“ECT is like a heart defibrillator,” the psychiatrist said. “It jolts the depressed brain back to life.” The hospital pamphlet explained that ECT was safe and effective, and that it was a “myth” that it caused brain damage or permanent memory loss.

“I don’t want it,” my father said to me, his voice barely audible over the telephone.

“Well, Dad, tell them, and get out of bed. Eat more, so they don’t worry about you not eating. If you don’t want the electroshock, get up.” I filled my helplessness with a commanding tone.

“I don’t want it,” Dad said, more feebly.

The psychiatrists scheduled the ECT. I was stunned. Could they do that? I knew my father as intelligent, responsible, a dedicated teacher, a fisherman, a lover of the outdoors, and basically a stable, ordinary person. Could he so easily be branded and treated as a certifiably insane mental patient?

I contacted a civil rights attorney. “Yes, psychiatrists have that power,” she said. “But I’d think they’d be reluctant to do something as drastic as ECT without family support.”

The psychiatrists swayed Kevin and my mother. They gave my father nine rounds of electroconvulsive therapy over three weeks.

* * *

At home shortly after the electroshocks, Dad mowed the lawn, chatted with neighbors, and ate ravenously. “I don’t know why I was feeling so down!” he said.

Two weeks later, he remembered. A social worker was regularly dropping by, and Dad admitted he still felt suicidal. The police took him back to the hospital. Dad told me that, though the police were polite, being handcuffed and escorted into the police car was one of the most humiliating experiences of his life. The police returned later and confiscated his souvenir gun from his early years in the air force.

The treating psychiatrist proposed more electroshocks. “We normally do twelve rounds at a time,” he said.

The nurse explained, “It’s like we’re trying to fill a gas tank, and nine rounds didn’t quite fill the tank.”

Everyone in our family became more vociferous with our concerns. The ECT had worked, in a way, but only for two weeks. Didn’t the risks increase with more shocks? It was becoming unnerving to hear medical staff compare the ninety-billion-cell living computer of the human brain to a four-valve pump and an empty gas can.

We again lobbied the psychiatrists to let Dad stay in the hospital without any treatment. The psychiatrists reacted like we were bothersome bugs flitting around a surgical room. Hospital staff stopped responding to our calls. They discouraged my mother’s daily visits, suggesting that she represented “old mental patterns” fueling Dad’s depression. Then, they moved Dad to Riverview Hospital in Vancouver—a four-hour drive from my mother. “Riverview is more appropriate for long-term stays,” a psychiatrist said.

Riverview Hospital was an asylum from the 1920s and ’30s that used to house thousands of psychiatric patients. By the 1990s, many of the buildings were shut down. This lack of a future inhabited the building where Dad was held: walls bare, rooms dank and rank with West Coast rains, floors worn down into curves, decades-old plastic-covered furniture. I wondered how any mental health professional could imagine that a depressed person could possibly become better in such a place.

In preparation for more rounds of forced ECT, the Riverview psychiatrists took my father off the antidepressants he'd been taking since the previous rounds. I was hopeful this might clear his head; however, he plunged into a state that looked near-comatose.

"Could that be some kind of drug withdrawal effect?" I asked.

"Antidepressants don't cause withdrawal," the psychiatrist claimed. "That's his underlying mental illness manifesting more strongly."

They gave Dad twelve more rounds of ECT. Not long afterwards, my father struggled to recall his name. I wasn't sure if he recognized me or was just acting like he did. He spoke only in slow, brief, barely audible slurs and mumbles. He had no idea why he was in a hospital. I tested his ability to count to ten and he got lost between four and five.

He did docilely get out of bed, eat, and take medications when staff told him to. "Your father is doing much better," a psychiatrist said. This man had never seen my father in anything close to a normal state—portaging a canoe over his head with sleeping bags and gear packed into both ends, training computer programmers for the country's biggest companies, or shouting passionately about smaller government and individual freedoms.

"He'll recover his memories within a year or two," the psychiatrist said, as if I should find this completely reassuring.

Our family was devastated. Any threads of confidence we'd held in the mental health system had unraveled. Finally, nine months after he first got detained, and seemingly because he simply wasn't functionally capable anymore of posing any kind of risk, the psychiatrists let my father go home.

* * *

During this period, Dad slid out of bed, shuffled around, and muttered comprehensibly when pushed to it. My mother, fortunately also retired, devoted herself to doing whatever it took to keep Dad home, safe, and alive. I told her that research showed most people could recover from depression on their own with time and support. She cuddled Dad in bed, reminded him of memories, and encouraged friends and relatives to connect in whatever ways they could. In equal measures, she told him she loved him and she prodded him.

"I've made sunny-side up eggs," she'd say. "I'm not bringing them in here, so you'd better not waste your favorite kind of eggs by staying in bed."

"The shower is already running," she'd say. "I know there's no point in being clean. But just get dressed and pretend there is a point. For me."

Over the following months and years, my father rebounded. He got up of his own accord, ate, did chores, and talked with people more regularly. He adjusted to his incontinence and found ways to gain some independence again. He weaned himself off the remaining sedating medication that he'd been prescribed. He practiced memory recall with crossword puzzles. Eventually, he was fishing, talking literature and current events, and heading out with my mother on international travel adventures again. My father did recover a lot of his long-term memories—though at times everyone who knew him was startled by gaps.

Yet my father would never remember virtually anything from the year surrounding the ECT treatments. That is, nearly everything of what I just described on these pages was for my father utterly gone.

If someone's retelling wove together a few of the scattered images that his own memory still retained, the resulting story terrified him. He became angry. He confessed to me much later that one day he went back to confront one of the doctors, saying, "I'm not going to sue you. But why in hell did you do that?"

In response, the doctor said that "depression is a serious, chronic illness" and recommended that my father start getting weekly "maintenance" ECT treatments.

Everyone in our family retained scars. Perhaps as part of my own healing, I had questions I wanted answered: Was that *normal*? Was everything that happened with my father a case of psychiatric malpractice, or was he one of an unknown number of similar, isolated sufferers? Were law-abiding, intelligent people normally getting incarcerated and treated against their will by mental health practitioners? Was modern involuntary psychiatric treatment frequently so aggressive, invasive, ineffective, and harmful? If so, then why was involuntary treatment still practiced? And if the line between voluntary client and involuntary patient was so thin, shouldn't we be more careful about advising people in vulnerable emotional states to "seek help"?

As I investigated, everything that happened with my father took on whole new dimensions of significance.

PART ONE

THE EXPANSIVE REACH OF PSYCHIATRIC POWER

CHAPTER 1

STOLEN VOICES

Efforts to improve mental health and treat mental disorders have become a pervasive cultural movement. Since the emergence of the first blockbuster, billion-dollar-a-year psychiatric drugs in the 1980s, our once marginalized mental health system has been penetrating into nearly every facet of society and threading into our lives from cradle to nursing home. Across North America, awareness-raising campaigns in schools, workplaces, and mass media encourage us to talk about problems, "spot the signs and symptoms" of mental disorders, and get ourselves or others into early treatment.

Along with these campaigns, various claims are promoted: At any time, one in five adults has a mental disorder. Mental illnesses alter brain-chemical balances, and medications can correct these imbalances. Modern treatments are safe and effective. The only major systemic problems are that stigma and underfunding prevent too many people from getting help. Involuntary treatment is rare but sometimes necessary, and patients are thankful afterwards—just as we thank the doctors who performed lifesaving surgery on our unconscious bodies after a car crash. How could anything possibly be wrong with "improving people's mental health"?

These campaigns have had broad impacts. Surveys suggest a majority of US adults have sought professional mental health help. While in 1950 an infinitesimal percentage of the population had ever taken a psychiatric drug, today, in any year, tens of millions of North Americans, nearly 20 percent of adults, are taking one or more psychotropics. That number continues to rise and, of those people, nearly 80 percent have been taking psychiatric drugs for more than three years.[*]

Essentially, the modern mental health system has been presented as a supportive social safety net and, for some people, that image reflects their personal experiences.

But for many others, these promoted messages have woven a society-wide net of false and misleading beliefs that threaten and entrap them, and strangle their voices. Many are nonviolent, law-abiding citizens who’ve become subject to civil psychiatric detention and involuntary treatment. The numbers of people in this group are rising dramatically, too. They are part of an underreported but escalating war over what kinds of inner experiences and outward behaviors are permitted—a war that’s spreading into our streets, schools, workplaces, nursing homes, and countless other corners of society. And as mental health laws get used in this widening array of situations, ever more people are astounded and sometimes horrified to witness the immense, discretionary powers that our mental health system has at its disposal.

* * *

In 1998, I started working as a freelance investigative journalist based in the metropolitan regions of Victoria and Vancouver, British Columbia, Canada. I covered many community social issues, but kept returning to people’s experiences of psychiatric detention and forced treatment. Eventually, I began writing for news outlets with American audiences as well, and my investigations of civil commitment became continent-wide.

One of the first people I ever interviewed who’d been involuntarily treated was Gerald McVeigh, a burly, bearded, fifty-eight-year-old. He’d been working as a logger in centuries-old Pacific Northwest rain forests when a dispute developed over a possible clear-cut. Environmentalists and police clashed. Tangled between his own environmental sensitivity and need for more money to meet alimony payments, McVeigh was stressed and barely eating or sleeping when he argued with his boss and got fired.

At home in Victoria and still not sleeping, McVeigh got thrust into a heightened state where his senses, thoughts, and emotions intensified, and events took on mystical symbolism. For hours, he washed himself and his apartment as if cleansing his spirit. “At one point, I was chatting with God!” McVeigh told me. “I was having all sorts of delusions. I guess delusions.”

But the energy also brought fear—what was happening? McVeigh fled into the street seeking reassuring interpersonal connections. When he became afraid of losing eye contact with a friendly woman, she called the police. Even as they interrogated him, McVeigh simply turned away to follow her again. Someone grabbed him. McVeigh panicked.

“A police officer put a choke hold on me,” said McVeigh. “I thought, this was it, I was fighting for my life. I fought so hard I shat myself and pissed myself. It took six of them to get me in the paddy wagon. I had shackles around my ankles, I was handcuffed behind my back.”

He was calmer by the time the police van arrived at the psychiatric hospital. He was briefly interviewed, promptly committed, and forcibly drugged with the tranquilizing antipsychotic haloperidol.

The drug made him mentally numbed and physically exhausted, McVeigh said. He spent hours and days alternately sitting and wandering in a white-walled, window-barred, sterile hospital ward with a central television droning constantly. No one spoke with him about what he’d been going through. “If somebody’d given me a hug, I’d have been happy!” he told me.

McVeigh described feeling trapped in a “hell” of humiliating powerlessness. He soon realized that the only way he’d get his freedom back was if he started behaving as “normally” as he could—so he did, despite feeling stranger than before he’d been brought in.

Upon discharge, McVeigh was told that he had bipolar disorder and needed to take antipsychotics for the rest of his life. Instead, he read *Toxic Psychiatry*, psychiatrist Peter Breggin’s book about the harms of common treatments, and *Touched with Fire: Manic-Depressive Illness and the Artistic Temperament* by Kay Redfield Jamison, a psychologist labeled with bipolar disorder who believed the condition fueled many artists and thinkers. McVeigh stopped taking the drugs, moved to a remote north-coast squatters’ encampment, and decompressed over six months.

In the decades since, McVeigh has usually been settled, occasionally lived out of his car, and gotten briefly involuntarily hospitalized during several other difficult periods. In 2021, passing eighty years of age, he was still speaking out against forced treatment. “They don’t treat you as an intelligent human being.”

* * *

Tracy Myers’s story started very differently.

A slim, animated woman with shoulder-length dark hair, Myers was thirty when she was sexually assaulted twice while traveling. At a hostel, she became unwilling to get out of bed. “I was lying in the fetal position, shut down and so scared,” she said. “I felt like a small child.” She imagined things that would then manifest before her eyes. She believed she could quickly walk a thousand miles back to a safe place she’d visited.

Myers allowed herself to be taken to a psychiatric hospital, where her experience was strikingly similar to McVeigh’s—right down to the droning television and forced drugging with haloperidol. Nurses behaved professionally enough, but mostly stayed behind glass walls, handed out drugs in paper cups, and spoke to patients as if to children. Many of the other patients were slack-jawed and shuffling, she said, and there were no therapists asking about her feelings. She recalled pleading in vain to be allowed outside to walk in fresh air.

At one point, Myers had severe neck spasms. “In the middle of the night, my head started to twist to the right further and further and I couldn’t stop it. It went on for about an hour. It was as if someone was wringing me out.” She was terrified she’d become the possessed girl from *The Exorcist*. She only learned later from a fellow patient it was an antipsychotic side effect.

Myers got transferred to a hospital closer to home where a doctor was a family friend. The psychiatrist expressed shock at the amount of haloperidol she was on, and promptly discontinued the drug and discharged her. A friend invited Myers to help with a log cabin he was building in the wilderness. “For a month I hauled wood up this mountain, and physically worked,” said Myers. “It got me back into my body. That was the best kind of therapy I could have.”

Most psychiatrists used to be extensively trained in talk therapy and other techniques. However, after the discovery of “neuroleptic” drugs with anesthetizing effects in the 1950s (later marketed as “tranquilizers” and then “antipsychotics”), political pushes by psychiatric guilds alongside new legislation and policy changes reinforced a trend of hospitals hiring primarily biomedical psychiatrists. By the 1990s, psychoanalysts, psychologists, psychotherapists, and other non-medical mental health specialists had much-diminished roles or no presence at all in most psychiatric hospitals. Yet Myers was the first to tell me what I’d soon learn abundant evidence shows—that altered states with spiritual tones like McVeigh’s and traumatized states like Myers’s are common among psychiatric patients, and many would prefer to explore their feelings in hopes of understanding their meaning and finding healing. They often don’t want invasive biomedical treatments like tranquilizers and electroshock and don’t respond well to them. Such people get “coerced, pressured, forced," said Myers. "Their lives can become unmitigated terror."

Myers later attended a public reading by Vancouver author Irit Shimrat recounting her own experiences with unusual states of consciousness and forced treatment. Myers described it as "revolutionary" for her to see a talented, intelligent woman speaking "without shame" about madness. "I remember just weeping listening to her. I had never talked with anybody about the kind of thoughts I'd had. The most painful thing for me was the isolation and loneliness." Myers met McVeigh at the event, and they launched a group for people to share their experiences of unusual states and forced treatment.

Myers went on to work at a nonprofit as a counselor for children who'd been exposed to violence, and then went into private practice. She did not take psychotropics and was never again psychiatrically hospitalized. When we talked in 2021, I asked if she still felt the same about involuntary treatment.

"People are suffering," she said. "The idea that sticking them in a cell and giving them drugs is a solution for this is insanity."

* * *

During that period, I also interviewed Irit Shimrat, the author of a history of modern activism against forced treatment, *Call Me Crazy: Stories from the Mad Movement*, and sometime-editor of various long-running periodicals written by patients and ex-patients. Shimrat educated me about "consumers" who identify as willing clients of mental health services, "survivors" who identify as unwilling victims of those "services," and the "mad movement" loosely unifying current and former patients from both groups, critical practitioners and academics, lawyers, artists, and others defending the rights of those labeled as mad.

Shimrat and I developed an enduring friendship, and I witnessed how she twice went more than a decade living independently and without any mental health system involvement. Yet in between, shortly after deaths of people close to her, she behaved in distraught, strange ways that worried or annoyed neighbors, and got psychiatrically incarcerated more than a dozen times.

"Here I was this privileged kid with a nice family. Middle-class. A good student," said Shimrat of her first experience of civil commitment at age twenty. Several significant disappointments coincided in her life and she wasn't sleeping much. She'd always had a quirky personality and rich fantasy life, and after taking the psychedelic LSD one night, she didn't come down. Over the ensuing weeks she believed she could control traffic lights, others could read her mind, and she was communing with alien beings. Most of it felt fascinating and enjoyable, Shimrat said, but her worried father took her to a doctor. “All of a sudden I’m incarcerated and being tortured. It was an appalling shock.”

Promptly labeled with schizophrenia, Shimrat more than once screamed and fought back as groups of men stripped her, restrained her in a gurney, and forcibly injected her. What had she done to deserve this, she asked herself. Had some wacky thoughts and said some wacky things? “I was fully cognizant of the injustice of it right away. The experience of being locked up and then debilitated with antipsychotics is brutal.”

She acknowledged that while some people could eventually find a tolerable dose that quelled their minds but left them still functional, for others—especially when not allowed to participate in dosage decisions—antipsychotics can be disabling. “The whole time that I was ever on antipsychotics I sort of fluctuated between wanting to die and thinking that I had died and gone to hell,” Shimrat said. “All color was drained from the world, like everything was grey, and I couldn’t remember where I was from moment to moment. There was just a sort of sense of grinding, endless tedium and pain, physical pain as well as the pain of not being able to think.”

One reason that opinions on involuntary treatment are so polarized, said Shimrat, traces directly to these most obvious effects of antipsychotic tranquilizers, by far the most common class of psychotropics forced on patients. If a person in crisis has been behaving fearfully or disruptively, the instantaneous numbing of emotion and slowing of thought and behavior can sometimes seem like relief to the person and even more so to others in the person’s life. But for many, antipsychotics feel like a “chemical straitjacket.”

Her experiences in psychiatric hospitals have been “infinitely worse than even the worst moments” of her “so-called mental illness,” Shimrat said. “I’ll never recover completely from the trauma of it.”

* * *

Over the years, especially after I began freelancing in 2014 for science journalist Robert Whitaker’s web magazine, *Mad in America*, I connected with hundreds of people who’d experienced civil commitment in the US and Canada—and gathered perspectives from thousands more via groups, organizations, research papers, and public events. Similar stories kept emerging: frightening police interventions; prison-like stripping under guard; meetings with psychiatrists that lasted only minutes before diagnoses were rendered; uncommunicative staff; heavy tranquilization; seclusion; four-point restraints; resignation to days languishing on bleak wards; unexpectedly long detentions and abrupt discharges; and enduring impacts of fear and trauma more than of healing. And while pro-force psychiatrists, governments, or organizations frequently suggested, without providing evidence, that I was only hearing about "unusual" cases unrepresentative of most people's experiences, I noticed that, whenever I was able to review sources' medical records, the treating psychiatrists themselves rarely characterized such cases as anything but *typical*.

Very occasionally, I found people who were glad they were detained. But when I delved into their stories, it seemed they'd usually experienced something entirely different. Medical staff had talked with them respectfully. They liked the effects of the drugs. They rapidly developed collaborative relationships with their treatment providers. They weren't forcibly treated for long, if they ever really had been at all. I never came across anyone who'd exhibited real resistance to treatments, and had no criticisms about what happened next.

There's a cliché caricaturization of involuntary patients as chronically insane, dangerous madmen, utterly divorced from reality. But the vast majority of the people I was encountering seemed more like my father. They'd gone through long periods of their lives before and after their incarcerations when they'd shopped for groceries; gone to school or held jobs; developed relationships; walked in nature; experienced hope, ambition, boredom, and love; created art; and basically did most things ordinary people do. Their crises and altered states of mood or consciousness usually emerged amid various combinations of sudden tragedies, major life transitions, escalating anxieties, loss of sleep, homelessness, poor eating, job losses, financial stresses, conflicts with family, and misuse of recreational or prescription substances—basically, circumstances that could potentially drive anyone "over the edge." Most got hospitalized as a result of behaviors that simply confused, frightened, or annoyed others, and had rarely engaged in violence or lawbreaking any worse than disturbing the peace or appearing threatening. Some agreed that their disruptiveness at the time merited getting briefly apprehended—but why, they asked, were they also subjected against their will to invasive medical interventions into their brains?

Certainly, some people I spoke with were less articulate, also had addictions or intellectual disabilities, or had longer histories as victims of childhood sexual or physical abuse or other challenges that had led to chronic problems and repeated hospitalizations—but these people tended to describe the impacts of restraints, seclusion, and forced drugging as even more disorienting, humiliating, and frightening.

And virtually everyone spoke of voicelessness. No matter what people's backgrounds or how their crises unfolded, they were devastated to suddenly be trapped in a hospital being treated as if everything they'd been going through and all of their perspectives and wishes were now nothing more than "sickness" that needed to be immediately shut down—by force if necessary. After release, they'd still find the gag hard to remove. Studies have repeatedly found that most mental illness–related stories in news media are about dangerousness and violence, while less than 10 to 20 percent ever quote people labeled with mental disorders, let alone people who've been forcibly treated.

This particular kind of stifling oppression stayed with Shimrat forever after. Now sixty-three, a long-lasting effect of forced hospitalizations, she told me, was a crushing of her creative soul: "[Involuntary treatment] left me unable to write fiction, which I had previously done easily. The kind of self-doubt that comes from being punished for imagining things devastates your imagination."

Shimrat ultimately found some degree of healing and creative revitalization through writing about her experiences and helping create platforms for others. "Forced psychiatry is oppression and silencing," she said. "If you give voice to people who have been silenced and oppressed and forced to suppress their emotions, they find out that they're not alone. That can be the beginning of reemerging."

* * *

For two decades, the overriding message from the mental health system has been that a drastic shortage of beds, along with strict, civil rights–protecting laws, have made it nearly impossible to hospitalize and involuntarily treat anyone—even the "sickest and most dangerous" often can't be detained.

For example, in a *60 Minutes* episode in 2013, prominent pro-force psychiatrist and author E. Fuller Torrey talked about how few hospital beds there were, and was asked, "How difficult is it to get somebody admitted who does not want to be admitted?" Torrey answered, "Almost impossible in most states. The laws will read, 'You have to be a danger to yourself or others,' in some states, and judges may interpret this very, very strictly. You know, we kiddingly say, ‘You have to be either trying to kill your psychiatrist, or trying to kill yourself in front of your psychiatrist, to be able to get hospitalized.’”

But this didn’t square with what I as a journalist was seeing on the ground in communities: relatively ordinary distresses or disruptive activities getting people forced into hospitals from schools, seniors facilities, workplaces, subsidized housing, and so on.

It also did not square with the actual numbers—I was investigating those, too.

After many of North America’s long-term asylums closed, most civil psychiatric detentions lasted for days, weeks, or months rather than years, so comparisons before and after the 1980s are challenging. Today, good statistics are hard to come by—federal, state, and provincial governments don’t gather them, don’t gather them in full, or don’t share them publicly. Nevertheless, everywhere decent statistics can be found, they show that Americans and Canadians are getting forcibly detained at per capita rates that have been rising steadily and dramatically since the 1990s.

In the province of Alberta in Canada, between 2008 and 2017, the per capita rate of psychiatric detentions more than doubled. From 2005 to 2016, British Columbia’s population grew by only 6 percent but its number of involuntary patients doubled to nearly 20,000 annually. Similarly, in Ontario, between 2008 and 2018, the population grew by 10 percent while the number of involuntary psychiatric hospital patients nearly doubled to 46,000 people annually. In some provinces, about half to 75 percent of adult psychiatric hospital patients were involuntary, and overall it appeared that more than 150,000 Canadians were getting detained every year. Most stays were for periods of ten to thirty days at a time—and, apparently, about three to fourteen days in the US.

In Florida, from 2001 to 2016, the number of detainees doubled to nearly 200,000—outstripping population growth by a factor of five. In California, the per capita rates of psychiatric detentions for three-day periods increased about 30 percent between 1991 and 2016, surpassing 150,000 annually. In that same time frame, California’s population-adjusted number of thirty-day detentions nearly tripled, and child detainees more than doubled. In Colorado, emergency psychiatric detentions from 2011 to 2016 nearly doubled to 39,000.

Rudimentary “one-day estimates” gathered by the US Substance Abuse and Mental Health Services Administration from facility administrators reported that 34 percent of people in all psychiatric or general hospitals for mental health reasons were detained under civil commitment laws. (Another 19 percent—most in large state hospitals—were involuntary patients under criminal charges, detained in the forensic psychiatric system on grounds of “not guilty by reason of insanity.” The criminal-forensic psychiatric system also merits more public attention, but is only occasionally discussed in this book where it sometimes overlaps with the civil system.)

But even those numbers didn’t tell the whole story. Many experts suggested that in both countries potentially 80 to 90 percent or more of psychiatric hospital patients may be there unwillingly. In part this is because, if people actively seek help, ironically, they’re often refused services and sent home with drugs in hand, to keep beds for forcing people. But it’s also because the legal tool of civil commitment is not unlike a loaded gun—it’s often enough to just wave around the threat while promising that following the doctor’s orders could lead to freedom sooner. Many people I spoke with said they’d indeed been unwilling “voluntary” patients.

The facts about civil commitments are so heavily cloaked from public view, though, it took me much searching and many freedom of information requests just to gather this much reliable data. However, in 2020, Gi Lee, a PhD student at the University of California–Los Angeles (UCLA), and David Cohen, a social welfare professor, research scholar on psychotropic drug efficacy, and longtime critic of “overmedicalizing” emotional distress, published the results of their own five-year quest in *Psychiatric Services*.

Like me, Lee and Cohen found hodgepodges of data with many glaring holes. But in the twenty-four states where they found data, at least six hundred thousand detentions occurred under mental health laws in 2014—by extrapolation 1.2 million nationally. In some states, like Nevada and Indiana, the rates had nearly doubled in eight years. In twenty-two states with continuous data between 2011 and 2018, psychiatric detentions had increased every single year, and on the whole three times faster than population growth.

And these weren’t just the same patients getting re-hospitalized many times. As I had, Cohen also found that wherever those numbers could be separated out, repeat hospitalizations comprised just 5 to 20 percent, and most of those were only twice.

All told, at more than three hundred adults per one hundred thousand, the rates of psychiatric detention in the US and Canada appeared to be more than double and triple the rates in the UK, Sweden, Finland, Germany, France, and most other European countries with comparable mental health systems.

In an accompanying commentary in *Psychiatric Services,* psychiatrists from several universities pointed to the dangers. “[I]n the absence of consistent data,” they wrote, the public has “no assurance” that these forced psychiatric interventions are being implemented in just and responsible ways. And, they added, psychiatrists cannot answer the “fundamental question” of whether these forced interventions are actually, on the whole, helping people.

“The concern,” Cohen told me in conversation, “is that we’re probably doing exactly what we were doing sixty years ago. My concern is, the mental health system is just as coercive as it’s always been, and possibly more.”

Cohen said he had many reasons to doubt the completeness of his numbers, and he suspected that today closer to 1.5 million Americans get psychiatrically detained each year—plus large numbers of voluntary patients feeling under threat. I noticed, though, that the numbers tended to be higher wherever the data seemed more detailed and reliable. When I averaged several of those states, the number of Americans getting psychiatrically detained projected closer to 2.3 million annually. Either way, although for comparatively shorter stays, it would appear to be many times the number of people detained at the 1950s peak of massive psychiatric asylums (see chapter seven).

And for reasons that will become clear throughout this book, even these numbers likely enormously understate the extent of psychiatric coercion going on in our society.

The apparent wide variances in rates between states—up to thirty-three-fold—also raised questions for Cohen. “Why is it that there’s such a difference? Is one of those states doing something right or doing something wrong?” And without decent data, Cohen asked, how can we answer the most important question: “What happens to people who get committed?”

He was frustrated by so many data black holes. We discussed Colorado and Ontario, where governments were collecting good data but in recent years, without explanation, made the statistics much less accessible. As the Covid-19 pandemic and lockdowns set in, some hospitals seemingly temporarily emptied while others became death traps—overall, statistics became still more difficult to unearth. I asked Cohen if he believed, in this era of electronic records, the many data holes were intentional. He replied, “Overall, there’s little information available; it’s part of the functioning of the system. In that sense, it’s deliberate. But is it a conscious effort?”

Most governments and treatment providers, Cohen argued, don’t want to publicly expose “the dark heart” of our mental health system—that a core function is to incarcerate and control masses of people. “There’s nothing pleasant about that. There’s nothing beautiful and pretty. It’s just exclusion: ‘Please take them away from me.’ And because we’re saying we’re doing it to help them, there’s a kind of systemic dissonance.”

Did he suspect that civil commitment powers were being used on a growing diversity of people in an expanding array of circumstances?

“Yes, I think we’re going too far,” said Cohen. “But I wish we had more information to be able to say that. I don’t really know who they are.”

That’s what I was trying to discover. And I soon learned that, to understand what’s driving the dramatic increases in psychiatric detentions, it’s essential to first understand the core science, laws, financial levers, and social goals that drive our civil commitment system. Then, it becomes clearer how and why this system, with alternately understandable, dubious, or corrupt intentions, is capturing ever broader spectrums of people from anxious children and depressed teens to frustrated workers, vulnerable seniors, and political protesters.

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* See Notes and References for sources listed by page number (available online at https://robwipond.com/your-consent-is-not-required).

CHAPTER 2

THE EXPANDING DIAGNOSTIC NET

During her Democratic presidential nomination run in 2019, spirituality and self-empowerment author Marianne Williamson got lambasted by CNN anchor Anderson Cooper as “irresponsible” for questioning whether depression is caused by a chemical imbalance that can be corrected with drugs. “Clinically depressed people aren’t depressed because the world is depressing,” Cooper insisted. “They have a chemical imbalance.” Other media commentators piled on the scorn at the “dangerously wrong” Williamson.

Yet already in 2012, psychiatrists and editors of leading psychiatric journals from Harvard Medical School and the University of Texas acknowledged to NPR that the belief that a “chemical imbalance” could cause depression was “outmoded” thinking. There was never “any convincing body of data” to support the chemical imbalance hypothesis, the psychiatrists explained; instead, this psychopharmaceutical industry promotional idea merely caught on with the public because people then “felt more comfortable taking a drug.”

Later in the trade journal *Psychiatric Times*, former editor-in-chief Ronald Pies argued that chemical imbalances were always just a pseudoscientific “myth” and that “psychiatry as a profession and medical specialty never endorsed such a bogus ‘theory.’”

Yet still in 2022, the Johns Hopkins University Medicine website declared that schizophrenia “is caused by a chemical imbalance and other changes in the brain,” and that “mood disorders” such as depression, anxiety, and bipolar disorder are “likely caused by an imbalance of brain chemicals.”

Conversely, also in 2022, the Harvard Medical School website said that the phrase *brain chemical imbalance* was only ever a “figure of speech” referring to many possible biological, social, and environmental factors that defy scientific understanding.

So, how exactly do you get diagnosed as having one of these figure-of-speech disorders? Only one answer is certain: every year, larger percentages of us allegedly have them—and thereby meet the step-one criteria for getting detained under civil mental health laws.

* * *

In truth, American psychiatry’s own diagnostic manual shows that there are no consensus-based, scientifically testable, known biological aspects to most mental disorders.

Routine updates to scientific manuals don’t typically generate angry petitions, public calls for boycotts from other scientists, and controversial headlines in news media from *Scientific American*, *Slate*, and the *New York Times* to Fox and CNN. But for several years leading up to the 2013 publication of the fifth edition of the American Psychiatric Association’s (APA) *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*), the book came under siege.

Criticism of the *DSM* actually goes back decades, in books such as *Of Two Minds: The Growing Disorder in American Psychiatry* by anthropologist Tanya Luhrmann; *They Say You’re Crazy: How the World’s Most Powerful Psychiatrists Decide Who’s Normal* by psychologist Paula Caplan; and *Mad Science: Psychiatric Coercion, Diagnosis, and Drugs* by social work professors Stuart Kirk, Tomi Gomory, and David Cohen.

If you’ve never opened the diagnostic manual, you might wonder why anthropologists, psychologists, or social workers feel qualified to critique medical science. But that’s the issue—there’s barely a whiff of medical science anywhere in the *DSM*. Virtually none of the listed mental disorders have any identified biological, genetic, anatomical, or biochemical aspects whatsoever.

Instead, hundreds of disorders are described with lists of symptoms that are generally ordinary experiences and behaviors, like eating a lot or a little, feeling anxious or sad, acting meekly or boldly, or believing in conspiracies. These are then identified as disorders if they occur often or excessively, or cause difficulty in doing normal activities.

But how often constitutes “often”? How much difficulty constitutes “difficulty”? And who says what’s “normal”? And does normal or commonly accepted truly mean healthy? None of this is clarified in the *DSM*, leaving immense room for personal prejudices and cultural biases. Furthermore, even if you’re experiencing only a few of the listed symptoms slightly or occasionally, you can still be labeled as having a mental disorder that’s “moderate” or “mild.” All of this together, critics suggest, makes the *DSM* less a medical diagnostic manual than a vast net for labeling countless experiences and behaviors as diseases and virtually anyone as disordered, capturing ever more customers for mental health professionals.

The APA’s official response has long been relative silence, while tens of millions of dollars in book royalties have rolled in and US and Canadian governments have entrenched the manual’s authority in billing for all public and private health insurance. However, as the *DSM-5* developed, a new twist emerged: a whistleblower from inside.

* * *

Psychiatrist Allen Frances had chaired the APA’s task force for the previous, fourth edition of the *DSM*, originally published in 1994. By 2010, Frances was publicly shouting that *DSM-5* was moving psychiatry ever deeper into the “business of manufacturing mental disorders” in “a wholesale Imperial medicalization of normality.” Frances warned that vast swaths of ordinary people would be “caught in the excessively wide [*DSM-5*] net.”

Frances’s voice was amplified by Gary Greenberg, a psychologist and journalist for *Wired*, the *New Yorker*, and *Harper’s*. As Greenberg explained later in his *The Book of Woe: The DSM and the Unmaking of Psychiatry*, Frances was in part doing a mea culpa; Frances lamented how, when his own *DSM* edition “simplified” the process for diagnosing ADHD, it led to a huge leap in the number of children getting labeled with ADHD and put on drugs.

Sensing a possible tidal shift happening at last, other critics rose up. The British Psychological Society issued a twenty-six-page manifesto, accusing the APA of “the continued and continuous medicalisation of . . . natural and normal responses.” A related protest petition was co-signed by thousands of mental health professionals and sixteen divisions of the American Psychological Association. And the American Counseling Association wrote a critique of the *DSM-5* on behalf of its 120,000 members. One King’s College London psychologist summarized in a widely replayed quote: “The proposals in *DSM-5* are likely to shrink the pool of normality to a puddle, with more and more people being given a diagnosis of mental illness."

Greenberg also reported, though, on leading psychiatrists who said, for example, that other mental health professionals should just "get over their hang-up" and stop trying to "avoid implying that everyone has had or will have a mental illness."

Under pressure from confused journalists who'd long been told by pharmaceutical companies and biomedical psychiatrists that mental disorders were detectable chemical imbalances curable by drugs, not inflatable label balloons, the APA admitted: "In the future, we hope to be able to identify disorders using biological and genetic markers"; however, that future "remains disappointingly distant."

At times anxious about what he'd helped unleash, Frances occasionally qualified his criticisms to Greenberg—but the way he did that was also telling. "I don't want people who need help to get disillusioned and stop taking their medicine," said Frances. "The full truth is usually best, but sometimes we may need a noble lie."

The most consequential development came from the US National Institute of Mental Health (NIMH), the federal government's premier psychiatric research funding body. The NIMH announced plans to gradually cease funding research into common mental disorders such as schizophrenia, ADHD, or major depressive disorder, because these labels had proven to be clinically misleading and scientifically useless for helping find brain-based, biological causes of people's emotional distresses. The NIMH explained that, for example, "patients who meet criteria for one mental disorder often tend to meet criteria for other mental disorders"—e.g., depression is a symptom of anxiety disorder and ADHD, while anxiety is a symptom of ADHD and depression, while all three are symptoms of schizophrenia, and delusions can be symptoms of schizophrenia, depression, or anxiety, and so on, such that even specially trained diagnostic experts don't agree very reliably on diagnoses. The fundamental problem, the NIMH summarized, is that "[c]linical criteria for defining a disorder . . . are somewhat arbitrary." The NIMH directed researchers to instead try investigating common sensory, emotional, or cognitive changes that might be associated with various different mental disorder labels.

Greenberg concluded that "psychiatric diagnosis is fiction sold to the public as fact." The editor of the *DSM-5*, Columbia University psychiatrist Michael First, acknowledged to Greenberg that labeling people as having particular mental disorders has “no firm basis in reality.”

* * *

It’s not that nothing biochemical happens in our brains when we have unusual or intense mental experiences—it’s just that what happens is complex, difficult to discern, widely varying, and usually proves nothing about cause versus effect or disorder versus natural response. So, while all psychiatric medications impair or alter many brain and body neurotransmitter communication systems in a myriad of ways—which is also why psychotropics can have so many, varied adverse effects—exactly how or why certain psychotropics make some people apparently improve, and other people with the same diagnosis seemingly worsen, continues to be much debated. Consequently, many long-term psychiatric patients end up with innumerable different diagnoses and drug prescriptions—doctors just search for anything that “works.” As the APA acknowledged during the *DSM-5* development, in psychiatry “lack of treatment specificity is the rule rather than the exception.”

A reassurance that some mainstream psychiatrists like Ronald Pies offer is that doctors usually don’t know what’s causing people’s migraines, either, but painkillers can still help. Which is a good comparison—until we consider situations where people say they aren’t experiencing any headaches, but doctors then say they’re deluded and force them to take painkillers every day anyway.

Additional evidence for the lack of known, biological causes of common mental disorders is the fact that most psychiatrists rarely even medically examine emergency psychiatric patients. Ironically, this means that many psychiatrists frequently miss diagnosing *actual* biological illnesses *known* to cause mental problems. As one manual for physicians lists, nutritional deficiencies, hypothyroidism, cardiovascular conditions, Lyme disease, hypoglycemia, infections, parasites, autoimmune problems, detectable brain conditions like tumors, and dozens of other physical ailments can produce extreme depression, anxiety, hallucinations, and more. Many drugs can, too, including steroids, antihistamines, antibiotics, antihypertensives, and, notably, all psychotropics.

A special task force of the American Association for Emergency Psychiatry (AAEP) issued a damning report on this phenomenon in 2017. The AAEP described wide variation in how emergency physicians, nurses, and psychiatrists conduct medical examinations, and stated that physical ailments getting “misdiagnosed as mental illness” and inappropriately “treated” with unhelpful psychotropics may well be “fairly common.” They pointed to studies finding as many as half of emergency psychiatric patients had physical problems causing their unusual mental experiences, yet these had gone undetected. The AAEP found that, in all, physical diseases seemed to “contribute to, exacerbate, or cause” people’s emergency psychiatric symptoms anywhere from 19 to 80 percent of the time. The report concluded, “The consequences of misdiagnosis may be grave.”

Surveillance video released in 2021, for example, showed a man crawling in agony, for twenty long minutes, toward the exit of a Toronto hospital, after a psychiatrist diagnosed him as merely having an anxiety disorder—instead of identifying the severe immune system disease that was attacking the man’s nerves, which got diagnosed once he made it to another hospital.

Kristen Freed, a professional restaurant server with a master’s degree in psychology, was visiting Newport, Rhode Island, and walking around on a hot day during the pandemic lockdowns. She became hungry, sunburned, and dehydrated and, unbeknownst to her, a small cavernoma in her brain suddenly caused a brain bleed. Abruptly, she no longer knew where she was; she was so disoriented that she walked into the nearest house. “I didn’t know it was a stranger’s home,” Freed told me. “I thought it was somehow rented by my family or something like that, even though it didn’t make any sense.”

Eventually, Freed wandered back out, passing the startled homeowner returning, who presumably called the police. “I knew something was wrong,” said Freed. “I knew that I needed help, so at this point I was calm.” Police called an ambulance, and Freed’s medical records indicate a CT scan did detect a possible brain bleed.

The bleed wasn’t overly dangerous and would stop on its own. But Freed, still experiencing the effects, remained confused, and worried it could become a devastating brain hemorrhage. Hospital staff decided her continuing anxiety wasn’t a simple misunderstanding or residual effect of the brain bleed but instead bipolar disorder. They involuntarily detained Freed and, over the ensuing days, pressured her to take antipsychotics, transferred her to the psychiatric ward, and told her they might put her in a state hospital—all of which heightened Freed’s anxiety further.

Fortunately, said Freed, the effects of the brain bleed dissipated and she realized she’d better start behaving calmly. Freed was discharged after eleven days, with a bill for $20,000.

Freed has since returned to her normal life and work, but her brush with involuntary psychiatric hospitalization haunts her more than the possibility of another brain bleed. “There’s a guy who says that, once you’re labeled mentally ill or even alleged, you’re no longer protected by the Constitution,” she said. “I now know that to be true.”

◆

So, how are psychiatrists taught to label you as mentally ill?

I asked three psychiatrists who’d recently been in education and residency training—James, Daniel, and Jen. (When only a first name is given, usually, the person requested anonymity and chose their own pseudonym. As will become clear, there can be personal, professional, and legal repercussions to having been psychiatrically detained, or for speaking out critically about civil commitment.)

All three said the biologies of mental disorders were sketched only speculatively during their education. The phrase “chemical imbalance” is now used less often than other hazy, suggestive phrases like “faulty wiring,” “neurotransmitter dysregulation,” or “dysfunctional brain circuitry.” Daniel said the “chemical imbalance” phrase, though, “continues to seep into how things are communicated to patients, particularly when medications are being recommended.”

With so many people coming through busy emergency rooms, the psychiatrists all said they typically talked with a patient for only about fifteen minutes, while being on “high alert” for cue words. “Diagnosis very much takes the form of running through checklists of symptoms,” said Daniel. “If someone uses the word *sad*, then you go down the depression checklist.”

“You get trained to not focus so much on the context of the person’s life,” said James. “You get trained more to look at symptoms and match those up with something in the *DSM*.”

“Each kind of diagnosis will have, say, nine possible symptoms,” said Jen. “You’re listening to the person’s narrative, and then you’re going ‘ping, ping, ping’ each time you hear one. And then you count them up.”

They were taught to then match the labels to the most commonly recommended drugs. “It was taught as, ‘This is the guideline: if someone has this diagnosis, use that drug, and don’t question it,’” said James.

“You move down the guideline,” said Jen. “It’s been decided what we’re supposed to do, and our job is to learn that.”

“We created cue cards in our group and would quiz each other,” said Daniel.

This complete reliance on unreliable *DSM* diagnostic labels raised a question for me: How do certain psychotropics get approved by health regulators as effective treatments for specific diagnoses in the first place, when, even at the highest levels of scientific research in clinical trials for psychiatric medications, diagnoses are done using equally simplistic, subjective, cue card–like symptom checklists (see chapter twenty-three)? The crucial voice of the Food and Drug Administration (FDA) was noticeably missing during the many public *DSM-5* debates.

So I asked the FDA: How can they possibly approve drugs as effective for curing mental disorders that have arbitrary definitions and are impossible to biologically detect or validly diagnose? FDA psychiatrists refused to discuss it; I had to appeal and negotiate up through the FDA’s media relations hierarchy over months. Finally, an unnamed FDA psychiatrist issued a terse written reply that psychiatric drug trials use “contemporary widely accepted diagnostic criteria.” I was forbidden from asking any follow-up questions.

* * *

Yet, if there’s no way to scientifically, biologically determine if anyone does or doesn’t “have” a mental disorder, then how do we know that one in five adults is mentally ill, and that X percent of prisoners, children, homeless people, and so on have mental illnesses, and the many other statistics we commonly hear about our society’s epidemic of mental illnesses?

Those percentages typically come from surveys using mental health screening questionnaires with even broader, less scientific labeling nets. Three of the most widely used are the Kessler Psychological Distress Scale (K6), the Patient Health Questionnaire (PHQ-9), and the Generalized Anxiety Disorder (GAD-7) survey (the latter two notably created by the drug company Pfizer).

The K6, used in national surveys conducted by the Substance Abuse and Mental Health Services Administration, has just six questions. “During the past 30 days, about how often did you feel: 1) nervous, 2) worthless, 3) hopeless, 4) restless or fidgety, 5) that nothing could cheer you up, or 6) that everything was an effort?” If you answer that you felt five of those “some of the time,” you’re labeled with a mental disorder. Basically, the K6 is a fast way to diagnose as mentally ill any recently upset person who’s loose with how they mean “some of the time.” If they say that they’ve had these feelings *often* this month, respondents get labeled as *severely mentally ill*.

Similarly, the nine-question PHQ-9 asks how often over the past two weeks you've slept too much or too little, had poor appetite or ate a lot, felt bad about yourself in some way, or felt tired. If you've experienced any five more frequently than never, you're already labeled with a mild mental illness.

The seven-question GAD-7 asks how often you've felt anxious, worried, easily annoyed, or had trouble relaxing, and labels you as mentally ill equally easily.

In public pleas for increased mental health funding, these screening tools are routinely promoted as having "excellent" validity, but they're actually well known to "find" many times more mentally ill people than even the tools' designers believe are ill. In 2019, a McGill University–led meta-analysis determined the PHQ-9 typically labels 2.5 times as many people with depression as ordinarily expected. The GAD-7 overdiagnoses seven times as many people with anxiety disorders. The K6 performs worse. So, surveyors will "calibrate" their results to stricter standards when their numbers start to seem ridiculously high even to them.

I asked the NIMH press office why NIMH promotes unreliable prevalence rates from these surveys, like "one in five are mentally ill" and one in eighteen of us have "serious mental illness"—especially when their own website elsewhere acknowledges mental disorder labels are "arbitrary." The NIMH replied that the rates they post are "the best information currently available."

I asked the Canadian Institute for Health Information (CIHI) where they got their prevalence rates for mental disorders in children. CIHI cited a study using a questionnaire purported to accurately diagnose seventeen mental disorders in just fifteen minutes, even without talking with children directly. Why would CIHI promote such statistics as if scientifically valid? CIHI pointed to other "surveys that reach similar conclusions"—directing me to surveys using the K6, PHQ-9, and GAD-7.

* * *

How does all of this diagnostic inflating add up? According to the most recent lifetime-prevalence rates from 2005, more than half of Americans at some point have a diagnosable mental disorder. The numbers continue to rise: the NIMH now says 50 percent of Americans will have had a clinical mental disorder before the age of eighteen. This suggests that lifetime prevalence for adults has climbed toward 60 or 70 percent or more.

So, *60 to 70 percent of us will at some point meet the step-one legal criterion for getting locked up in a psychiatric hospital*. What about step two?

The US Supreme Court weighed in already back in 1979, concluding that “psychiatric diagnosis is an inexact science.” The court then decided to lower the standards of evidence required for civil commitment, declaring that it is worse for “a mentally ill person to ‘go free’ than for a mentally normal person to be committed.”

CHAPTER 3

“WISE AND BENEVOLENT PATERNALISM” WITH A GAVEL AND NEEDLE

At age twenty-nine in 2019, Andrew Rich became convinced he’d never be free from forced psychiatric treatment, and killed himself.

His mother, Elizabeth Rich, is a Wisconsin attorney who knew little about mental health laws when Andrew first got detained. “Because civil commitment hearing cases are sealed, general lawyers rarely, if ever, see mental health law cases,” she said.

Rich described Andrew as creative, intelligent, charming, and generous. After a car accident in high school, he struggled with pain, OxyContin addiction, and trouble with the law, but by 2013, Andrew was clean.

In May of 2017, though, FOX6 News in Milwaukee reported that a 911 caller had seen someone in a parking lot naked and “howling like a wolf.” Police responded and tasered Andrew after he reportedly attacked them.

Rich presented a more nuanced version of that crazy-sounding event. Andrew was living with her at the time, and the night Andrew was tasered was his late father’s birthday. Before he died, Rich’s husband and two boys had often swum naked in the river near their rural farm. “My husband thought that there was a magic to rivers,” Rich explained, “and he wanted to impart awe and wonder of a river to his sons.” Sometimes, they also howled at the moon. “One time, I did it with them. There’s actually something very visceral and freeing and exciting about howling at the moon.”

That evening in May, Andrew had stripped and gone swimming in the river. According to Andrew, he was carried downstream and, after climbing out and doing some howling in his father’s honor, he didn’t feel able to swim back upstream. He sought assistance in a nearby parking area.

What did police videos show? All camera footage from five separate police squads got “lost.”

After some legal twists and turns, Andrew was incarcerated for a month at a psychiatric hospital and drugged against his will at home for an additional five months. Then, because Andrew seemed to be doing well on the drugs—since he hadn’t been mentally unwell to begin with, said Rich—the requirement that he stay on the drugs kept getting extended by court orders.

Rich said her son complained vociferously that the antipsychotic tranquilizers were stealing his life. “He had no physical sensation. He couldn’t taste food. He couldn’t feel, there was no physical pleasure in life. There was no emotional pleasure. He couldn’t laugh. He couldn’t cry. He couldn’t concentrate. He loves to read; he couldn’t read a book.” She said she felt like she was witnessing her son get slowly “chemically lobotomized.”

Andrew would do everything the mental health practitioners recommended, and then he would plead with the judges, asking what it would take for him to ever be released from the forced drugging that had now been going on for two years. Rich recounted, “The judge said, ‘I can’t second-guess the doctor’s opinion.’”

After Andrew’s suicide, his mother started representing people in commitment hearings. Rich said she frequently sees people trapped by the same broad legal powers. She followed the case of a homeless client who lit some cardboard on fire for warmth. “That was enough to be committed for dangerousness,” she said. One client of hers was looking for homes to buy, and distractedly crashed his car into a tree. Police saw that he’d been committed four years earlier, and he was soon hospitalized for allegedly trying to kill himself by crashing his car. He pleaded to Rich, “That’s my favorite car! I restored that car lovingly!”

Confirming what other attorneys told me, Rich said many of her clients aren’t in any way dangerous, but instead “just annoying,” socially provocative, or disruptive, while psychiatrists have admitted to her that they sometimes “exaggerate evidence” and commit people “in order to help them.”

The US Supreme Court has recognized psychiatric detention as “a massive curtailment of liberty.” Higher courts have equated the rights to avoid detention and refuse psychiatric treatments with the rights to freedom of thought and expression, privacy, and bodily integrity. In a seminal case, a court wrote that a law-abiding citizen should be able “to protect one’s mental processes from governmental interference.” In another case, the court stated that the right to refuse psychotropics raises concerns as intimate and vital as cases about the right “to give birth or abort.” Higher courts have also recognized that psychiatric treatments vary vastly in how much they may help, and can have extremely deleterious effects, such that “even acutely disturbed patients might have good reason to refuse these drugs.”

Michael Perlin, a former public defender and professor at New York Law School, reviews judgments such as these in his coauthored, multi-volume, annually-updated treatise, *Mental Disability Law: Civil and Criminal*—generally considered to be the essential legal reference on civil commitment in America. Perlin also offers commentaries in his summary book *The Hidden Prejudice: Mental Disability on Trial*.

Perlin writes that, despite these occasional “cutting edge” higher-court decisions upholding constitutional rights, thousands of commitment hearings take place daily around the country in “unknown cases involving unknown litigants, where justice is often administered in assembly-line fashion. Sophisticated legal arguments are rarely made, expert witnesses are infrequently called on to testify, and lawyers all too often provide barely perfunctory representation.” Consequently, writes Perlin, in reality, most civil commitment hearings are “meaningless rituals, serving only to provide a façade of respectability to illegitimate proceedings.”

Perlin describes in encyclopedic detail how, at every step, overriding people’s civil rights is central to how mental health laws operate.

* * *

The process usually starts with the emergency intervention. Any medical doctor or psychiatrist, and in some jurisdictions social workers and other mental health professionals, can order police to find and transport anyone to a psychiatric hospital. In addition, any ordinary person can initiate a police “wellness check” by calling 911 and expressing concerns about someone’s emotional well-being —generally, police are duty-bound to respond.

Because police are coming to "help" rather than criminally investigate, the rules of exigent circumstances apply—meaning their powers are much more flexible. Police can break into your home or workplace without warrants. They can search you, your belongings, your car, and your electronic devices. Police can interrogate you or question others about you, handcuff you immediately without charge, and take you to a hospital simply because they feel concerned. As a result, police mental health assistance can easily become more aggressive and uncontrolled than criminal investigations, leading to notoriously high numbers of police shootings during wellness checks.

Wellness checks are by far the single largest funnel into psychiatric detentions. City-level statistics suggest millions of people across North America call 911 every year about people who are upset, disruptive, or "emotionally disturbed." In New York City, 86 percent of their 170,000 yearly wellness check calls result in police taking a person to a hospital. Perlin writes that these emergency-intervention laws were originally created to get people help when there was "peril of serious harm," but uses have expanded boundlessly and "empirical studies tend to reveal that in many cases no real emergency exists."

There've been no recent large-scale, structured analyses of the sources and outcomes of these calls, but the extraordinary power has become so widely known about that many appear to be using it with biased, questionable, or even malicious intentions. A female student told me she was having an affair with a much older professor, and when she threatened to tell his wife, he called 911 expressing "concern" about her emotional state. She was detained for two weeks in a hospital and became too afraid to say anything to the man's wife. A middle-aged man returned from his mother's funeral and narrowly avoided forced hospitalization—the 911 caller turned out to be a friend who was himself in treatment for extreme anxiety. In 2019, Californian Eric Zink, in recovery from addiction, was livestreaming his usual life-advice to some of his millions of YouTube and TikTok fans when an anonymous person called 911. "I was taken down by the police," described an angered Zink in a video he posted the next day. "I was taken at gunpoint. I was handcuffed." YouTube's recommendation algorithm swirled me into intersecting worlds of therapists and pseudo-therapists, current and ex-patients, and fans driving up views as they hurled adoration, vitriol, and either worried or angry 911 calls at each other.

I said to a senior police officer that wellness checks were an extraordinary power to make so accessible; was any vetting of callers done? "We can't afford to have those debates, because we do have a duty of care," he said. "We still have to go." He pointed out that calling in phony reports of violence to get an innocent person targeted by police is a prosecutable offense (often called "Swatting"); by contrast, it's usually impossible to prove someone's concerns about another person's emotional wellness were phony. He added that police "err on the side of caution" when detaining distressed people. "Our officers are under the understanding that if they make that decision to apprehend someone and take them to the hospital, they will get care there, and good care."

What's clear in medical records is that the reasons people give for calling 911, or that police give for apprehending someone, are usually assumed by doctors to be basically trustworthy and nobly intended.

* * *

At the hospital, you're subject to an emergency hold, so that a psychiatrist can examine or evaluate you. What a mental health "examination" or "evaluation" involves is not defined in law, but you cannot refuse to submit to it. You do not have the right to remain silent; refusing to answer a psychiatrist's questions, even about your most intimate inner experiences, can be and often is considered evidence of a mental disorder.

These emergency holds typically, initially, last one to several days. During this time, a psychiatrist may declare that you likely have a mental disorder and potentially meet one of the criteria for civil commitment. Often a second psychiatrist must nominally sign off. Depending on the jurisdiction, you can then be detained for days to weeks more before you're allowed a hearing.

Some jurisdictions allow routine forced treatment during these periods. It appears that all jurisdictions allow forcibly treating anyone in cases of emergency—though it's rarely clearly defined in law what constitutes a mental-emotional emergency. Patients and practitioners alike frequently report people getting "emergency" drugged for appearing threatening or aggressive, but also for simply seeming loud, annoying, or very emotional.

After getting labeled with a mental disorder, there are generally two possible criteria for getting civilly committed and forcibly drugged for a longer period.

The most well-known is that you pose a danger or risk of causing harm to yourself or others. This concept of "danger" is only loosely defined in most laws. Perlin writes that, "No question in the area of involuntary civil commitment law has proved to be more perplexing than the definition of the word 'dangerousness.'" The notion does not refer to actual serious violence that's occurred—such cases typically get diverted to criminal courts or the criminal-forensic psychiatric system. Instead, civil commitments involve psychiatrists attempting to predict the possibility that some "harm" might occur in the future. Perlin explains that psychiatrists and judges consider factors as varied as whether a person is attending school or working, engaging in risky recreational activities, eating or sleeping appropriately, getting along well with family, or tending to speak or gesture in angry or aggressive ways. Dangerousness therefore is a "vague" and "amorphous" notion, writes Perlin, and judges usually follow the lead of psychiatrists and simply employ an "I-know-it-when-I-see-it attitude."

Nevertheless, pro-force advocates successfully fought for still broader criteria. In most jurisdictions across North America, you can now also be committed if a psychiatrist feels you're "at risk" of becoming "gravely disabled" or of simply experiencing "mental or physical deterioration." And you can now be forcibly drugged in many institutions beyond only hospitals, including in your own home.

While these broad, vague laws already give psychiatrists immense discretionary powers, Perlin states that psychiatrists and judges often anyhow ignore them, and commit anyone "whom they believe should be committed." For example, Perlin quotes various prominent psychiatrists in trade journals encouraging colleagues to resist "tyrannical laws" and let decisions about what's best for patients be guided instead by their own "wise and benevolent paternalism." In his book *Out of the Shadows: Confronting America's Mental Illness Crisis*, prominent pro-force psychiatrist E. Fuller Torrey acknowledges approvingly, "It would probably be difficult to find any American psychiatrist working with the mentally ill who has not, at a minimum, exaggerated the dangerousness of a mentally ill person's behavior to obtain a judicial order for commitment." Paul Applebaum, today a member of the American Psychiatric Association's Council on Psychiatry and the Law, has also written that "mental health professionals and judges alike" are "reluctant to comply with the law."

Perlin calls such attitudes a "blatant attempt" by psychiatrists to "aggregate power." And these attitudes appear endemic: a 2019 study of twenty-two Western countries found large variations in rates of civil commitment that had "no clear association" with either the "clinical need" of patients or with "any characteristics of the legal framework."

Jennifer Mathis told me that, “It’s not constitutional to lock people up unless they are, quote-unquote, ‘mentally ill and dangerous.’ And the Supreme Court describes dangerous illness in a way that I think most of us interpret it to mean: real, imminent danger.” At the time of our interviews in 2021, Mathis was director of policy and legal advocacy at the Bazelon Center for Mental Health Law, America’s most prominent policy and litigation nonprofit focused on psychiatric civil rights. Mathis subsequently became deputy assistant attorney general at the Department of Justice’s Civil Rights Division.

Over the years, Mathis observed, state legislators, lower courts, and psychiatrists have “whittled down” the meaning of dangerousness to apply much more broadly. And the adoption of grave disability or deterioration criteria, she said, has created similarly “foreseeable problems.” She pointed to a case where someone was psychiatrically incarcerated for “lethargy.” Mathis recognized that this seemed like “an extreme example”; nevertheless, she said, “In many states now, people are too often committed based on very little.”

At the same time, she acknowledged, proponents of involuntary detention can point to cases where people whom some might see as dangerous were not detained—if only because the definition of dangerousness has become so malleable.

For these very reasons, Mathis is most concerned about the apparent national upsurge in psychiatric “emergency holds” that are lasting ever longer. “The majority of people in some states who get brought to the psychiatric hospital involuntarily don’t ever get a lawyer or a hearing, because state laws allow people to be locked up for a significant amount of time before a hearing.”

This is happening in general hospitals, too. In a 2015 American College of Emergency Physicians poll, 70 percent of ER doctors admitted that they were “boarding” psychiatric patients—holding people for weeks or months in a legal limbo of “emergency” treatment.

* * *

The next step: once declared at risk or in danger, and slotted for formal civil commitment, you finally, definitely have the right to a hearing.

In the US, these hearings usually take place before judges; in Canada, before three-person tribunals comprised of a psychiatrist, lawyer, and a general citizen. Depending on the jurisdiction, the proceedings are often hidden from public view, or the written decisions are hidden, or both. If it’s deemed to be better for your mental health, you can be excluded from attending your own hearing, forcibly drugged for your hearing, and denied access to your own medical records.

As Perlin describes it, there's a "significant measure of ambiguity" concerning which, if any, rules of evidence apply. Basically, any evidence can be allowed or disallowed. Even where there are rules, he writes, "it is not clear that these rules are generally adhered to in practice." For example, commitment decisions routinely hinge on "hearsay" evidence never allowed in normal courts—such as a psychiatrist relaying what a police officer purportedly told him about what a neighbor told her about something you purportedly did to warrant getting detained.

You have a right to a lawyer, but the lawyer's knowledge of commitment law and their preparation can vary dramatically. Surveys in both the US and Canada suggest public defenders typically spend just fifteen to forty-five minutes preparing, and hearings last just fifteen to thirty minutes. Worse, Perlin notes that "sanism"—paternalistic prejudices about what's best for people labeled with mental disorders—is so rampant that it's not uncommon for lawyers to subtly work against their own clients' wishes.

In theory, what's primarily before the court is your mental capacity or competence to make reasonable decisions. In practice, writes Perlin, "courts regularly and routinely weigh predictions of a patient's potential refusal to take antipsychotic medication in a community setting as the most probative evidence on the question of whether involuntary civil commitment should be ordered." Essentially, simply declining drugs is usually considered to be strong evidence that you're incapable of making reasonable decisions. Consequently, states Perlin, many patients view commitment and competency hearings as "a sham."

Only 10 percent of people typically win their freedom—though even these people can be promptly re-detained based on an alleged new concern.

In summary, as many legal experts have noted, criminal laws give suspected serial murderers substantially more due process protections than civil mental health laws give to ordinary citizens.

* * *

During pandemic lockdowns, many civil commitment hearings shifted online, allowing me to attend in various jurisdictions where public attendance is permitted. Michael Simonson, a communications professional and journalist in

New York, also shared recordings and notes from hearings he attended. Simonson himself had been briefly psychiatrically detained while attending college in 2005, and was now doing background research to help write his own story.

Many attorneys asserted to me that only about 5 percent of their civilly committed clients truly meet the standards for “dangerousness” established by the US Supreme Court, and Simonson and I agreed that only a tiny percentage of the cases that we saw revolved around behaviors that either of us considered truly dangerous. Although, the mere act of refusing forced psychotropics got people described with innumerable adjectives that made them sound dangerous: “resistant,” “uncooperative,” “belligerent,” “combative,” “oppositional,” “aggressive,” “openly hostile.”

Most hearings were blindingly brisk. There wasn’t time to truly investigate anyone’s testimony—many decisions hinged on just whoever or whatever sounded most immediately believable.

Simonson and I were both shocked by how often psychiatrists trivialized people’s concerns about adverse drug effects, or asserted that the effects were actually caused by the patients’ mental illnesses—even very serious adverse effects listed in the manufacturers’ drug labels. Anita Szigeti, a Toronto attorney and legal scholar who’s represented clients in commitment hearings for thirty years, told me that this is indeed common. “I have clients, men who have grown lactating breasts in response to being on antipsychotic medications, who have even had to undergo major surgery to remove those lactating breasts—which is then reported by psychiatrists in a hearing as, ‘This gentleman underwent some elective cosmetic surgery,’” said Szigeti. “‘A bit of weight gain’ is discounted; meanwhile, the client has put on two hundred pounds and has developed diabetes and heart disease in direct response to these medications.”

Some patients at hearings obviously felt railroaded, and became angry and interrupted frequently. It seemed equally obvious that judges often reacted by assessing such people as mentally-emotionally out of control. Simonson’s own summary of the cases he’d witnessed? “Kafka-esque and surreal,” he said.

In one case I attended, a woman had been drugged while living at home—for ten years. She said that in the past she’d been very distressed, but since then she’d aged, she’d changed, she wanted to see what life would be like without the constant brain dullness from the drugs. The psychiatrist believed that she was living a better life than she would without the drugs—she was getting along with her family, taking classes, avoiding hospitalization. She, however, was willing to risk all that to be free of the drugging. The final judgment was that the psychiatrist knew better how the woman should live.

CHAPTER 4

THE CATCH-22 OF “INSIGHT”

Mark ran his own sales company and, as a pilot and search-and-rescue volunteer, he’d witnessed injuries and deaths. He sometimes experienced distressing memories.

One morning, Mark awoke feeling especially anxious and having tremors. He sought help at the nearby University of British Columbia–affiliated hospital. He said he’d tried sedatives and didn’t like them, but hoped to talk with someone about non-drug treatments. In the Reasons for Judgment in Mark’s subsequent lawsuit, the judge noted that Mark “clearly” had come to the hospital seeking help “voluntarily” with “complete co-operation.” Mark “was not violent,” the judge stated, there was no “emergency situation,” and there was “no indication” Mark posed any threat to himself or anyone else. Mark was “placidly waiting” in an interview room for mental health advice.

Suddenly, four security guards appeared, tackled a startled and confused Mark, and pinned him facedown to the floor. The guards then dragged Mark to an isolation cell as he fought and yelled in panic. The security guards cut Mark’s clothes off his body with scissors, injected him with a sedative, tied his feet with a sheet, left the cell, and locked the door.

For five more days, Mark was heavily drugged and locked in the concrete cell with no windows or furnishings except a platform with a mattress and combination toilet and sink. When Mark’s father, an attorney, appeared with lawsuit notifications for everyone involved, though, Mark was immediately assessed by another psychiatrist and let go.

During the court proceedings, it became clear that a psychiatric residenttrainee who'd interviewed him had suspected Mark might have bipolar disorder. When Mark had said he didn't want drugs, the hospital doctors had summarily decided that Mark was lacking insight and mentally "incapable" of understanding his need for medications and should be committed. Therefore, based on psychiatric experts' testimony, the judge concluded that—though unnecessary in the circumstances—virtually everything that happened to Mark was intended "to aid him," and was common, "appropriate" practice in psychiatric hospitals.

All of which highlights a key question: What qualifies as "insight"?

* * *

The first psychiatrist I ever interviewed was Donald Milliken, chief of psychiatry at Victoria's main hospital around the same time Mark was incarcerated in Vancouver. He'd later become president of the Canadian Psychiatric Association. Middle-aged and balding, Milliken spoke with measured calm, and his hands gestured deliberately over the ordered desk in his hospital office.

"Clearly, admitting someone involuntarily is a fairly strong infringement of their civil liberties, and we don't want to do that without good and just reason," said Milliken. "Just as there are physical diseases, there are diseases of the brain. The reasons that most people get admitted to this hospital is because of a major depression, or because of a schizophrenic illness. Those illnesses are clearly brain-based illnesses with lots of biological factors involved and there is no question that the treatment for those illnesses in fact has to include . . . pharmacological treatment."

I asked if patients were given access to counseling and non-medical therapies.

"It is not a predominant part when you're dealing with the acute illness." He added that the hospital had limited staff and few private rooms.

What percentage of patients were not put onto drugs?

"It would be a very small percentage."

We discussed potentially serious adverse effects of antipsychotics—such as neurological damage and permanent motor dysfunction—and I asked if the hospital's psychiatrists fully informed patients. Milliken said that patients were informed "when appropriate," and lists of side effects were available "from any pharmacy."

He probably noticed my concerned look in light of laws about informed consent. “Let’s be realistic about this,” he said. He digressed into describing “floridly delusional” mental states. “Let’s be sensible. I think there’s no point in telling someone who is totally delusional and not in touch with reality. If I simply inform them at that time, I might be following the spirit of the law but I certainly wouldn’t be—or I might be following the letter of the law, but I certainly would not be following the spirit of the law.” Milliken’s verbal slip seemed incidental, but also like someone comfortable acting on his own interpretations of the law.

Later, Milliken asked with a hint of derisiveness, “Are you a Scientologist?” I knew nothing about Scientology except its mainstream reputation as a “cult.” I said no, and pressed on with my remaining questions. But it rankled, like I’d just been “assessed.” The weight of his medical authority brushed against me.

I later learned that the Church of Scientology believes forced treatment stifles self-development, and that it cofounded the Citizens Commission on Human Rights, a “nonprofit mental health watchdog,” with the late, libertarian-influenced psychiatrist and scholar Thomas Szasz. Many psychiatrists now often label any critics as likely Scientologists.

Milliken similarly dismissed the concerns of many involuntary patients: some people resist treatments due to a “lack of insight” into their illnesses and need for treatment, he said. “That is the reason you have the Mental Health Act. It’s the whole *raison d’être*.”

* * *

The most common reason given for treating people against their will is that they “lack insight”—they’re incapable of understanding their mental illness and their need for treatment. Such people allegedly cannot be reasoned with and cannot sensibly make choices.

The Maryland-based Treatment Advocacy Center, founded by pro-force psychiatrist E. Fuller Torrey, states that lack of insight “is a symptom of severe mental illness experienced by some that impairs a person’s ability to understand and perceive his or her illness. It is the single largest reason why people with schizophrenia or bipolar disorder refuse medications or do not seek treatment.” This notion of “lack of insight” is also promoted by the National Alliance on Mental Illness, WebMD, National Institute of Mental Health, the Substance Abuse and Mental Health Services Administration, and similarly widely among mental health organizations and government agencies in Canada, such as the

British Columbia Schizophrenia Society, which intervened in Mark's case to defend the hospital's actions. The idea is so closely linked to the rationale for involuntary treatment that it's explicitly written into many states' laws as a criterion for commitment; for example, in Idaho, if a person is "lacking insight into his need for treatment," and in New York, if a person's "judgment is so impaired that he is unable to understand the need for such care and treatment."

Certainly, some people who are obviously struggling nevertheless assert that they don't have a "clinical mental illness"—but that's much more understandable in light of the questionable science of diagnosing and the potentially dire legal consequences of getting so labeled. Meanwhile, characterizing such people as merely "lacking insight" encourages thoughtlessness—like when we brand those who vote for a certain political party as "too stupid to realize how stupid they are," while not seriously considering that this notional Zen koan could as well apply to us. In fact, surveys regularly show that the most common reasons patients give for refusing psychotropics are consummately understandable: they feel that the drugs don't help them enough and the adverse effects are too severe.

However, there's another glaring contradiction to the claim that involuntary patients are usually people who don't believe they're having mental health problems and won't voluntarily seek treatment: one of the most common ways people get locked up occurs when they believe they're having mental health problems and voluntarily seek treatment. With dramatically increasing numbers of people seeking mental health help, this has become a major contributor to rising rates of commitment. And these kinds of cases reveal exactly what psychiatrists truly mean by "insight."

Many people who sought help and checked in voluntarily at psychiatric hospitals, like Mark, described to me how merely expressing dislike for their psychiatrists' recommended treatments got them labeled as unable to make reasonable decisions. Indeed, a scientific review of even formally structured psychiatric insight-assessment tools states—uncritically—that the tools mainly assess whether patients agree with their psychiatrists' diagnoses and treatment recommendations. And the practice of instantly converting voluntary clients to involuntary patients for this sole reason has become so common that some states have streamlined the process in law. Texas Health and Safety Code Section 572.005, for example, declares that "a patient receiving voluntary inpatient services" may be made involuntary if the patient "refuses to consent to necessary and appropriate treatment recommended by the physician."

In 2017, ABC affiliate WFAA in Texas began reporting on the trend: “Voluntarily checking into psychiatric hospital, easy. Checking out? Not so much.” Outraged state legislators promised change. In 2021, though, WFAA reported that nothing had changed.

Autumn’s case is especially chilling—and revealing.

* * *

Autumn grew up in Colorado Springs where her father taught at the United States Air Force Academy. Autumn described her home and Christian school environments as militaristic, evangelical, and abusive. She became verbally rebellious and had bouts of anorexia and depression. When she was sixteen, her parents sent her to a psychiatrist who told her she had a chemical imbalance in her brain, and prescribed an SSRI antidepressant.

She remembers having unusual experiences on the drugs, feeling like she could only move in slow motion, and sitting blankly for long periods. These effects went away, but then she started to have daily suicidal thoughts. She never acted on them, but might imagine shooting or gassing herself, or see herself standing atop a tall building. “It’s something that I’ve learned to accept having in my life,” she said. “I wake up, and I have these thoughts. But then I get out of bed, I shower, I get dressed, and I go about my life.” She said she also began to feel entirely “asexual.”

Autumn eventually learned that increased suicidal ideation and lowered libido are both adverse effects of SSRIs listed in the manufacturers’ drug labels. However, after two decades taking the drugs, she’s had trouble quitting due to severe withdrawal effects—what drug manufacturers now acknowledge as “discontinuation syndrome.”

“I don’t believe they’re helping me,” she said. “I take them now because I have to.”

She graduated from the University of Virginia with a double-major in linguistics and classics, and returned in 2018 to do a master’s degree. However, feeling under mounting stresses at school, Autumn said she became “depressed and overwhelmed” and contacted the university student health department.

Over the next few months, Autumn got several mental health screening evaluations, lived at a residential treatment center for a couple of weeks, and attended individual therapy sessions. However, one day in 2019, a case worker, over Autumn’s protests, decided that Autumn was having more suicidal thoughts than normal. Autumn was abruptly taken by police to the University of Virginia hospital, where her clothes and belongings were confiscated and urine samples were demanded.

“You feel incredibly violated,” said Autumn. “So I turned into kind of a bitch. I was yelling at people a lot. I’ll admit, I was pretty pissy. You don’t show weakness coming from my background.” She was also worried about how much the hospitalization would cost her.

Autumn described being confined “in a tiny little ER room” with nothing to do and “a little commode full of your own feces” and “an obnoxious little [suicide-watch] babysitter sitting outside your door.” The hospital staff wanted to compel Autumn to take medications, but Virginia law required a hearing before a judge first, unless it was an emergency. Autumn’s medical records indicated that staff had an antipsychotic tranquilizer and sedative ready to inject into her, along with two other sedating drugs. “I was afraid,” said Autumn. “Then they would come around with more drugs. And I would think that this is the time that they’re going to actually do it [forcibly inject me]. And so that would make me freak out more, and I would cuss them out harder.” As the hours became days, said Autumn, the whole experience “was horrible. It was traumatic.”

* * *

Autumn’s descriptions of events barely differed from those written by hospital staff in the medical records. And it was clear she shared everything she told me of her personal history with the staff as well. She’d assumed that the staff would be reassured by her openness and by how well she understood and managed her distress, and they would let her go home.

But medical staff characterized things differently: Autumn didn’t exhibit a good understanding of how her childhood had affected her; rather, she’d admitted to having risky childhood “predispositions” toward severe mental illness. Autumn hadn’t managed reasonably well for many years, then wisely recognized her recent difficulties and appropriately sought mental health assistance; rather, staff wrote, Autumn admitted to having a long history of struggles, and was now nearing the breaking point, unable to help herself and desperately reaching out. And Autumn’s repeated assurances to medical staff that she was managing well enough with her current medication and therapeutic supports, had no intention of killing herself, and wanted to be released from the hospital and get back to school also got reframed: staff wrote that Autumn exhibited “poor insight” because she “believes she does not need to be here.” Essentially, all of Autumn’s insight and help-seeking were interpreted by hospital staff as *confessions* of long-standing and suddenly worsening severe mental illness.

Staff then surmised that Autumn might have manic-depressive or bipolar disorder and, using that framework, pathologized everything she did. When she looked at and engaged with them, staff described Autumn’s eye contact as abnormally “intense” and her speech as too loud, too fast, or otherwise not “appropriate”—symptoms of mania. Conversely, when Autumn didn’t look at or engage with staff, they wrote that Autumn would “stare off into space”—a symptom of dissociation and depression.

Staff also described Autumn as having frequent, bipolar-like, seemingly inexplicable ups and downs. Multiple entries, sometimes made over just a few hours, stated that Autumn would “swing from being deescalated right back to biting, dysphoric, and angry,” and could be heard “raising her voice and using obscenities,” then “sulking,” then “tearful and red in the face from crying.” Autumn’s emotional “impulse control” was clearly “impaired,” one note said, as she “gets irritable/angry very abruptly.”

But Autumn told me there was nothing inexplicable going on with her emotions; she frequently asked staff to let her go, and became upset when they instead threatened her with longer-term commitment. And indeed, several entries confirmed Autumn’s version: “When not talking about her frustration of being here [in hospital], she is pleasant and cooperative”; “Abruptly became irritable/angry and tearful when discussing recommendation for commitment.” At one point, Autumn specifically explained to staff that the detention and threats of committing her were what was making her emotional; nevertheless, they reframed that, too. Staff wrote that Autumn failed to recognize that her mental illness was causing her negative emotions, and was delusionally “externalizing” the cause of her distress by blaming the medical staff.

After three days, the hospital applied to court to commit Autumn for longer and forcibly treat her. Staff described Autumn as actively suicidal and as having “poor judgment” because she “does not comply with medical therapy.”

Many civil commitment lawyers I spoke with confirmed all of this is common. “Once you’re in the hospital, everything you do or say is considered a symptom,” said Alaska attorney James Gottstein. In medical records, he said, legitimate anger about something gets recorded as the patient being emotionally “labile” or “agitated,” not reacting is “flat affect,” and laughing cynically to oneself about it all is “responding to internal stimuli” like a self-absorbed madman. “It’s basically *Alice in Wonderland,*” said Gottstein.

“That’s how I felt the entire time I was there,” commented Autumn. “I was trying to explain that I was not a danger to myself. And they were saying, ‘No, Autumn, we know more than you. You’re insane. You’re totally gonna [kill yourself] the second you leave here.’”

Autumn compared it to situations in her childhood with authoritarian evangelical leaders. “The psychiatric community has this kind of power to decide what reality is and isn’t.”

The judge, though, ruled against commitment. Autumn was soon outside, waiting at the bus stop to go home. “It was so surreal,” she said. “What just happened?”

The experience shattered her. What if, in court, she’d become visibly upset, or hadn’t been white, accomplished, educated, and articulate? “I feel like, if you’re American, you believe that your civil rights are very, very secure,” she said. “Unless you do something terrible, unless you obviously break the law—in which case, you are entitled to a thorough and fair trial and lots of due process. And when something like this happens to you, and you realize that, no, your civil rights are hanging on a very tenuous thread, there’s just no telling what will make you get committed, it makes you very paranoid. I can never trust a mental health professional again.”

CHAPTER 5

“MINIMALLY ADEQUATE” CARE

In a landmark 1979 decision, the US Court of Appeals for the First Circuit acknowledged that Massachusetts psychiatric hospitals were “dirty, stark, austere and smelly.” Nevertheless, the court observed, these hospitals did not have “a dungeon-like atmosphere that would shock the conscience.” Therefore, the court concluded, though modern hospitals were “unpleasant places to be confined, to say the least,” being trapped in them did not trigger constitutional protections barring cruel and unusual punishment.

With seminal judgments like this, writes Michael Perlin in his treatise on mental disability law, the expected standards of care in psychiatric hospitals got set very low.

Other precedent court decisions, Perlin describes, have mandated that hospital staff who administer physical and chemical restraints should have “minimally adequate” training, and simply exercise “professional judgment” in their actions. Similarly, on almost every issue of patients’ rights, including the right to have visitors, communicate with the outside world, speak freely, or have privacy and patient-doctor confidentiality, courts have upheld these basic civil liberties but always with a caveat: “except where special restrictions are imposed by a qualified treating mental health professional.”

Consequently, even as there’s a major cultural effort underway to “get the mentally ill out of prisons” and into psychiatric institutions, people who’ve been incarcerated in both often remark on how they had more rights and freedoms in prisons. A potent example: Peer activist and former patient Jonathan Dosick doggedly campaigned for years to get Massachusetts psychiatric patients the right of daily access to fresh air. Daily outdoor access is a right that convicted criminals in prison and organic livestock have; but hospital administrators, mental health professionals, unions, and the hospital industry declared that providing fresh air for psychiatric patients was unnecessary, costly, and too risky. After more than a decade of battles, in 2015 a new Massachusetts law did get passed, stating that psychiatric patients should be allowed "reasonable" access to air "as determined by the treating clinician."

Unlike criminal sentences of fixed duration, civil psychiatric detentions can be indefinitely renewed and, ultimately, virtually any other rights can be waved away if a doctor believes your rights aren't good for your mental health. One's right to sue is also constrained. "[T]ort remedies are generally not available to persons aggrieved by misuse of the involuntary civil commitment process," writes Perlin. The US Supreme Court has upheld special immunity for mental health professionals, and many jurisdictions have also explicitly legislated broad immunities. Courts have further determined, writes Perlin, that a mental health professional is not liable for egregious errors, so long as "he does what he thinks is best after careful examination." Civil commitments are merely expected to meet accepted medical standards—standards that currently include unreliable diagnoses, vague commitment criteria, incarceration, seclusion, physical restraints, and forced treatment.

One of the main drivers of rising rates of psychiatric hospitalization is that most people who admit themselves, or call 911, or take someone to a hospital, assume there will be high-quality help. In fact, the standards of care vary vastly; landing in any psychiatric hospital is risky.

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The American Psychiatric Association did not respond to repeated requests for interviews about civil commitment. But James, a psychiatrist who currently works in emergency rooms and as a consultant at several hospitals in Texas, acknowledged that the criteria for involuntary psychiatric admission and forced treatment have many "grey areas." Consequently, the line between well-intentioned, responsible professionalism and potentially harmful abuse can become unclear.

Much of what drives psychiatric detentions, said James, isn't the diagnosis or a person's current situation so much as imaginings about the future. "An emergency room is very much like a legal job; it's risk mitigation. Do we want to be responsible? How dangerous would it be for [the patient], for me, for my medical license, for the emergency department, if we were to let this person go?" Some psychiatrists are more risk averse, and if they believe they can help someone—even when the person doesn't meet commitment criteria—James said they may decide, "I'm just going to admit this person, because no one's going to come and take my license away after admitting them."

Meanwhile, psychiatrists have different levels of willingness or time to try to tackle complex underlying problems in people's circumstances. "Sometimes," said James, "it's a hell of a lot easier to send someone to an inpatient unit than to put together a plan for, 'Where are you going to stay? How are we going to solve these XYZ social issues, medication issues, financial issues?' I can just kick that can down the road."

And commitment hearings, he said, are routinely unfair. "In all of my experiences, I never saw a judge rule against the psychiatrists. Public defenders and judges don't seem to question us much."

Yet psychiatrists' decisions about forced treatment have strong subjective components. James described people who get into energetic or "manic" states and enjoy how they're feeling, but are acting in ways that could lead to drained bank accounts, lost jobs, or broken relationships. Antipsychotics can temporarily "put the brakes on," he said, but over the longer term, predicting people's actions and the future impacts of the drugs is "not clear cut."

Many people have just one of the experiences associated with psychosis or schizophrenia, such as hearing voices, having strange beliefs, or feeling afraid of others' intentions, but are otherwise lucid and competent. Some may do strange, disruptive, or risky things—but only very rarely. Forcibly drugging such people can backfire, he said. "They're sharp. They're funny. And you're giving them this medication, and they hate it. This is totally ruining the rapport between them and the psychiatrists and the staff, and they're not improving."

James believes that involuntary hospitalization can sometimes help people—for example, temporarily take a person out of harm's way, calm someone down, give time for a meth-induced psychosis to pass, or help a person get some sleep, reset, and get medications adjusted and community supports rallied. "But it's very easy for me to see how, for some individuals, it could lack any benefit and in fact be damaging," he said.

In particular, overdrugging is common. "It's a big problem in psychiatry. I see so many drug side effects. I see so much akathisia manifesting in different ways. So many different drugs can cause psychiatric problems." Akathisia is a very common adverse effect of antipsychotics and some other psychotropics. A sensation of discomfort, irritability, or agitation inside one's own body that moving cannot alleviate, akathisia can sometimes become so persistent or severe it causes suicidal feelings and violent rages. Akathisia can also be severe during sudden withdrawal from psychiatric drugs—shedding a different light on why otherwise peaceable people may sometimes become violent when they've "gone off their meds."

During his psychiatric residency at a Texas university, James said he was taught relatively little about adverse drug effects—a startling fact that other, current psychiatry students in the US and Canada confirmed to me. "It's something that you learn on your own, if you're curious. Otherwise, you don't learn it at all; you get taught to diminish it." Whenever patients' conditions worsened on medications, he was taught to see that as "treatment resistant" illness, or the emergence of new mental disorders—and to drug people more.

James has never worked anywhere he thought was "purposely" abusive, but he frequently sees patients "inadvertently" made worse when their real issues are poverty, homelessness, substance abuse, domestic conflicts, fixed beliefs, or other kinds of problems that are "unresponsive" to medication. "The things that I see that are really bad are when people are aggressively treated with multiple psychiatric medications, and new-onset adverse effects are missed, and they've developed akathisia or they're overly sedated or medicated into a state of cognitive impairment. That really gets under my skin."

Too often, James said, he's trying to solve with drugs what are actually complex mixes of personal, social, and economic problems needing diverse community responses. "It feels more like a 'helpless situation' in 50 to 70 percent of folks. Some days you feel like you're really helping people. And other times you feel like you're watching a slow-motion train wreck that you're powerless to stop."

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The blurry boundaries between responsible care and harmful abuse are still more evident when viewing psychiatric institutions and systems as a whole.

All psychiatric hospitals are subject to government regulations, yet can elude routine government inspections by joining a third-party accreditor like the Joint Commission, which keeps inspection reports secret. A 2019 *Seattle Times* investigation found that six for-profit psychiatric hospitals in Washington had officially reported just fifteen serious adverse events over three years to state regulators—while in fact there'd been more than 350 incidents "in which patients or staff were assaulted, suffered an injury, attempted suicide, escaped or died suddenly."

In 1986, Congress enacted the Protection and Advocacy for Mentally Ill Individuals Act, funding and empowering "Disability Rights" nonprofits in every state to investigate individual and systemic cases of neglect and abuse, and pursue legal remedies for people with disabilities. Reviewing just the past five years alone, investigations by these disability rights nonprofits and others show systemic abuses of civilly committed patients occurring in institutions around the country involving countless issues of concern. Regional news media tend to portray these as unusual situations—there's a severe dearth of attention on the whole national picture. Yet it's actually difficult to find any state that *does not* constantly have many psychiatric hospitals with serious, ongoing problems. Once people are detained under mental health laws, their utter disempowerment evidently creates an institutional environment ripe for abuses.

* * *

Entrenched cultures of abuse, cover-ups, and retaliation? In 2014, in response to endemic problems, Portland, Oregon's entire psychiatric hospital system was revamped. By 2018, though, state and federal investigations of the new facilities revealed sexual assaults, patient neglect, overdrugging, untrained staff administering restraints, ignoring of patient complaints, preventable patient deaths, and management retaliation against staff who raised concerns. As the main hospital nearly lost its accreditation in 2018 and again in 2021, it was revealed that Portland had based its new system on a California model that had itself been overwhelmed by similar problems for years. Similarly, according to the *Anchorage Daily News* in 2019, Alaska's only public psychiatric hospital almost lost its accreditation after it was "the target of multiple investigations by federal regulators that found serious and widespread problems ranging from slow responses to sexual assaults to excessive use of restraints and seclusion rooms."

Ignoring rules for chemical restraints? In 2016, Disability Rights New York (DRNY) used multiple sources of data to investigate Bellevue hospital practices. "Troublingly," DRNY found, the records Bellevue publicly reported "massively undercounted" uses of restraints. Bellevue staff's "disturbingly erratic" documenting failed to comply with laws aimed at lowering uses of chemical restraints, wrote DRNY. Bellevue's records indicated that staff forcibly tranquilized their few hundred patients either zero times daily, or thirty-six times daily, or 270 times daily.

Institutionalized racism? Disability Rights California sued Alameda County in 2020, having found that area hospitals forcibly detained people "at a rate more than three-and-a-half times California's statewide average." Relative to population size, Black residents were targeted for repeated hospitalizations five times as often as whites.

Abusive uses of seclusion? In 2016, Disability Rights Montana found that some civilly committed patients at Montana State Hospital had been locked in seclusion for nearly twenty-four hours a day for a year—authorized by psychiatrists as "treatment."

Skyrocketing uses of restraints? A 2020 report from Disability Rights DC (DRDC) found that at Washington's St. Elizabeths Hospital, between 2012 and 2018, the use of locked seclusion inexplicably increased nearly tenfold and restraints more than 150-fold. Incidents captured on video showed patients merely attempting to speak with staff, passively wandering, or lying down—and then being set upon by multiple staff members and dragged, stripped, strapped down, and forcibly injected with psychotropics in ways that, DRDC wrote, "appear routine, punitive and dehumanizing."

Staff immunity? In 2018, Disability Rights Florida learned that complaints of hospital security guards abusing patients were being ignored. The health department had decided that guards were not by law "caregivers" and therefore the department didn't have to investigate.

Ignoring even attorneys' rights? In 2019, the Arizona Center for Disability Law finally won its lawsuit against both the Arizona State Hospital and the state government; for years, hospital officials had been illegally blocking federally mandated disability rights attorneys from even entering the facility or talking to patients.

Abusive strip searches and cover-ups? In 2019, Disability Rights Washington (DRW) sued several psychiatric facilities for unnecessary strip-searching and video recording of hundreds of teen and adult patients. According to the DRW court submission, one victim of previous sexual abuse was ordered to "pull her underwear down to her knees, bend over, squat down, and spread her vagina and behind for a cavity search." The woman started "shaking and crying" and "curled up in a ball on the floor." A staff member threatened to get a man to forcibly finish the cavity search. After the patient formally complained, the video footage from multiple cameras disappeared.

Cultures of child sexual abuse? Criminal charges and a 2020 lawsuit from families of twenty former patients alleged that both the medical director and psychotherapist at a Virginia psychiatric hospital engaged in sexual abuse of children for a decade, despite repeated complaints. Similarly, Disability Rights Texas (DRTx) has been raising alarms about abuses of children in Texas hospitals and juvenile facilities since 2013. DRTx described a psychiatrist who was allowed to continue working even after the eighth allegation against him of sexual abuse of children he was treating—allegations going back twenty years. After conducting a statewide investigation, DRTx found that the state health department "hired and continued to employ physicians despite reports of abuse and neglect, restricted medical licenses and criminal convictions" and "routinely discounted the credibility of the alleged victims . . . due to their mental illness."

Patient dumping? In 2018, the Nevada government and state hospital were penalized $9 million because hospital staff had been sending patients on one-way bus trips to other states. In one case reported by the *Sacramento Bee*, the psychiatrist's discharge order said the patient should be given supplies of antipsychotics, sedatives, antidepressants, and "snacks for a 15-hour bus ride." The patient was instructed to "call 911" when he arrived in Sacramento. Nevada's state hospital, between 2008 and 2013, bused 1,500 patients to other states just to get rid of them; many became homeless, some went missing, and others died. Former patients told of similar practices in other states.

This list goes on. And on.

There's scant funding for systemic investigations in Canada, but the few that do occur are equally disturbing. A 2017 investigation by Vancouver's Community Legal Assistance Society found that tranquilizing and putting newly admitted patients into seclusion and shackling their wrists and ankles was "a standard admission practice" in some hospitals, while "rights violations and procedural unfairness" had "flourished" across British Columbia "in the absence of systemic oversight." In 2019, the New Brunswick Ombud found that patients at the province's main psychiatric hospital were "victims of negligence, abuse, and unacceptable treatment" due to "deeply entrenched" systemic problems.

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Jennifer Mathis of the Bazelon Center for Mental Health Law said there are actually *far fewer* of these types of systemic lawsuits against psychiatric hospitals going on than in previous decades—but not because hospitals have improved. It's true, she said, that involuntary psychiatric patients in America are "no longer locked in cages getting hosed down"; nevertheless, the low expected standards that courts have set have contributed to many organizations in the disability community like Bazelon focusing less attention on suing hospitals.

"After decades and decades of litigation, you don't really make change that lasts," said Mathis. "These places are awful, and you could make them a little better for a little while, and then the litigation ends at some point and they go back to being what they were. You'll never make these places good."

For Mathis, a lastingly illustrative case was the Department of Justice's 1995 lawsuit against Pennsylvania's Ebensburg hospital. "The place was so horrible. I used to call it the 'maggots and blood' case," said Mathis. The court found ant infestations, people dying from improperly treated medical conditions, widespread overdrugging, and one resident with an infestation of maggots in his ear. "There were mounds and mounds of evidence," said Mathis. "But the DOJ lost the case."

Consequently, she said, Bazelon and most other disability-rights organizations now focus more "on getting people out and keeping people from going in."

* * *

So, does even government know whether the majority of psychiatric hospitals are reasonably good or systemically abusive?

In 2014, the Centers for Medicare & Medicaid Services and the Joint Commission set out, for the first time, to systemically track a handful of quality-of-care concerns across all American psychiatric hospitals. Yet stunningly, they decided not to track what would arguably be the most revealing indicator: the percentage of patients that specific hospitals forcibly prevented from leaving. In any case, the first review, conducted by Harvard researchers, found "wide variation in performance by hospitals on most measures." With no established criteria for proper or improper uses of seclusion, overuse of physical or chemical restraints, or overmedicating with multiple psychotropics simultaneously, the authors said they didn't know how to interpret the data. A 2020 study in *Psychiatric Services* also found that rates of seclusion and physical restraint varied by factors of five or ten times, for reasons seemingly unrelated to the types of patients the hospitals were serving. A *Health Affairs* paper concluded, “Inpatient psychiatric care has been left on the sidelines of efforts to measure and improve patient safety, despite glaring need.”

This “studied ignorance” is global. A 2019 review in *BMJ Open* identified only nine “good” quality studies examining standards of care in psychiatric hospitals across thirty-one countries and twenty years. “Patient safety in inpatient mental health settings is under-researched,” the authors commented.

So are governments and treatment providers rising up to assure us that they’ll crack down on abusive hospitals and uphold the highest standards of care?

Early drafts of former representative Tim Murphy’s (R-Pennsylvania) Helping Families in Mental Health Crisis Act, passed by Congress in 2016, would have massively cut funding to state Protection and Advocacy disability rights organizations, and barred them from conducting systemic investigations and lawsuits of the kinds described in this chapter. Murphy also intended to ban them from lobbying to improve laws. Only sustained pressure from patients’ rights groups got those provisions changed.

In 2019, the National Association for Behavioral Healthcare (NABH), a lobby organization for 1,800 inpatient psychiatric treatment providers, issued a report called, “The High Cost of Compliance.” The NABH acknowledged that 80 percent of their member psychiatric hospitals had recent health and safety citations against them—so NABH argued that a slew of regulations should be abolished.

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Problems in psychiatric care are compounded by the fact that health staff in hospitals are in self-regulating professions that are notoriously protective of their members. Public Citizen, which annually monitors the reports of medical licensing boards and health institutions to the National Practitioner Data Bank, has described the system as “dangerously lax.” For example, of the more than eight thousand physicians with five or more malpractice settlements against them, three-quarters have never once even been reprimanded—and it’s impossible for the public to find out who they are. Public Citizen argued that state medical boards need a culture-change “so that their first priority is to protect the public from incompetent or miscreant physicians, not protect the livelihood of questionable physicians.”

In Canada, a 2003 provincial ombudsperson investigation similarly found that physician and nurse professional licensing bodies "do not appear to have fully accepted or understood what it means to act in the public interest." Seventeen years later, the government acknowledged that the problems "have persisted." Similarly, in 2018, the *Toronto Star* found that, across the country, licensing bodies "keep an ocean of patient-safety information hidden."

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The American Psychiatric Nurses Association did not respond to repeated requests for interviews. One of the few psychiatric nurses to speak out publicly about civil commitment standards of care is Jonathan Gadsby, cofounder of the Critical Mental Health Nurses' Network and coeditor of *Critical Mental Health Nursing: Observations from the Inside*. Gadsby worked as a psychiatric nurse in the UK, and now teaches at Birmingham City University. Reflecting on why so few nurses speak out, he told me, "I don't think that nurses have yet been able to really talk about this properly amongst themselves. This is a very painful set of issues."

Like James, Gadsby sees inpatient psychiatric care as an overly "medicalized" system trying to use drugs to address or suppress problems often caused by interplays of personal challenges, social conflicts, and economic inequities. "I think that understanding oppression of all kinds needs to be part of understanding mental health," said Gadsby. Nurses often appease themselves by saying forced treatment is only a "last resort"—but, he said, "They haven't tried anything else. There's one system for everyone. There's usually no alternative."

In that context, he said, psychiatric nurses are just part of a bigger, hierarchical system of social control. Gadsby said he's aware of rare situations—such as a fight on the ward—for which staff need training in responsible physical interventions. But over the years he felt like he was frequently administering forceful interventions on people only because other staff believed it was necessary or right. "You have to work with others. If you're always the difficult one in the team about this, then that's very hard."

Consequently, Gadsby suspects that hospital psychiatric care can never improve unless nurses start speaking out. "We are the biggest facilitators of the mental health system, the biggest by number," he said. "So, what happens there happens because we do it."

For Gadsby, psychiatric care must become more "democratic" and respectful—not only for patients, but for nurses, too. Although not many nurses dare risk their jobs by openly resisting, Gadsby believes that many inwardly struggle with forced treatment. While he's seen some nurses "getting off on the power of it," others are so traumatized that they quit to work in other settings. "They vote with their feet." He believes nurses should have the right of "conscientious objection," and has helped start a campaign to put pressure on nurse licensing bodies. "I believe that the emancipation of service users and the emancipation of nurses is a linked project," he said.

Gadsby recalled one experience that was pivotal in making him depart for teaching. A petite woman of eighteen had been admitted to the hospital experiencing intense fear. "I remember her like a mouse, very, very frightened." She managed to remove a windowpane and escape. Gadsby ran after her, across the road and into a parking lot. UK psychiatric nurses often don't wear uniforms, and just as he grabbed the fleeing woman, police appeared and rushed toward Gadsby, shouting at him. "There was this moment in which I had to explain to them that this was the kind of 'man chasing young woman in a car park and grabbing her' that was the *right kind* of 'man chasing young woman and grabbing her,'" said Gadsby. However, he told me, he actually wasn't so certain. "To this day, I think how awful that would have been for her, to have this guy at six foot four thundering after her."

When his student nurses first participate in forcibly treating someone, he said, the most sensitive and thoughtful "become horrified" and switch specialties. But, he asked, who does that leave to do the job?

PART TWO

CORE DRIVERS OF CIVIL COMMITMENT

CHAPTER 6

“YOU ONLY FIGHT BACK ONCE”: PSYCHIATRIC POWER AND PREJUDICE

“It’s a vulnerable thing to open up,” said Louise, an Indigenous woman from a Coast Salish nation of the Pacific Northwest, whose traditional territories span Oregon, Washington, and British Columbia. “In a way, it’s really scary to talk to you. But at the same time, part of the reason I’m willing to do this is, I want to give a sense of comfort to other people who are experiencing the same kind of fear as I do.”

As Louise began her story, it sounded similar to how some non-Indigenous people tell their stories of mental health problems. At age thirty, Louise gave birth to an unplanned child. Amid other mounting stressors in her life, she plunged into postpartum depression, which morphed into psychosis. She landed in a psychiatric hospital. After that, there were stable years, and years of instability and hospitalizations. Eventually, she said, she recognized that she has bipolar disorder, and now accepts an antipsychotic injection every month while she gets her life and career back on track.

As Louise and I became more comfortable with each other, though, she began to relay her perspectives differently. It became clear that her Indigenous heritage, and contemporary Indigenous political issues, had influenced many aspects of her experiences.

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To understand how and why the psychiatric incarceration system is expanding into ever more people's lives, it's important to understand what the system's core functions have been historically. Many of those functions continue to operate in adapted forms today. In these next three chapters, we'll investigate some of the system's main cultural, political, and economic drivers.

The first major expansions of the modern mental health system are usually placed in Europe in the 1600s. As philosopher and historian Michel Foucault describes in *History of Madness*, all manner of people considered insane, unduly different, disabled, incurably physically ill, impoverished, disruptive, troublesome, revolutionary, or criminal were housed together in prison-hospital institutions. Essentially, a core function of civil commitment has always been social control, and state "hygiene" laws and powers have always been intertwined with dominant cultural prejudices. What's varied across eras is how much is proclaimed to be for protecting societal standards versus helping people "for their own good."

One of the most well-known, recent examples: homosexuality was considered a mental illness until mass protests prompted American psychiatrists to remove it from the diagnostic manual in the 1970s (some of the older people I interviewed for this book had been forcibly treated for homosexuality). Other cultural-political influences, such as racist tendencies, have continued to this day.

The social influence of the medical professions grew substantially in the nineteenth century, and with it the idea that a subclass of humanity had specific "diseases" of the spirit, mind, or brain. Foucault suggests that Western civilization itself in some ways "created" many modern maladies and shapes and definitions of madness, in part by establishing ever stronger strictures around acceptable behavior. In any case, physicians began to conduct all manner of "great and desperate cures" through bloodletting, brain surgeries, electrical shocks, extreme hot and cold baths, insulin and barbiturate comas, and more—usually without patient consent.

During that period, proponents of psychiatry, eugenics, and fascism began to recognize their mutual affinities. Many well-to-do white people were attracted to the idea of having genetic superiority and needing to protect themselves from "others," and psychiatry readily provided rationalizations. In 1934, a *New York Times* article hailed the "great nation" of Germany for sterilizing all manner of degenerates, including schizophrenics, to "improve its future population in a wholesale manner." Adolf Hitler and other Nazis openly acknowledged drawing inspiration and support for their genocidal policies from American eugenicists and psychiatrists, and the role of psychiatry has generally been described as "central and critical" to Nazi ideology and the ensuing mass incarceration and extermination programs.

American psychiatrists had a head start in developing ideas of genetic superiority through their close collaboration in colonialism. In *The Protest Psychosis: How Schizophrenia Became a Black Disease*, psychiatrist Jonathan Metzl traces the history of psychiatry's attitudes toward African Americans, and the connections to oppression and forced treatment, through many now-notorious examples. In the 1850s, writes Metzl, mainstream American psychiatric thinking held that "African American slaves who ran away from their white Masters did so because of a mental illness called drapetomania." Another mental disorder common to the "inferior race," white psychiatrists explained, often caused symptoms of "rascality" that could be therapeutically treated with whipping. Early in the twentieth century, Metzl notes, some leading academic psychiatrists were still declaring that African Americans were "psychologically unfit" for freedom. Then, as the civil rights movement emerged in America in the 1960s, its leaders became targets for mental illness labels.

Schizophrenia had long been characterized as a disease of harmless, anemic debilitation that predominantly plagued women. Women as a group, too, have historically been subjected to special psychiatric control efforts, and early in the twentieth century they often comprised the majority of inmates of US state psychiatric hospitals. In reviewing records of one major hospital, Metzl found reasons for commitment of women explained as, for example, "this patient wasn't able to take care of her family as she should," or "this patient is not well-adjusted and can't do her house work," or "she got confused and talked too loudly and embarrassed her husband."

Between the mid-1950s and 1970s, Metzl found, the demographics of hospital inmates shifted away from women and toward rebellious African American males labeled as having schizophrenia, now based on alleged symptoms of "paranoia" and "dangerousness." Metzl also points to prominent psychiatric writing describing a common symptom of schizophrenia as a "protest psychosis" exhibited by "hostile and aggressive feelings" and "delusional anti-whiteness." This especially dangerous form of schizophrenic illness, two psychiatrists explained in the esteemed *Archives of General Psychiatry*, could develop after listening to Malcolm X, converting to Islam, or aligning with resistance groups.

Metzl describes how even the FBI embraced the trend. They declared

Malcolm X to have “pre-psychotic” paranoid schizophrenia, and distributed wanted posters describing civil rights activist Robert Williams as a violent schizophrenic. Still in the 1980s and ’90s, studies showed psychiatrists diagnosing this purported dangerous paranoid subtype of schizophrenia in Black men five to seven times more often than in comparable white men.

Most contemporary studies suggest that, in predominantly white Western countries, people of color are often much more likely to get committed—and even more so immigrants of color with poor English skills or different cultural standards and spiritual beliefs. In North America, the lack of reliable data on civil commitments prevents the formation of nationwide overviews, but in recent years some cases have sparked headlines due to how obviously prejudicial they seem. Frances Chan, an Asian American woman, went for a breast-cancer check-up at Yale University’s clinic, then had to force-feed herself junk food for weeks because doctors felt her natural stature was too slim. Kamilah Brock, a Black woman, argued with a New York police officer after her impounded vehicle was apparently lost, and got committed for nine days. The police officer had doubted she actually owned an expensive BMW, and one of the jurors in her failed lawsuit later said to media that Brock showed too much “grandiosity” in touting her life and career accomplishments.

The ongoing racism throughout psychiatry has generally been so well documented that, in 2021, the American Psychiatric Association issued a formal confession. “We apologize for our role in perpetrating structural racism in this country, and we hope to begin to make amends for APA’s and psychiatry’s history of actions, intentional and not, that hurt Black, Indigenous, and People of Color,” said APA president Jeffrey Geller. Very recently, the APA acknowledged, a study had presented vignettes to APA members, and contemporary psychiatrists still “diagnosed more Black than white patients with schizophrenia, even when both had otherwise identical vignette-style clinical presentations.” Nearly 70 percent of current APA members said they’d observed racism in psychiatric care.

The APA noted that stereotypes in psychiatry have included characterizing Black patients as “hostile,” “unmotivated for treatment,” and “child-like.” The APA seemed oblivious that this prejudicial characterization reflects how psychiatrists tend to describe all patients they civilly commit: dangerous, not recognizing their need for treatment, and in need of paternalistic assistance. And such obliviousness appears endemic among psychiatrists—the APA conducted four surveys of its members for suggestions about the most important ways racism in psychiatry could be reduced, and protecting patients against racialized incarceration and forced treatment was never mentioned. On the contrary, psychiatrists consistently ranked the top priority as increasing the numbers of people of color getting psychiatric services.

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Through much of the nineteenth and twentieth centuries, in both the US and Canada, there were deliberate efforts to weaken and displace Indigenous peoples to open their lands for resource exploitation and white settlements. As part of this, generations of Indigenous children were abducted and put into white-run residential schools or foster homes, many rife with physical and sexual abuse. The overrepresentation of Indigenous children in foster care continues today in both countries.

Louise told me that she believed her purported mental disorder originated not in her genes but in this racist history. As an infant, she was taken from her Indigenous parents and put into foster care, where she suffered abuse. She later saw in child welfare records that, at one point, she nearly died from dehydration and her throat was so damaged she could not eat for six weeks. She believes these early traumas may have harmed her brain. “I don’t handle unremitting stress over long spans of time well,” she said.

Louise’s childhood experiences also politicized her. By her twenties, she’d become a writer, speaker, and activist on Indigenous rights. And the demands and stresses of protesting, public speaking, and becoming a target of criticism contributed significantly to her giving up her baby and then plunging into depression.

Louise wanted a better life for her unplanned child, and she chose the non-Native adoptive parents in California because of their values. Still, she soon felt horrified by the idea that she’d repeated with her own child what had been done to her.

Louise convinced herself she could return to California and undo what had happened. “The way I understand it now is, it was just easier for my mind to believe that the adoption had not taken place.” But after arriving back in California, escalating anxiety led to her instead getting psychiatrically hospitalized for the first time.

Though she’d initially described herself to me as delusional during that period, Louise eventually clarified that she didn’t truly believe in the dominant

Western framework of mental illness—at least, not fully. Instead, this framework had been forced upon her, and over time she'd learned to speak and behave in conformity. "It really depends who I'm talking to," she said.

For example, she actually thought of her "delusion" as simply a "story"—not unlike any partly made-up story we might tell ourselves about the apparent reality of the world. It's mainly the intensity of "pushback" from others, she suggested, that determines whether a particular story is considered reasonable and acceptable. If California had a legal method for returning adopted infants within a short period to regretful mothers—or even a prominent movement of people lobbying for such a law—her belief and wishes could have been considered common and understandable.

Louise also didn't think of herself as dangerously mentally ill and in need of detention. So, on her second day at the hospital, she went outside to get some air, and then went for coffee. About three hours later, Louise returned. "I was immediately surrounded by six security guards, and they held me down, injected me, and put me into this room. I didn't know what was going on, I didn't understand, and I fought back." Her next memory is of waking up three days later. "I was literally drooling, groggy, and I had bruises all over my arms and legs from where they'd held me down."

Louise concluded: "You only fight back once. Ever since then, if I've ever had any issue in the psych ward or wherever, in terms of whether I'm going to be compliant or not, I make it very clear: I'm compliant. I'm not refusing anything." And that means, she said, sometimes embracing psychiatric labels and drugs.

Louise said she's had many experiences of her own culture's approaches to understanding pain and healing getting pathologized.

Her religious beliefs often become heightened when she's in extreme states, she said, and "are seen as extremely weird" by white psychiatrists. For example, during one difficult period, the police were twice called, and let her be. But when she gave her bank card to a distraught friend to take the last money she had, that got her hospitalized. "Yet that is totally consistent with Coast Salish practices. They would think that's a really honorable thing to do, to take care of a family that's in mourning and a child that's hungry."

Another practice from her culture is to wear a covering or bandana over the head when sick. "You do that because, in our beliefs, that's where your spirit comes out of your body. And it's sharp. If you're in pain, or you're hurting, that sharpness can hurt other people." But the belief that one's own eyes or energy can hurt other people is listed in the *DSM-5* as a schizophrenic delusion, and in the hospital her explanations got the bandana taken away.

A medicine woman advised Louise that, when in distress, she should visit “the big house.” In the Coast Salish big house, explained Louise, caring people stay constantly with the distressed person. They provide support and encouragement along with carefully prepared, healthy foods, and participate together in spirit dancing to invite the ancestors “to come back to life through us and mourn and lament and cry.” Conversely, though, psychiatric hospital staff have always isolated her from community, labeled ancestral voices as hallucinations, and degraded more than encouraged her. In many ways, her experiences in psychiatric hospitals have been “an outrageous affront to my spirit, my sense of self,” she said. “It’s inhumane how they treat you in there.”

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Most Indigenous people who get forcibly treated are struggling with substance use or suicidal feelings related to their experiences of social oppression, said David Edward Walker. But biological models of mental disability and the alleged need for forced treatment were getting imposed on Indigenous peoples long before psychiatry’s recent hypotheses about brain chemical imbalances. A longtime psychologist on the Yakama Nation in Washington, Walker is partly descended from a Cherokee family that got tribally disconnected during the forced relocations along the 1830s’ Trail of Tears, and recently authored *Coyote’s Swing: A Memoir and Critique of Mental Hygiene in Native America*.

“The eugenics movement in the US was a tremendous moneymaker for early applied psychologists,” said Walker. “Psychologists were making their bread and butter doing testing and research.” Racist-influenced mental health professionals developed theories that directly contributed to the rationale for taking Native children from their families and placing them in foster care or residential schools, added Walker, and they also had “enormous influence” on the training of Indigenous children for servitude.

When Walker and I were talking, the unmarked and disappeared graves of hundreds of Indigenous children had recently been discovered near several former residential schools in both the US and Canada. I asked Walker if he was saying that these residential schools were essentially mass-scale forced mental health treatment programs that became brutally abusive. “I absolutely am,” he answered.

With such historical roots that continue to influence our society to this day, said Walker, seeing a contemporary Native person suffering and then asserting that the person has a brain disease is a harmful way of "individualizing" their pain. "As soon as you do that, you have made invisible the social phenomena. As soon as you've erased all that, and you've located their problem inside their bodies, you've engaged in an enormously racist and oppressive act."

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At the time of her first hospitalizations, Louise suspected she was being persecuted in part for her beliefs and activism. She knew of two crusading attorneys for Indigenous land rights, Bruce Clark and Jack Cram, who'd been forced into psychiatric hospitals amid prominent, confrontational challenges with judges, with an enormous discrediting effect on their careers.

In hindsight, Louise isn't sure; nevertheless, political impacts occurred, anyway. "It's put a straitjacket on my mouth, on my writing, on my willingness to take certain positions, because I know at any given point in time, I'm just three or four sentences, the wrong sentences, away from being locked up again."

The first time we spoke, Louise considered going public with her real name. But she started consulting for the courts on racially sensitive criminal sentencing, and worried her psychiatric history could be used to discredit her opinions. "I have more to lose now," she said.

CHAPTER 7

“HOUSING FOURTH” AND THE MYTH OF DWINDLING HOSPITAL BEDS

“The emerging pattern of violence is clear,” claimed a 1998 *Wall Street Journal* article, “Why Deinstitutionalization Turned Deadly.” Its authors drew pictures of “increasing numbers of severely mentally ill individuals” with no hospital beds for them, instead “loitering in parks, public libraries and transportation stations” and “incarcerated in jails and prisons for offenses committed while psychotic.” The authors wrote darkly that it was therefore “not a question of whether” another murderer would emerge from among these people, but “merely a question of when.” So, they concluded, “If we hope to stem this tide of unnecessary violence and preventable tragedies, we will have to address squarely the issue of involuntary treatment.” From 1998 to 1999 alone, versions of this same article appeared in syndicated newspapers and dailies in dozens of states.

Starting in the 1950s, many large, long-term mental institutions were shut down, with the intent of liberating people from oft-decrepit asylums, and helping them live more freely and integrated into their communities. Today, there’s arguably no bigger driver of public sentiment and political will to expand forced treatment than the characterization of these deinstitutionalization efforts as a disaster, and the strange mix of compassion for, and fear of, “the violent mentally ill” it has engendered alongside beliefs that shortages of psychiatric beds have caused rising homelessness and imprisonment.

“Bring Back Asylums?” asked a 2018 article in the *New York Times*. Journalist Benedict Carey explained that “the number of public psychiatric beds available has plunged, to 11 per 100,000 people from 360 per 100,000 in the 1950s." And, declared Carey, the "downstream consequences" of this deinstitutionalization "are now generally accepted" as fact: "Homelessness swelled . . . [and] an increasing number of people with mental disabilities landed in prison."

"A severe shortage of inpatient care for people with mental illness is amounting to a public health crisis," agreed NPR. "The disappearance of long-term-care facilities and psychiatric beds" means people diagnosed with mental illnesses "find themselves homeless or more and more in prison."

A PBS television production declared jails and prisons "The New Asylums." In an inflammatory article about schizophrenic murderers, the left-leaning *Mother Jones* reported that the consequences of deinstitutionalization are now so well known that "Homelessmentallyilldeinstitutionalized" has essentially become a compound noun.

In conservative media, the same story: A 2018 *National Review* article stated that hospital downsizing left states "impotent in the face of exploding homelessness and the mass incarceration of the mentally ill that have inevitably followed." A 2019 *Breitbart* article stated that deinstitutionalization "led to streets and prisons filled" with the mentally ill.

Innumerable media outlets from *Kaiser Health News* and *BMJ* to *Vox*, *Washington Post*, *Slate*, the *Daily Beast*, *Bloomberg*, and *Time* have continually blared a 2014 report's findings: "Jails house ten times more mentally ill than state hospitals."

In Canada, too: The mentally ill "went to the streets and into the jails" stated an article in the national *Globe and Mail*. "A lot was wrong with the old asylums. But mass deinstitutionalization has been a tragedy."

This same narrative drives political lobbying. A 2020 article in *Psychiatric News* described how representatives of the American Psychiatric Association were ringing "alarm" to Washington legislators that a "drastic" and worsening "shortage of inpatient beds" was driving a "mental health crisis" spreading "to the nation's city streets and to its jails and prisons."

And all of this is blamed on people too easily evading involuntary treatment. In a 2018 presentation, senior Substance Abuse and Mental Health Services Administration (SAMHSA) leader Elinore McCance-Katz described the dwindling beds in state hospitals and claimed that "commitment criteria make it nearly impossible to be admitted involuntarily," so people cycle through "unstable housing, justice involvement, risk for incarceration."

At a time when political parties and polarized news media generally cannot seem to agree on whether one plus one equals two or qualifies as a conspiracy theory, it's remarkable that this singular political narrative has gained such wide traction.

The story's enduring popularity over the past thirty years is all the more remarkable considering that virtually all of its key "facts" are demonstrably misleading or incorrect. When we track the origin of the viral misinformation, though, the real political agendas at work become clear.

* * *

Every one of the above-mentioned stories cited and/or quoted the same key source: psychiatrist E. Fuller Torrey and the organization he founded and still today sits on the board of—Treatment Advocacy Center (TAC). And Torrey and former executive directors of TAC coauthored the 1998 *Wall Street Journal* article and the 2018 *National Review* article.

University of Illinois criminologist Liat Ben-Moshe raises questions about this dominant narrative, and similarly observes in her 2020 book *Decarcerating Disability: Deinstitutionalization and Prison Abolition*, "It is quite troubling that almost every document written about this axiom of prisons as the new asylums, and the 'mentally ill in prison/jail' since the 1970s has referenced, was authored, co-authored, shadow authored by, or otherwise involved Torrey or the Treatment Advocacy Center."

Torrey's personal prominence may be diminishing now that he's in his eighties, but there's no single person who's been more directly responsible for beating the drum of deinstitutionalization-as-disaster—and for the resulting expansion of civil commitment laws across North America.

Torrey's influence has for decades been heavily aided by hundreds of millions of dollars from the late direct-mail billionaire Theodore Stanley—whose son was labeled with bipolar disorder—routed into TAC activities and through Torrey's Stanley Medical Research Institute to universities like Harvard, Johns Hopkins, and MIT. This unrivaled funding pool effectively transformed Torrey into a kind of George Soros or Koch brothers of the mental health field, by far the biggest funder of studies, reports, and public relations efforts outside of the government and pharmaceutical industry. Still, Torrey is rarely contextualized in news stories in this way, but usually described as simply a humble "advocate for patients with schizophrenia" or "a clinical and research psychiatrist."

It's important to note, though, that Torrey's refrain isn't new. Labeling poor and homeless people as deranged, diseased, dangerous, and in need of rounding up and locking away has gone on for hundreds of years. In *History of Madness*, Michel Foucault notes that the Royal Proclamation that launched the era of "the Confinement" and established the Hôpital Général in Paris in 1656 declared that the massive hospital's core purpose was to "prevent begging and idleness, the sources of all disorder." Are today's claims—that people's mental disorders and a shortage of psychiatric beds have caused rising homelessness, violence, and imprisonment—any less prejudicial?

* * *

Torrey and TAC's widely cited bed numbers aren't technically incorrect—but they completely disguise the truth.

Torrey and TAC state that, in the 1950s, there were about 550,000 "total state hospital beds," or 330 psychiatric inpatient beds per 100,000 people. Today, they write, there are about 37,000 beds, or just 11 state hospital beds per 100,000 people. These numbers put the US near the bottom of Organisation for Economic Co-operation and Development (OECD) countries in an apparent bed-shortage catastrophe. Torrey and TAC suggest that, ideally, there should be 40 to 60 psychiatric beds per 100,000 people.

But these are the numbers for US *state hospitals* only. This limitation serves Torrey and TAC's rhetorical purposes, but is so nonsensical that its emergence in countless public discussions is like a radioactive dye-marker for every journalist and politician that Torrey and TAC have seemingly persuaded not to ask questions. State hospitals represent only a tiny fraction of America's available inpatient psychiatric beds.

In 2017, NRI—the research arm of the US National Association of State Mental Health Program Directors (NASMHPD)—examined this issue in a report titled, "Trend in Psychiatric Inpatient Capacity, United States and Each State, 1970 to 2014." Led by longtime NRI researcher Ted Lutterman, the authors observed that "[t]he shortage of psychiatric inpatient beds has become a major national issue," even while "most analyses fail to include a comprehensive depiction of the total inpatient and other 24-hour mental health residential treatment capacity across the nation." The NASMHPD report promised to "fill that need." In 2019, SAMHSA also produced a study and report on the topic. Its authors flatly stated that “E. Fuller Torrey and colleagues from the Treatment Advocacy Center” were making comparisons that were neither “apt” nor “meaningful.”

Both reports first clarified the number of state hospital beds historically. Few usage details existed from the 1950s; however, even as late as the 1970s, many state psychiatric hospital beds were occupied by patients with alcohol or drug problems, brain injuries, intellectual or developmental disabilities, or elderly dementia. All of these people—about 42 percent of the patients—are supported in other settings today, which were uncommon in that era, such as detox facilities, group homes, and long-term-care facilities. So, in the 1950s, there were not 550,000 but closer to 319,000 state hospital inpatient beds occupied by people diagnosed with mental disorders, or about 187 beds per 100,000 people at that time—roughly half the number typically cited by Torrey and TAC.

And how many inpatient psychiatric beds exist today?

In addition to state hospitals, today there are also beds in private psychiatric hospitals, in dedicated beds and psychiatric wards in general hospitals, in Department of Defense (DoD) and Veterans Administration (VA) hospitals, and in psychiatric residential treatment centers. Lutterman tallied these up to 53.6 psychiatric inpatient beds per 100,000 people. This puts the US squarely at the OECD average and comfortably within TAC’s proposed range of 40 to 60 beds per 100,000 people.

But many long-term-care facilities also provide psychiatric inpatient beds for both elderly and non-elderly patients. Lutterman found that 183,534 nursing home beds are currently assigned for treating people labeled with “serious mental illness,” such as schizophrenia or bipolar disorder.

Altogether, then, Lutterman found 362,029 inpatient psychiatric beds—more than the number of beds dedicated to people diagnosed with mental illnesses in the 1950s. Adjusted for population growth, that’s 114 beds per 100,000 people today—and *ten times* the number of inpatient psychiatric beds commonly cited by Torrey and TAC, politicians, news media from the left and the right, and mental health organizations clamoring for more funding. And far from “Going, Going, Gone,” as a widely cited TAC report is titled, since 1970, the number of private psychiatric hospital beds has increased more than two and a half times, general hospital psychiatric ward beds went up 76 percent, and residential treatment center bed numbers more than tripled.

And that’s not all. There’s a recognized national trend to hold psychiatric patients in general hospital emergency rooms for long spans of time, but there’s no national tracking of how many beds that comprises. Jails and prisons sometimes have specialized inpatient mental health units, but those bed numbers aren't currently known, either.

And there's still more . . .

In a phone conversation, Lutterman confirmed to me the main thrust of the NASMHPD study's findings: "E. Fuller Torrey or others are always talking about how there used to be half a million people in state hospitals, and if we had that number of beds today, at equivalent rates, we'd need so many beds." But Torrey's numbers, Lutterman said, "just don't add up." Many large asylums closed, but they've been replaced by a diverse multitude of smaller facilities. "The community service system has gone up hugely. There are many more people getting psychiatric inpatient care in settings other than state hospitals now."

In fact, Lutterman's approach was conservative. He counted only facilities that were licensed to provide inpatient services as, or very much like, state psychiatric hospitals. But his research revealed still more 24/7 psychiatric beds, where treatments are also provided, monitored, or enforced.

America has thirty-one beds per one hundred thousand for people with substance use disorders.

There are hundreds of thousands of beds in long-term-care facilities occupied by people diagnosed with depression or anxiety.

There are group homes and assisted living facilities large and small; a 2021 federal government data brief identified 918,700 people living in these residential-care communities. Many of these have doctors, nurses, or other professionals on staff or contracted to assist with or enforce treatments, and about 40 percent of their residents are labeled with "serious mental illness." So that's another ninety beds per 100,000 people or, if we consider the fact that many people with intellectual/developmental disabilities now also get labeled with mental disorders, it could be closer to another 150 beds per 100,000.

Roughly tallying these, we'd be up over six hundred or seven hundred beds per one hundred thousand people, several times the per capita number of beds in the 1950s. In short, depending on how one analyzes this data and accounts for any overlaps, it's possible to make a strong argument that America has many more beds for people labeled with mental disorders than it has ever had in its history.

And it's not only the colossal increases in bed numbers that are significant. Lutterman pointed out that there's been virtually no research focused on all of these other inpatient services and whether people are getting good care in them. As bad as many psychiatric hospitals seem to be, these smaller facilities are less regulated.

“Many more people are getting inpatient care outside of the state hospitals, largely invisible,” said Lutterman. “There are people that are in locked units in those programs. There are different places of overt and less overt coercion.”

Significantly, all of this aligns with what many on-the-ground studies have shown actually happened in the wake of the international movement to close asylums. For example, Canadian researchers tracked down, five years later, every single person in a study group of 189 people who’d been discharged from British Columbia’s last large asylum between 2001 and 2004, all previously long-term patients and 80 percent labeled with schizophrenia disorders. Just one former patient was in prison, and one had “spent some time homeless.” Most had been moved into these smaller, coercive, long-term institutions.

Basically, psychiatric “deinstitutionalization” not only didn’t “fail”—it never really happened.

* * *

I asked Lutterman why such important findings—which fundamentally flip on its head the entire national discussion around numbers of psychiatric beds and coercive treatment—have received so little attention. No one has been promoting the actual number of inpatient psychiatric beds—not even SAMHSA and the state mental health commissioners who commissioned the study, let alone major mental health organizations, Torrey and TAC, or state or national politicians. Why?

“I don’t know. We actually were interested in trying to update it to 2021, and SAMHSA hasn’t been willing to fund more work on it,” answered Lutterman. “For years, SAMHSA and NIMH haven’t wanted to fund any studies or research looking at what’s happening in inpatient care.”

The black hole in the dark heart again.

E. Fuller Torrey only briefly answered a handful of questions via email before refusing to answer any more. He said he was unaware of the NASMHPD and SAMHSA reports and cut off communication before I could clarify their details. Treatment Advocacy Center did not respond to emails and phone messages.

* * *

The other statistics behind the narrative that deinstitutionalization has caused skyrocketing homelessness, violence, and imprisonment are equally dubious.

Estimates of the number of homeless people who have had a mental disorder range from 25 to 70 percent. But most are ordinary substance use issues, along with depression, anxiety, and so on. And those are lifetime prevalence numbers. Recall that, according to National Institute of Mental Health (NIMH) statistics, 50 percent of Americans have had a mental disorder already by age eighteen. So those rates among homeless people seem surprisingly low, considering how stressful, depressing, health-harming, and anxiety-inducing that living without a home can be. Indeed, one night without sleep—let alone the chronic sleep deprivation common to street life—can induce visual and auditory hallucinations and other symptoms of psychosis in nearly anyone.

The most widely cited statistics for prisoners come from a 2017 report from the Bureau of Justice Statistics (BOJS) that found “1 in 7 state and federal prisoners (14%) and 1 in 4 jail inmates (26%) reported experiences that met the threshold for serious psychological distress.” But the BOJS itself clarified that inmates simply completed the Kessler Psychological Distress Scale screening tool, with its six questions about whether you’ve recently felt nervous, hopeless, fidgety, and so on. The BOJS itself admitted these numbers “should not be interpreted as representing a clinical diagnosis of a mental disorder.”

The BOJS also found that “37% of prisoners and 44% of jail inmates had been told in the past by a mental health professional that they had a mental disorder.” That sounds high. But again, those are lifetime prevalence rates—so, if anything, criminals appear to be more mentally healthy than the general population.

* * *

Are people labeled with mental disorders more likely than average to be violent? Before delving into this, it’s important to be clear that Torrey and TAC often misleadingly use statistics about murderers in the forensic psychiatric system to make arguments about changing civil commitment. This is essentially to suggest that we should handle anxious children, depressed workers, and psychopathic murderers all in the same way. Is this the path we want to go down?

Some of the most commonly promoted numbers are that 50 percent of mass shooters have had mental health issues, 5 to 10 percent of people with mental disorders will be violent, and people labeled with schizophrenia are twenty times more likely to murder someone.

But in its 2020 shootings report, the US Secret Service itself acknowledged that “over half of the population in the United States will be diagnosed with a mental health disorder at some point.” So, half of mass shooters having had mental health issues, the report noted, is simply statistically expected.

Studies have indeed found that mental disorders are associated with heightened violence, though usually only alongside heightened use of alcohol or drugs. However, alcohol is well known to heighten violence dramatically, whether people have mental disorders or not.

In a 2021 review of such studies, Oxford University researchers newly determined that about 3 to 5 percent of people labeled with schizophrenia and personality disorders would commit acts of violence over a ten-year period, reaching 5 to 10 percent when these people also had substance use disorders. Those percentages may seem high in Sweden, where the researchers based their comparison, but in America? A 2018 study found 15 percent of adults in Georgia, and 10 percent in Florida, Indiana, Louisiana, and Texas have prior felony convictions. Dozens of states were in the 5 to 10 percent range for prior felonies.

And what does “violent” mean, anyway? In many of the studies of mental disorders, the bulk of offenses were simply drug possession, traffic violations, disorderly conduct, and so on.

As for people labeled with schizophrenia being twenty times more likely to murder someone, the odds of getting killed by a person labeled with schizophrenia are still barely higher than the odds of getting struck by lightning. Meanwhile, expert predictions of violence are, at best, only slightly better than chance, and typically among practicing psychiatrists worse than random guessing. So, we’d have to lock up forever hundreds of innocent, peaceable people labeled with schizophrenia to potentially prevent one murder.

But these new findings also raise a question: What’s changed to make schizophrenia and personality disorders apparently become more violent conditions?

For one, it’s increasingly rare for youth who exhibit violent tendencies *not* to get directed into mental health treatment. And many prisons now administer the common, diagnosis-inflating mental health screening questionnaires to all new inmates. The Oxford researchers themselves hint at what’s happening: since “aggression and criminality from adolescence are included in the *DSM* diagnostic criteria, antisocial personality disorder is the most important of all personality disorders in relation to violence risk.” Basically, people with mental disorders aren’t becoming more violent; violent people are increasingly getting labeled as having mental disorders.

* * *

So, when every key element of the dominant deinstitutionalization narrative is wrong or misleading, why does the story remain so popular? Sam Tsemberis suggests that the story is part of a long-standing, ideologically driven war on people who are homeless or labeled with mental disorders.

In the 1980s, Tsemberis—a psychologist now based out of UCLA and a leading advocate for Housing First—worked at New York’s Bellevue psychiatric hospital and did street outreach with homeless people labeled with mental disorders. He got people forcibly taken to the hospital frequently, he told me. “The people that we committed, 70 or 80 percent of the time, it was not because of their mental illness per se, but because they had an acute health problem that had developed,” said Tsemberis. “They were coughing up blood, or they had pus coming out of their sneakers. I thought, ‘We are saving these people’s lives.’”

Nevertheless, even these people often resented the forced psychotropic drugging, and it didn’t improve their situations. Upon discharge, they’d be back on the street, or moved to smaller group living facilities where they were under monitoring, control, and constant drugging against their will. Over the ensuing years, Tsemberis found not a single person who’d been helped to get into their own residence and independent living. Eventually, he concluded, “This makes no sense. We’re not helping people.”

Tsemberis began asking the patients themselves what they wanted, what they believed would truly help. And the predominant answer was, simply: Housing. Not treatment. Not housing with forced treatment. Housing.

“That’s how we got to Housing First,” said Tsemberis.

Many government-subsidized housing providers require aspiring tenants labeled with mental disorders to accept psychiatric treatment—so if someone is poor and addicted to a substance or doesn’t find psychotropics helpful, they remain homeless. Homelessness then precipitates crises, police interactions, hospitalization, and forced treatment—which drives such people back into homelessness to get away. Basically, many people are homeless in part because they’re actively fleeing forced psychiatric treatment, not because they’ve been unable to get treatment. Tsemberis started to propose simply giving people affordable housing without any treatment mandate, and additionally offering them supportive practical services and help with treatment if they wanted it.

Over the next two decades, through projects in the US, Canada, and Europe, and broad implementation by the US Veterans Administration, the Housing First approach has proven successful in keeping 80 to 90 percent of people housed, and in reducing expensive policing interventions and hospitalizations. In recognition, some states like California have passed legislation supporting housing programs that accept tenants "regardless of their sobriety or use of substances, completion of treatment, or participation in services." And the federal Department of Housing and Urban Development (HUD) ranks funding applicants higher if they say they offer Housing First.

But Tsemberis said such proclamations are more mirage than reality. "Everyone says, 'We're doing Housing First.' But there's no money, no housing, no teams that provide support services. It's just a hollow policy statement." The 2021 Biden Democratic administration did invest in Housing First, but at "nowhere near the scale" that's needed, said Tsemberis.

So, what's preventing broader implementation of Housing First in North America? Many governments, said Tsemberis, argue that homelessness is caused by people's "individual flaws" or "psychopathology" rather than by structural economic inequities. Some federal Republican leaders even coined "Housing Fourth"—declaring that housing should be offered *after* forced institutionalization, forced sobriety, forced psychiatric interventions, and only with ongoing coercion.

This perspective fits comfortably alongside psychiatry's biomedical model that says people's struggles are caused more by flawed brain chemistry than social circumstances, and therefore they cannot be trusted to make independent decisions. "It's the psychopharmacology and mental health industries' propaganda that says people need medication and to be in a place where they can be watched," said Tsemberis. Compelling people into coercive institutions, he added, "has been going on for hundreds of years. It's part of the mental health system's DNA. It's very, very difficult to change established mindsets." In tandem, corporations running group homes, long-term-care facilities, and other forms of institutionalized housing lobby heavily against approaches like Housing First that give people more freedom to choose where they live.

Yet abundant research, said Tsemberis, shows that what promotes recovery is not prolonged coercive treatment in institutions large or small, but independence along with support in developing agency and skills and integrating into community. “There are so many ways that we can work with people who have symptoms to manage their lives much better on their own terms.”

* * *

There are many other examples of how promoting the misleading deinstitutionalization story serves political agendas.

Blaming deinstitutionalization provides a convenient scapegoat after mass shootings. Treatment Advocacy Center is well known for wading in after high-profile incidents of violence perpetrated by people labeled with mental disorders to stoke public and government sentiment for expanding forced treatment. The NRA and conservative politicians latch on to shift attention away from gun laws, and liberals grasp onto increased mental health funding as at least a potentially constructive step. In the bipartisan legislation passed in 2022, hailed as “the first significant gun reform bill to make it out of the Senate in three decades,” most of the initiatives and billions of dollars in funding were actually just directed at mental health-related programs.

Inflated rates of mental illnesses from inmate surveys serve the interests of prison wardens. In *Silent Cells: The Secret Drugging of Captive America*, Wesleyan University sociologist Anthony Ryan Hatch tracks the history of antipsychotic tranquilizers being used for behavior control of inmates. “No survey has ever asked prisoners if they were forcibly administered psychotropics,” notes Hatch. Most surveys are so useless for understanding the extent of forced tranquilizing for inmate control, writes Hatch, “that it might be said to qualify as a kind of nonknowledge, willful ignorance, or a front for malicious state secrecy.” However, it’s well documented in detention centers for immigrants. For example, in 2018, refugee advocates described distressed and rebelling youth in Texas immigrant centers getting moved to psychiatric facilities “without the most rudimentary procedural fairness or transparency,” where they were “routinely” coercively administered psychotropics.

Blaming people’s mental illnesses helps governments deflect blame from their economic policies. Most state hospital closures were long concluded by the 1970s, but protests against deinstitutionalization gained steam in the 1980s and ’90s. That was when average real wages were declining, and governments reduced supports for affordable housing and social safety nets. The squeeze has continued; according to the National Low Income Housing Coalition, America is now short seven million affordable homes for “extremely low-income renter households.” Simultaneously, aggressive anti-panhandling, anti-loitering, anti-streetcamping, and related bylaws have been enacted. A 2019 report from Disability Rights Oregon (DRO), for example, found that, in one year, more homeless Portlandians were arrested than the federal homelessness count found in the city. These arrests often resulted from calls from businesses and neighborhood organizations, leading to minor charges of disorderly conduct, drug use, or trespassing, and then imprisonment or psychiatric incarceration. Arrests of homeless people, DRO wrote, “appear to be driven by their circumstances.”

In addition, blaming homelessness and imprisonment on people refusing treatments distracts from how cynical even many frontline practitioners are about the helpfulness of treatments. That same DRO report and a similar Disability Rights Washington report described staff at Portland and Seattle hospitals collectively making hundreds of calls annually to police. Hospital staff were charging impoverished patients or people in their waiting rooms with “trespassing” or various forms of minor “assault,” and getting them jailed—mainly just to get rid of them. “[T]he assumption is often made that people with mental illness end up in the justice system because they refuse healthcare interventions. In these cases . . . the healthcare system refused them,” wrote DRO. “[J]ail commanders report a tension with their local hospital over a high need population that neither system is eager to serve.” These practices were routine across many hospitals and, extrapolated across the country, could themselves account for a high percentage of the people labeled with mental disorders in prisons.

* * *

In all, like Paris’s Royal Proclamation of 1656, the false narrative about how deinstitutionalization played out encourages aggressive incarcerating of poor and homeless people. And nowhere does this occur more than in the psychiatric system itself.

In an illustrative 2019 legal case in Alberta, Canada, a poor First Nations man was detained and tranquilized for nine months, though hospital psychiatrists acknowledged he “did not suffer from any psychiatric condition whatsoever.” The psychiatrists simply believed he was better off in hospital because “there is no other place for him.” The psychiatrists confessed they had many similar patients, and the judge criticized Alberta’s “overbroad” mental health laws and how “the number of involuntary detentions has skyrocketed.”

This same practice is so well known in the US that the DOJ’s Civil Rights Division has been suing states to set such people free. From 2015 to 2020, the DOJ reached settlements involving “unnecessary institutionalization” of tens of thousands of people in Delaware, New York, Georgia, Louisiana, Texas, and New Hampshire. More cases were in progress in Connecticut, Mississippi, West Virginia, Oregon, and North Carolina. A 2019 Disability Rights Texas report similarly found that a third of youth in state care were being “unnecessarily hospitalized for months,” and class-action lawsuits cited similar rates among youth in Louisiana and Illinois.

Basically, many of these detainees either never met or long ago stopped meeting commitment criteria, but psychiatrists continue detaining them because they believe that these people have nowhere safe to go and therefore, if discharged, they might degenerate and eventually become committable. The DOJ argues that states should divert some of that hospitalization funding into affordable housing and community-based supports for such people. The DOJ usually wins pledges for gradual change, but it’s a grim reality: tens of thousands of people are being held against their will in psychiatric hospitals simply because they’re poor.

Another factor at work, as we’ll see next, is that there’s a lot of money to be made off detaining people in psychiatric hospitals.

CHAPTER 8

HOW MUCH IS AN INVOLUNTARY PATIENT WORTH?

“Even before the Covid-19 crisis, America’s infrastructure for mental-health and addiction services was fragmented, overburdened, and underfunded. The coronavirus has put far more stress on that broken system,” wrote representatives of the American Enterprise Institute, Well Being Trust, and Brookings Institution in *The Atlantic*.

For decades, the mental health system has been portrayed as desperately underfunded—an abandoned orphan child of the health care system, barely surviving on meager scraps from uncaring politicians. This characterization emerges in both the US and Canada, under many different state and provincial funding schemes. Starting in 2020, the pandemic became the latest opportunity to beat this drum. And the characterization has become so ubiquitous that it’s commonly uttered like this, as unquestionable fact just passingly intoned on the way to making another point. A *Washington Post* article, syndicated around the country, reported that “the United States mental health system—vastly underfunded, fragmented and difficult to access before the pandemic—is even less prepared to handle this coming surge.”

Most health care providers prefer to portray themselves to the media, general public, and funders as capable, equipped, competent, and reliable.

* * *

Why has the mental health industry conversely helped cultivate this image of itself as broken, threadbare, and desperately needy?

Mental health funding is varied and dispersed, but the most comprehensive estimate comes from the Substance Abuse and Mental Health Service Administration's periodic reports, "Behavioral Health Spending and Use Accounts." In the most recent 2015 report, total spending on mental health and substance use disorder treatments in America was a staggering $215 billion. That represented a 62 percent increase from 2006, and "was similar to growth in spending for total health care generally." The Canadian Institute for Health Information has estimated $16 billion; accounting for Canada's population at one-tenth the size and its cheaper health care system, the results seem roughly comparable. Both analyses included many caveats about what wasn't included; the real numbers are undoubtedly substantially higher.

By comparison with 2015 US Bureau of Economic Analysis data, American mental health industry revenues are therefore equal to nearly 60 percent of the entire education sector, 50 percent of mining sector revenues, or 40 percent of agriculture, forestry, fishing, and hunting revenues combined.

One striking comparison—as of 2021, the nonprofit Prison Policy Initiative calculates the entire US criminal justice system costs less: $182 billion annually to manage all police, the judicial system, public employees, buildings, the parole system, and public and private prisons with the largest population of prisoners and parolees of any nation in the world.

Sometimes, claiming that a system is "underfunded" serves as a convenient excuse for its ineffectiveness and brokenness.

* * *

One issue, of course, is that ever more people are being encouraged or forced to get psychiatric help even when they wouldn't otherwise have done so, thereby overburdening the system. But how does anyone argue that the mental health system is starved for dollars?

A typical example is a 2015 study led by economist Paul Greenberg, declaring that depression costs the US economy $210.5 billion annually. Similarly, in 2021, the Schizophrenia & Psychosis Action Alliance declared that schizophrenia costs $281.6 billion annually.

The costs of just these two conditions have seemingly dwarfed the entire mental health system budget. Both reports have been widely cited in pleas for more funding. But how are such numbers ascertained?

Greenberg’s analysis took typical costs for one person getting treated for depression, and then multiplied that by the inflated estimates of depression rates gathered from mental health screening surveys. This created $99 billion in mostly imaginary costs. Next, Greenberg assumed that all of those imaginary depressed workers would be less productive at their jobs—and thereby generated $78 billion more in imaginary financial losses. Much of the rest of the total came from calculating lifetimes of imaginary lost wages from suicides.

Similarly, the Schizophrenia & Psychosis Action Alliance number was based on hypothesized “lost wages, reduced quality of life and decreased life expectancy” multiplied by inflated rates of schizophrenia-like conditions. Another 40 percent of the total was hypothesized “unpaid wages” for families helping their loved ones.

Meanwhile, it’s simply assumed that more mental health treatments and services will ultimately help reduce all these costs. But will they? Even their own modeling doesn’t show where or how mental health services reduce any costs.

* * *

It would be enlightening to know how much of the very real $215 billion that America spends annually involves delivering treatments and “services” to people that those people don’t even want. As we’ll soon see, the mental health system is replete with informal coercion. But we can at least begin to roughly calculate the economics of formal psychiatric detentions and civil commitment.

Mental health laws give institutions broad powers to incarcerate people and bill the government and private health insurance companies. A large industry of for-profit psychiatric institutions has grown up around it. The private prison industry has managed to turn incarcerating criminals into a lucrative enterprise—so, what’s an involuntary psychiatric patient worth?

The Centers for Medicare & Medicaid Services (CMS) “base rate” cost-reimbursement per patient day in a psychiatric hospital in 2021 was $840. Reimbursement goes up from there depending on patient diagnoses, location of hospital, and many other factors. Private insurers are not forthcoming, but the range from patient reports is usually between $1,000 and $4,000 per day.

A 2012 study in *Psychiatric Services* found a large gap between how much hospitals “charge” for inpatient psychiatric care and what they actually get reimbursed by insurers, and the negotiations toward that middle ground are usually confidential trade secrets. After the researchers analyzed the data they could find across 418 hospitals, they concluded that inpatient psychiatric care "costs" hovered just below $1,000 per day, but "charges" averaged about $2,500 per day. The actual dollar amounts changing hands were somewhere unknown in between.

So, for the sake of discussion, a low-middle estimate suggests that, as of 2021, inpatient psychiatric care in the US rings in at an average of about $1,500 per day in payments. (This is close to figures calculated by some states.) Notably, this is between *ten* and *thirty times* the average daily rate for American prison inmates.

According to data from the American Hospital Association (AHA), 636 member psychiatric hospitals in 2019 billed for 26.5 million inpatient days. AHA did not provide information on involuntary patients specifically, but as discussed earlier, we know from other sources that somewhere between 35 to 75 percent of hospitalized psychiatric inpatients are typically involuntary. So, if we go with an estimate just below 50 percent, we'd then multiply about 13 million inpatient days by $1,500 per day.

This leaves out general hospital psychiatric units and many other places civilly committed patients are also held, but our beginning estimate is now this: the psychiatric detention and civil commitment of non-criminal, law-abiding citizens in America is at least a $19 billion-a-year industry.

By comparison, the entire US private prison industry garners $3.9 billion in annual revenues from its inmates.

* * *

With so much money in play, there are immense economic-political drivers pushing expansions to mental health services, and to forced treatment.

At the most visible public level, the major mental health nonprofits are usually led by professionals with backgrounds in mental health and social work, and funded by governments, pharmaceutical companies, and mainstream philanthropic foundations. They tend to generally focus on advocating for increased funding to mental health services. Some, like the National Alliance on Mental Illness (NAMI) and Treatment Advocacy Center, explicitly push for expansions to forced treatment. Others, like Mental Health America (MHA) and the Canadian Mental Health Association, have particular branches that sometimes express concerns about civil commitment, but generally they don't risk “biting the hand that feeds” by too strongly challenging a core practice promoted by governments. In addition, their support for biomedical approaches usually implicitly justifies forced treatment; for example, MHA accepts financial support from pharmaceutical companies, and its national website offers screening with Pfizer’s PHQ-9 and GAD-7, claims that mental disorders are caused by “an imbalance of natural chemicals in your brain,” and encourages “intervening early” with treatments. Some mental health organizations in the US and Canada also directly profit from forced treatment by contracting with local governments to help implement court-ordered treatment for people in communities.

But according to Jennifer Mathis of the Bazelon Center for Mental Health Law, the truly “big players” in mental health politics are largely invisible or unknown to the general public. Well-heeled, influential lobby groups are promoting agendas in Washington—and many of them make money in one way or another from civil commitments or forced treatment.

The National Council for Mental Wellbeing develops legislative policy and lobbies on behalf of 3,500 mental health treatment providers, many of whom implement forced treatment.

The National Association for Behavioral Healthcare (NABH) lobbies on behalf of 1,800 inpatient psychiatric hospitals and wards, residential treatment facilities, and others central to implementing civil commitment. The NABH’s board and staff are filled with people who’ve had long careers moving back and forth between the mental health industry and government, including prominent promoters of force; in 2021, longtime pro-force Treatment Advocacy Center executive director John Snook became NABH’s Director of Government Relations and Strategic Initiatives.

And the major organizations of professionals that earn part or all of their livings off of involuntary patients, such as the American Psychiatric Association and National Association of Social Workers, along with mental health organizations such as NAMI and MHA, sometimes lobby together as part of the influential, seventy-member Mental Health Liaison Group.

Of course, the pharmaceutical and health insurance industries are among the biggest lobbyists and political donors in America, and both profit from forced treatment. Both also fund—openly or covertly—many of these mental health and pro-force organizations. For example, the extensive financial influences of the pharmaceutical industry on the American Psychiatric Association, universities and academic psychiatry, and most psychiatric drug research have been well documented (see chapter twenty-three), but it took a congressional investigation in 2009 to reveal that NAMI was at that time getting 75 percent of its tens of millions in yearly funding from pharmaceutical companies.

“There is an overly intense focus on medicalizing psychiatric disabilities and treating them. The way that a lot of the advocacy and lobbying is focused on forced treatment is troubling to us,” said Mathis. “We have far less staff, far less bandwidth, far less ability to walk the halls of Congress or the agencies in the way that some of these groups do.”

Bazelon works with the Center for Public Representation, the National Association for Rights Protection and Advocacy, groups run by consumers and survivors like MindFreedom, and various “cross-disability” groups like the National Disability Rights Network and the National Council on Independent Living. But many of these really do, financially, barely scrape by. And many other possible allies with broader civil rights interests have been persuaded to accept the biomedical model of mental disorders and forced treatment—even the American Civil Liberties Union has only in the past few years become engaged again in psychiatric patients’ rights.

Bazelon itself is a member of the Mental Health Liaison Group. “We try to advocate for values that we believe in,” commented Mathis. While there are different interests among their members, she said, many of the major mental health organizations and lobby groups tend to eschew concerns about “autonomy, choice, self-determination, independence, and inclusion” in favor of advocating “for more hospital beds and pills or quote-unquote ‘access to treatment.’” This frame of thinking, she added, is driven by treatment providers, family members of people labeled with mental disorders, “and everybody but people with disabilities.”

Basically, there are no major lobbyists representing those who identify as patients, consumers, survivors, or people with mental disabilities—nor representing people resistant to expansions of forced treatment. Consequently, Mathis said, “anytime mental health bills are introduced in Congress, I start biting my nails, because 99 percent of them are either problematic or not particularly helpful. That’s true with Democrats as well as Republicans.” Both parties end up with similar views on mental health issues, she said, because “the folks on the Hill are educated by the people who lobby.” And the common feature among all these lobbying coalitions, Mathis emphasized again, is that they include “everybody except people with disabilities.”

All this works to the detriment of people labeled with mental disorders in countless ways. For example, Mathis said one reason that mental disorders keep getting linked to gun violence is because some mental health organizations have learned that touting such a link, despite the lack of evidence and its obvious stigmatizing impacts, drives up public attention and funding for mental health. And while more affordable housing would clearly reduce demands on mental health services, said Mathis, housing is “not a popular advocacy issue.”

“Many mental health organizations and lobbying coalitions are really pushing a narrative, to both members of Congress and through their affiliates to state legislators, about what the solutions are,” said Mathis. “And the solutions are: ‘We need more hospital beds.’”

The consistently bipartisan support that expansions to forced treatment have also garnered in recent decades is a testimony to how effectively these groups have spun stories to all of the major political parties, at federal and state levels, and in Canada. Among many liberals, forced treatment gets viewed as a caring expansion to public health care and supportive social services. Among many conservatives, forced treatment appeals to the same values that drive expansions to policing. Essentially, forced psychiatric interventions comfortably wed the liberal nanny state and the conservative police state. And as will soon become evident in the following chapters, the threatening, society-wide consequences are becoming immense.

PART THREE

MASS FUNNELS INTO PSYCHIATRIC INCARCERATION

CHAPTER 9

SCHOOLING CHILDREN TO BECOME MENTAL PATIENTS

Laws governing the age at which a child may grant legal consent to medical treatments vary, but generally, prior to late-teen years, only parental consent is required. So, in essence, all child and youth treatment is forced, or heavily coerced. And, of course, informed consent is undermined if people are given misleading information.

For the past two decades, many children, teachers, and parents have been increasingly inculcated by mental health awareness-raising, education, and early-intervention campaigns. It starts with organizations of psychiatrists, psychologists, and social workers that collaborate with government agencies and others, like the Connecticut Association for Infant Mental Health out of Yale University and the Michigan-based International Alliance for the Advancement of Infant Mental Health. One recent study of 35,000 Medicaid-insured children found that, before their first birthday, 0.3 percent of babies were already being given at least one psychotropic drug. By age four, 2 percent of children were taking psychotropics. By age seven, 10 percent. The numbers are nearly as high across the broader population; in both the US and Canada, about 9 percent of children aged five to seventeen are being given psychiatric drugs.

Yet a 2018 post from the National Education Association, representing three million members working in schools in 14,000 US communities, asked, “Are Schools Ready to Tackle the Mental Health Crisis?” The post declared that “the magnitude of the problem cannot be overstated” and touted the “urgent need” for still more aggressive interventions.

This fearmongering tone is common. In 2019, reports quoted the author of a *JAMA Pediatrics* study that found “alarming” numbers of children in emotional distress were not seeking or getting treatment. Yet after an American Academy of Pediatrics presentation, reports cried that the number of children seeking mental health help “continued to rise at an alarming rate.” So, is it alarming that kids don’t seek help, or alarming that they do? Either way, most such studies and reports conclude, more mental health education and services are needed.

And while the tobacco industry was banned from promoting smoking to children, the psychotropic drug industry has, through its relationships with mental health professionals and organizations, been embraced. Some states, such as New York and Virginia, have recently passed laws mandating mental health education in schools. Many educational programs are designed and implemented by mental health organizations in collaboration with school districts and parents’ groups. There are also programs delivered by groups such as Girl and Boy Scouts, 4-H Clubs, and churches, along with media and web campaigns.

Although such programs do usually begin by encouraging kids to learn coping skills and support one another, they also nearly always state that sadness, anxiety, or other common emotional distresses could signal brain diseases that require professional help and medications. For example, New York State’s “Framework for Mental Health Education Instruction” recommends that children as young as ten be instructed in how “genetics” and “brain chemistry” can cause emotional upset, how “to effectively recognize signs and symptoms,” and “where to turn for help.” Youth Mental Health First Aid (YMHFA) is a widely used training program that also repeatedly emphasizes the importance of children seeking professional help at the first signs of distress.

YMHFA is led in the US by the National Council for Mental Wellbeing, representing 3,500 treatment providers. The motives of schools may also not be pure: schools now usually get additional funding for children labeled with mental disorders.

* * *

Victoria Chaney experienced verbal and physical abuse during childhood, both at home and at her small, private Christian school. Identifying as queer, Chaney said she was so completely surrounded by proclamations that homosexuality was “sinful,” “an abomination,” and “evil” that she worked hard to deny and suppress her emerging feelings. She later attended a rural Colorado school rife with violence. “I had to start fighting for my own safety,” said Chaney.

She recalled telling her mother one day when she was twelve that she was having “bad thoughts” or feeling “very sad.” Her mother sent her to a therapist. After that, Chaney said that during their conflicts her mother frequently deflected any of her own responsibility by blaming Chaney’s “mental illness” and “broken brain.” Through her early teens, Chaney was labeled with depression and ADHD, and saw innumerable psychiatrists.

“All I can really remember is the amount of drugs that were pumped through me,” she said. “In really rapid succession. You know, like, ‘We’ll try this one for a week. And if it doesn’t work, we’ll try another one.’”

Chaney usually had no idea what drugs she was taking, but she often experienced strange, mind-altering reactions—like with recreational drugs, she said, but unpleasant. “I didn’t feel like reality was real. I felt like I was in a dream. But this went on for months. When I was peeing, I thought I was wetting the bed, but I was on a toilet and I would grip the toilet because I didn’t think it was real.”

Stimulants prescribed for ADHD are known to sometimes induce hallucinations and psychosis, and a 2019 Columbia University study found that, within the first year of stimulant use, up to 4 percent of children were also put on antipsychotics. Antipsychotics, though, can also induce psychosis.

Chaney said she spent much of her teens with each new drug taking her on a different, disturbing “trip through an alternate reality” that she didn’t understand, and “with weird urges, and weird thoughts, and visions and things.” She noticed that her memory and cognition became impaired, too. She sometimes forgot basic information, like what jobs her parents did.

At the same time, the doctors and her parents kept telling her that she had a brain disease. “You’re not sure it’s the drugs,” said Chaney. “Maybe that’s just how you are.”

Chaney also developed what she now knows was akathisia. Strangers saw her rocking and asked if she was okay. She turned down invitations to gatherings because she couldn’t sit still long enough. “It’s just this unbelievable urge, like your skin is crawling, and you have to move in order to alleviate it, but it never really goes away.”

Chaney sometimes tried not to take the drugs, but got caught and punished by her parents. Did she tell any doctors what she was experiencing? “They say it takes a while to get used to it. They tell you it’s the only thing that’s going to help. They’ll tell you it takes a long time to get the right cocktail of medication.”

She was also told that her rocking and agitated need to move indicated an anxiety disorder—for which she was prescribed more medication.

* * *

The University of Maryland's National Center for School Mental Health partners with the Substance Abuse and Mental Health Services Administration and state governments, the Centers for Disease Control and Prevention, and the American Academy of Pediatrics. Their most highly recommended educational program for schools is "The Mental Health & High School Curriculum Guide."

This course's lead medical author is Canadian child and adolescent psychiatrist Stan Kutcher, better known by some for his part in the biggest medical fraud case in US history. In 2001, a study authored by high-profile psychiatrists, including Kutcher, stated that the SSRI antidepressant Paxil from drug company GlaxoSmithKline (GSK) was safe and effective for children. Their findings, still cited today, effectively launched the antidepressant era for kids. However, as part of a $3 billion lawsuit settlement with GSK in 2012, the US Department of Justice stated that the authors "distorted the study results and gave the false impression that the study's findings were primarily positive, when they were, in fact, primarily negative."

Nevertheless, Kutcher went on to take a leading role in designing mental health education programs for children, teachers, and medical doctors, and got appointed to a prominent position in the Canadian government. Yet Kutcher's 2017 course and related teacher guides also arguably give many "false impressions" promoting drugs.

"Mental illnesses are medical illnesses; however, instead of a disorder of the pancreas, such as diabetes, mental illnesses are disturbances of usual brain function." The curriculum and guides say that emotional distress occurs when "[b]rain pathways that help different parts of the brain communicate are not working as they should." Drugs like SSRI antidepressants can help, since "the brain chemical serotonin" may "not be working well in people who are depressed or anxious." The curriculum reassures children that some amount of sadness, anxiety, or other distress is "normal"; however, any distress that "interferes with your normal routine" for more than two weeks could indicate a brain disease requiring professional help and drug treatments.

I provided these excerpts to Elia Abi-Jaoude, a University of Toronto psychiatrist and researcher who coauthored a 2015 *BMJ* critical re-analysis of the infamous Paxil study.

“These statements are so simplistic that I would consider them misleading pseudoscience,” said Abi-Jaoude—who obtained a PhD in neuroscience. “Is serotonin involved in mood? Yes, as is pretty much every other brain chemical. But there is no good evidence to say that serotonin is not working well in people who are depressed or anxious.”

Indeed, some of the statements in Kutcher’s curriculum and teacher guides, though legitimate personal opinions, would almost certainly provoke a written reprimand from the FDA as “false or misleading” if uttered *by a drug manufacturer* in promotional materials for a psychotropic (see chapter twenty-three).

However, Abi-Jaoude added, the “lack of validity” of such “neurobabble” concerned him less than the impacts of these messages on children. “First, it pathologizes their emotions, and it leads them to be suspicious of strong emotions, especially negative ones. Second, it is disempowering. It encourages them to see emotions as something over which they have no say, they are helpless, they have a brain disease.”

These narratives also create fear, of course—fear that trying to change oneself or one’s life circumstances won’t help, because medical interventions are needed. Could this be contributing to the widely documented, record numbers of children flocking to hospitals for psychiatric help in recent years? Indeed, Kutcher’s program is proudly touted to demonstrably increase the numbers of children who seek professional help.

Mental health programs and policies at colleges and universities also promote aggressive interventions in response to emotional distress. For example, a 2018 class-action lawsuit against Stanford University stated that many students who experienced emotional crises or were revealed to have been diagnosed with mental disorders were ordered out of school and required to prove they were undergoing mental health treatment before being allowed back. In *Review of Law and Social Justice*, a lawyer from UCLA’s Saks Institute described this as a national trend, stating that “college officials and administrators have continued to enforce mandatory leave policies or, alternatively, condition students’ continued enrollment on mandatory treatment.”

* * *

By the time she was at college in California, Chaney’s latest medications were making her sleep all day and miss classes. She began to feel desperate about her apparently broken brain. “Things just sort of spun out of control,” she said. “I got really sad and really alone and just suddenly decided to go try and overdose.”

She regretted it and called 911. Chaney was taken to Sempervirens psychiatric hospital.

“It is a garbage pile,” she said. “It’s like a jail cell. A sixteen-by-sixteen room. And there’s like nine beds just shoved in there.” Many patients were in the midst of meth-induced psychosis and withdrawal. “They’re screaming and banging on the walls.”

As a minor, Chaney got put into a separate, closet-sized room, with just a chair and a “janky little bed,” she said. “People had scribbled, ‘Help me!’ and ‘I’m in hell’ all over the walls.” She was under constant surveillance: “They hire some guy from some crappy gig service to sit in the chair all night. He watched me from, like, an inch away. It was terrifying. It was awful. That was one of the worst nights of my life. And I blamed myself completely, which just added to the narrative that there’s something wrong with me.”

In the morning, a doctor gave Chaney a new prescription and sent her home with her parents. She dropped out of school.

* * *

Chaney got new diagnoses of obsessive-compulsive disorder, bipolar disorder, and borderline personality disorder. New drugs came with each. She said it was the ease with which she kept getting labeled with new disorders after simply mentioning feeling anxious, or sad, or washing her hands frequently that ultimately made her start questioning what was happening and whether the medications were helping.

When she went to a larger California university to study wildlife biology, the cosmopolitan population offered a reprieve from her rural childhood. “I actually made friends for the first time in my life and met people who understood me,” she said. “I started kind of coming out of my shell a little. I went off all the medications and had a great time for about four years.”

However, when Chaney was in a blue period, a friend suggested Chaney visit the nearest hospital—Sempervirens. Chaney expressed misgivings. Her friend had never been to Sempervirens, but said it was “totally normal” to go to a psychiatric hospital and surely Chaney would get better help this time.

“I think that’s the problem,” commented Chaney. “You really hope that they’re going to help you.”

* * *

At Sempervirens, Chaney was prescribed the anti-anxiety sedative Ativan and sent on her way.

Did the Ativan make her feel better? “Well, yeah!” she said with laughter. “But it makes you reckless.”

Chaney wasn’t told that benzodiazepine sedatives—also popular street drugs—are highly addictive. Soon, her life went off the rails. “I had no idea it was going to be so addictive and so wild.”

As her body built tolerance to the Ativan, she unwittingly began suffering withdrawal between doses—and instead of just dropping into a normally low mood, she’d become acutely suicidal. “That’s when the cycle started,” she said. She’d reach out for help, and someone would call 911. She became identified as mentally ill in police and social service records, so virtually any unusual behavior got her taken to the hospital. “It became a revolving door,” she said. One time she was walking along the road crying, and police spotted her and took her to Sempervirens. She got in a minor car accident and was dazed, and got taken to Sempervirens. She talked with a therapist about her suicidal feelings, and the therapist told her to go to Sempervirens.

The image of “revolving door” patients—people getting repeatedly hospitalized—is a key part of the deinstitutionalization-as-failure story. It’s primarily blamed on people’s “severe mental illnesses,” and prompts calls for more aggressive forced treatment. At Sempervirens, staff started to derisively refer to Chaney as a “frequent flyer”—and then would send her off again with Ativan refills.

One time, Chaney objected to being compelled, yet again, to strip naked in front of staff. She blurted, “You’ve already seen me naked enough times.” In a lengthy email after our conversation, Chaney detailed how staff violently overcame her. She said it was possibly “the most traumatic incident” she’d ever experienced.

Years later, in 2015 and ’16, news outlets began reporting on “an exodus” of staff and successive medical directors from Sempervirens after many years of problems. Some issued public letters, describing “dangerous working conditions,” “overwhelmed medical staff,” “inadequate patient care,” and “a pervasive culture of bureaucratic indifference.” Federal inspections cited Sempervirens for having “failed to ensure patients’ rights were protected.”

* * *

School mental health educational programs never caution youth that help-seeking could possibly lead to psychiatric detention, forced treatment, or experiences like Chaney’s. And they rarely clarify that mental disorder diagnoses are arbitrary and brain chemistry imbalance claims unproven. Is this accidental, or deliberately manipulative? I conducted a few tests.

Three major organizations whose programs affect untold numbers of children in Canada—Girl Guides, Kids Help Phone, and the Psychology Foundation—have designed a curriculum called “Mighty Minds” that compares emotional problems to diabetes, and asserts that distress can be cured when “a person’s brain chemicals have been balanced” by psychotropics. I, along with thirty concerned psychiatrists, medical doctors, health researchers, and former patients, crafted a letter that proposed removing the medically incorrect and fearmongering statements, and offered revisions.

None of the organizations addressed our concerns. Psychiatrist Abi-Jaoude, who cowrote the letter, said, “I think their lack of response speaks volumes. It shows how difficult change is, given how this way of thinking pervades our culture.”

I also formally complained to Kutcher and Nova Scotia’s licensing College about the medically misleading statements in Kutcher’s Mental Health and High School Curriculum Guide and other related guides for school teachers. Nothing occurred—other than the College warning me it was illegal to publicly quote their response.

I then sent an article to the *Canadian Medical Association Journal* (*CMAJ*), highlighting the lack of adequate medical evidence to support many of the statements in common mental health educational programs. My article was approved by a *CMAJ* deputy editor and scheduled to appear on the *CMAJ* blog.

It never appeared. The *CMAJ* administrative assistant finally emailed me. A second deputy editor of *CMAJ* had intervened, explaining, “I think that we could get into a lot of trouble for publishing this. I think it’s an area where evidence is lacking . . . but kids are struggling and people are using this messaging to encourage them to get help.”

* * *

I asked Chaney why she kept reaching out for help. “It’s just so hard when you’re so desperately sad and alone; they just hammer it into you that there’s help out there. And if you’re struggling, hospitals and drugs are all they offer.”

In hindsight, Chaney compared being told that she had chronic mental illnesses to an abusive romantic relationship she was in for a time. “I was told that I was worthless. And if you’re worthless, you’re not going to aim for better. So that’s what I told myself, is that I deserved to be tied down and locked up and injected.”

* * *

Florida is one of the only jurisdictions that tracks and publicly releases sufficient data on forced psychiatric interventions on children to make visible the apparent impacts of these programs.

In 2019, a *Tampa Bay Times* analysis found that, over the previous seven years, children had been forcibly taken from public schools in Tampa Bay to psychiatric facilities more than 7,500 times. “They often leave campus handcuffed in the back of police cruisers,” reported the *Times*. “Some are as young as 6.” Across the state, detention rates have risen steadily for years, with a staggering 38,000 children forcibly taken to psychiatric hospitals between 2018 and 2019 alone—one in every hundred children.

The *Times* described examples of what had triggered these 911 calls, including one child putting a provocative post on social media, one scrawling in a textbook about death, one crying in a counselor’s office, another spotted with cuts on her arm, and one finding a loop of rope on the ground and jokingly wrapping it around his neck in front of friends.

Meanwhile, these better-safe-than-sorry responses often backfired horrifically. The *Times* described parents cut out of the loop, prolonged psychiatric detentions, and children hospitalized alongside older mental patients and being physically and sexually assaulted.

The *Times* noted how some of this was simply fueled by kids today writing their “darkest thoughts” on the web or in school-surveilled messaging systems, rather than in private diaries like previous generations. In addition, the *Times* pointed to Youth Mental Health First Aid and other school educational programs actively training students and teachers to call 911.

Similar upsurges are happening in Canada. A 2021 investigation by the British Columbia Representative for Children and Youth found a 162 percent increase in involuntary detentions of children over the previous ten years.

* * *

One time, Chaney wondered if there were better mental health services elsewhere, and drove to Oregon. Hospital staff there accused her of being a homeless person just looking for a place to sleep, and got her jailed for trespassing.

Released hours later, Chaney went to another hospital and stayed for two weeks. “The most helpful thing was talking with the other patients. I wasn’t talking to people coming off meth. It was people who had really similar situations to me.” It felt healing, she said, simply to feel less isolated with her pain. And this brought a revelation: “I kind of sat there and I thought about it, and I was like, you know, this has been going on long enough. You’ve got to stop coming to these places for help. You’re going to get locked up, and nothing’s going to happen. The meds aren’t going to help you, and the people in white coats aren’t going to help you, and the police aren’t going to help you. You have to figure this out yourself. You have to figure out a reason to live.”

Chaney got certified to do whitewater raft guiding. She moved into a broken-down bus in the Montana wilderness, living amidst a community of other nomadic guides. The months she spent there, she said, inspired a “spiritual transformation.”

When her worst feelings came up, the nearest mental health professionals were hours away, so she had to simply be with her feelings. And she didn’t die. And she didn’t get called ill, locked up, or drugged. Eventually, she’d feel okay again. “I had this epiphany of, there’s really nothing wrong with me, as long as I don’t tell anybody when I have this cycle of suicidal thoughts.”

Chaney is now in her thirties and most recently worked administering welfare applications in Colorado. In six years she’s only been in a psychiatric hospital once, briefly, and believes she’s finally out of the hurricane. Chaney said she still carries “a deep feeling of shame” about having been a revolving-door mental patient—though she now recognizes she was from childhood schooled, encouraged, and forced to become one. She’s trying to get past the humiliation, in part by being more open about it all with people close to her. “It’s a really lonely thing to be a survivor of psychiatric harm,” she said. She believes that her experiences have made her more understanding and helping toward others experiencing emotional struggles.

In her most troubled moments, though, she said she sometimes still thinks, “Maybe there is something wrong with me . . . something wrong with my brain.” In many ways, the stories that therapists told her undermined her confidence and sense of herself as much as any drug. “I don’t know if I’ll ever get away from that,” she added. “It was thrown at me at such a young age.”

* * *

For many children and youth, though, fleeing the mental health system like Chaney finally did is nearly impossible. I figured this out after piecing together disparate stories, and then finally digging up an expert willing to talk frankly.

In 2020, a *USA Today* article described how law enforcement authorities and the National Center for Missing & Exploited Children (NCMEC) retrieved twenty-seven missing children in Virginia. It seemed a good news story. However, I noticed that none of the cases involved abductions, trafficking, or criminal rings. The children “ran away from foster care situations.” NCMEC’s website stated that, in 2019 alone, NCMEC assisted law enforcement in 29,000 cases of missing children—of which 90 percent were runaways.

I thought of my friend Juli-Ann Aaron. Over the past twenty years, Aaron has told me stories about how her wealthy Canadian parents felt she was too rebellious and sent her at age fifteen to a US residential treatment center. Aaron was locked up for two years at centers in Idaho and Utah, and subjected to bizarre “therapies” such as group confessionals and militaristic rules of conduct that frequently devolved into insults, beatings, and forced psychotropic drugging. Aaron also told me that, at one point, Paris Hilton was her roommate.

In 2020, Paris Hilton opened up, too. The documentary *This Is Paris* showed how the famous heiress, actress, and musician had been partly shaped by her time at Utah’s Provo Canyon School. Suddenly, the “troubled teen industry” was getting exposed on nearly every mainstream media outlet.

“Although Provo Canyon School marketed itself as a premier treatment center, it was as if hell itself was on Earth,” Hilton told Utah legislators in 2021. She described beatings, forced drugging, and sexual violations. “I cried myself to sleep every single night, praying I would wake up from this nightmare.”

The phrase *troubled teen industry* loosely applies to a wide array of facilities and programs, but essentially they comprise our core, long-term mental health system for minors—licensed residential treatment centers slash schools for children and youth labeled with behavioral, substance use, or psychiatric problems. There are some 1,500 such centers in America with an estimated hundreds of thousands of detained children, generating billions of dollars in revenues. Wealthy, anxious parents aren't the only ones who use them; state governments also send foster children, often choosing facilities in jurisdictions with lax regulations.

In 2007, a Government Accountability Office (GAO) investigation of youth residential treatment centers found, in one year alone, 1,619 staff members were involved in incidents of abuse in thirty-three states. In 2020, psychologist Ronald Davidson, who for many years investigated such facilities as part of an Illinois class-action settlement, told the *Salt Lake Tribune*, "Exploiting troubled kids for profit is big business . . . and many state agencies are so desperate to find places that will take troubled children that they don't ask too many questions or monitor the quality of care that's supposedly being provided."

In 2018, Disability Rights Washington (DRW) investigated two facilities in Iowa, part of a national chain owned by Alabama-based Sequel Youth and Family Services. According to DRW, there were severe restrictions on freedoms, and inappropriate uses of involuntary detentions, forced drugging, and physical restraints. Disciplinary consequences followed for everything from not tucking in a shirt to not walking in single file. Breaking such "norms" ignited Sequel's documented "7 Levels of Intervention"—youth would be subjected to individual and group condemnations, and staff intervention through "being yelled at, cursed at, spit upon, and threatened." Amid scandals and lawsuits, by 2021, Sequel facilities had closed down in Michigan, Utah, Wyoming, North Carolina, Kansas, and Iowa.

The National Disability Rights Network issued a sweeping report in 2021 of other facilities across eighteen states, describing the widespread abusive use of physical and chemical restraints along with public shaming, fight clubs, sexual abuse by staff, and forced isolation. "In some facilities, children quite literally do not receive enough food to grow normally and are housed in vermin-infested buildings."

In her 2006 book, *Help at Any Cost: How the Troubled Teen Industry Cons Parents and Hurts Kids*, journalist Maia Szalavitz showed a pattern going back decades where facilities rake in profits until they get targeted by lawsuits and government investigations, then declare bankruptcy and simply get bought up and restarted by other corporations and investment companies operating in similar ways. Provo Canyon's most recent owner is Universal Health Services (UHS) and, according to the *Salt Lake Tribune*, "The allegations of abuse and mistreatment haven’t stopped in the two decades that UHS has owned Provo Canyon School.” The *Tribune* quoted Provo’s current CEO: “We are concerned that the current media coverage may increase the stigma around seeking help for behavioral health concerns.” As the CEO spoke, twenty UHS psychiatric hospitals were under investigation by the Department of Justice for detaining people fraudulently for profit (see chapter thirteen).

* * *

So, who wouldn’t try to run away from such places? My friend Juli-Ann Aaron told me that she escaped multiple times running through pastures and hiding in ditches. Every time, she was declared a “missing child” and tracked down.

Then I spotted a few more pieces to this puzzle.

Office of Inspector General reports in 2015 and ’18 found 30 percent of children in foster care were being given at least one psychotropic, and up to 70 percent without any appropriate medical monitoring. San Jose’s *Mercury News* ran a series about how the California foster care system had “grown dependent on quick-fix, taxpayer-funded, big-profit pharmaceuticals,” describing children drugged into passivity, suffering massive weight gain or chronic trembling from antipsychotics, and too “zoned out” to focus on school. *New York Post* stories described how staff at a Manhattan foster care center were daily getting rowdy children hauled next door to Bellevue hospital to be forcibly injected with antipsychotics and sedatives. “Nobody likes to be sent to the hospital,” said one girl. Local police said this one foster care center alone had called 911 with hundreds of reports to recapture “missing children” runaways.

Another investigation found that at any time half a million children are in foster care, family homes, congregate settings, or residential treatment facilities, and about 50 percent have run away at least once. The most common reason for fleeing is “abusive” situations, including “highly restrictive placements.”

So, how many of America’s hundreds of thousands of runaway children annually are fleeing forced psychiatric treatment? And when these children get recaptured, what are they brought back to?

I reached out to NCMEC and other prominent agencies and organizations working on finding missing children. None would discuss the issue; they were often partnering with mental health professionals, hospitals, and treatment providers to recapture children.

I finally found Darla Bardine, director of the nonprofit National Network for

Youth (NN4Y), based in Washington, DC. NN4Y does advocacy and lobbying on issues affecting homeless children, and also collaborates with community-based service providers that share NN4Y's values. Notably, Bardine said that NN4Y doesn't take government funding and roots its work in what children and youth tell them—NN4Y actively includes youth in its policy development.

"From our perspective, most young people are running from something," said Bardine. And that something, she said, is not uncommonly child welfare systems themselves.

She was unaware of any formal research examining how often children flee the mental health system specifically, but said, "Young people are definitely running away from any kind of forced treatment." And the core problem is that "young people in the child welfare system have no voice and choice. The system is your parents, and controls you."

At meetings of organizations and agencies that recapture missing children, Bardine said she often asks the same question I was asking: "How do you know that they're getting brought back to somewhere that's good for them?" She said she's never heard a reassuring answer.

Generally, minors cannot legally work, get housing, or apply for student loans, so runaways often become homeless and get driven into underground economies where they're at risk for abuse and exploitation. Bardine said that NN4Y therefore works to create "community-based alternatives to systems involvement" that empower rather than disempower children, such as rental supplements that children can use on housing they choose. For this to work, she said, as a society we have to give young people more rights to make their own decisions over everything from housing and finances to mental health care. However, Bardine said NN4Y continues to battle against many entrenched institutions that prefer maintaining complete control.

The impacts still haunt Juli-Ann Aaron, especially after her own child began school. "Teachers and administrators get a day of professional development training, and all of a sudden they're ambassadors of your child's mental health," said Aaron. With educators already also policing and disciplining kids, she said, "the barriers and boundaries get blurred so easily. They feel they have this right to administer any type of intervention." Aaron sometimes finds it re-traumatizing. "I'm not the only one who's been called into the office, and bombarded and cornered. Especially as a single parent, you have to fight if you have different values about finding solutions."

CHAPTER 10

TRACING "ANONYMOUS AND CONFIDENTIAL" COMMUNICATIONS

Public support for the National Suicide Prevention Lifeline (NSPL) has been soaring. In 2017, the rapper Logic released a Grammy-nominated song titled with the Lifeline's 800-number that peaked at three on *Billboard*. That led to call volumes increasing 25 percent. Covid-19 lockdowns pushed volumes higher. In 2020, the federal government mandated that, by 2022, all calls to "9-8-8" would be routed to the Lifeline.

Driving some of this is growing awareness that calling 911 for issues of emotional distress can lead to deadly police interventions. Yet, underreported is the fact that calls to the National Suicide Prevention Lifeline—which prominently advertises itself as "confidential"—are often covertly traced. Callers get subjected to police interventions and forced psychiatric hospitalizations. Police shootings have occurred. Many callers describe their experiences as terrifying.

NSPL has practiced call tracing for years. Inquiring journalists are told that it occurs only in "rare" situations of impending death, and are asked to avoid scaring people from seeking help. But complaints on social media are increasingly visible. Comments below YouTube videos promoting the Lifeline, for example, usually include many critical responses. "I texted a suicide hotline, and they called the local police department on me. It made me worse, and now I just hole up inside," wrote one. Another commenter wrote, "When I was 11 years old I tried calling the suicide hotline but then they sent the police to my house so now I don't trust anyone."

When the NSPL finally released the numbers to me, I realized that "anonymous" crisis lines are one of the nation's largest funnels into psychiatric detentions. And if 988 is implemented as planned, insiders told me, every remaining independent crisis call center will feel pressured to join the NSPL and trace calls.

◆

David is a veteran in his mid-twenties, who works in commercial aircraft maintenance. When feeling stressed at work, David sometimes called the Lifeline. "The negative emotions are less oppressive, like there's a burden lifted that someone's helping me share," he told me.

One day in 2019, David called during lunch. When asked by the call-attendant, he said he wasn't actively suicidal but was just "feeling pretty down." After ten minutes, he cut the call short to get back to work. Twenty minutes later, police arrived at the hangar. They said they'd heard he was suicidal, took his access badge, and escorted him to an ambulance.

David was stunned. He'd used his personal cell phone, and hadn't shared his name, location, or type of work.

"It was really embarrassing and traumatizing. All my coworkers and my lead and supervisor, they saw me get taken away." Police are especially intimidating to him, he said, because growing up in New York he was frequently subjected to random stop-and-frisks, and as a six-foot-three Black man, he imagines he can look dangerous.

David was detained in an "absolutely miserable" veterans hospital, and was only allowed to leave several hours later when his brother-in-law came to get him. David was saddled with a $1,050 ambulance bill, and had to get clearance from another doctor to be allowed back to work. He wondered if these events played a role in his getting laid off three months later, ahead of people with less seniority.

"The hotline was the most reliable place for me to get help when I needed it, and now I feel I can't trust that place anymore," he said.

Though David emphasized he'd never endanger anyone, an attorney confirmed to me that his chances of getting his needed security clearance in the future could be jeopardized by what happened.

◆

In 2018, Holly, a young white student, had recently left an abusive relationship and moved to Ohio for law school. She was feeling isolated and self-doubting, but had no health insurance and couldn't afford therapy. "I was just depressed and kind of wishing that I might just die," she said. "I wanted to talk to another person and maybe be reassured a little."

The Lifeline conversation was awkward. "I didn't feel like [the call-attendant] was really hearing me. She was kind of using canned responses." Much later, Holly learned the attendant had secretly been ushering her through a suicide screening questionnaire. "If you were going to kill yourself, when would you do it? How would you do it?"

Holly said she'd likely overdose with pills. "I just kind of gave her the first answer that popped into my head. I thought it was kind of a weird thing for them to be asking me, because isn't the goal to try to talk me out of committing suicide, instead of helping me make a plan?"

The call-attendant suggested Holly go immediately to a psychiatric hospital, but Holly said she had a class soon. The attendant wanted to send police out. When Holly said that was unnecessary, the call-attendant replied, "The police can determine that." Frightened, Holly hung up.

Fifteen minutes later, police and an ambulance appeared. Holly said she was "freaked out" and worried about her new neighbors seeing "this spectacle." The police, she said, "had already made up their mind." Holly was strapped to a stretcher.

At the hospital, she was forced to strip naked, with several people watching. She was put in a small room with nothing but a bed, and left for twelve hours with no explanation what was happening.

"I was terrified," she said. A social worker came by for about five minutes. "He diagnosed me with bipolar disorder. I don't know where he got that from. And he was trying to make it sound like I told them I had tried to overdose prior to calling the hotline. And I was saying, 'No, that's not what I said at all.' And he told me that now I was lying."

Holly had arrived at eight thirty in the evening and became too anxious to sleep. In the morning, feeling "brain dead" from exhaustion, she was subjected to a series of interviews and told she'd be detained for further psychiatric evaluation.

She felt panicked, but told herself, "Just try to act calm, don't give them anything they can use against me." The way she was being treated, she said, put her in a "criminal defense kind of mindset."

Eventually, Holly was put in a room with someone violently detoxing, prescribed two psychiatric drugs, and reprimanded for skipping breakfasts and some of the group therapies. After seventy-two hours, she was told a court application would be made to keep her longer. “It has very serious career implications, because when something like that goes to court, you’re introducing it into the public record,” said Holly.

When applying for a license to practice law, she explained, anything hospital staff wrote about her could then be accessed by the state board of bar examiners and cause them to question her “mental fitness.” This common bar practice is increasingly criticized by some within the profession. “I knew that I had to avoid going to court at all costs, and my only way to do that was to sign myself in voluntarily. There was fuck-all that was voluntary about this.”

Two weeks later, Holly was discharged—with a hospital bill for $50,000. “It was more than my student loans!” Holly negotiated it down to $20,000 and a ten-year payment plan.

She considered complaining to the NSPL. “But at this point, I just don’t want any further contact with any of these people.”

* * *

Some callers I spoke with were so shocked and outraged by what was happening that they resisted, and got violently restrained and forcibly injected. Many were baffled by why or how their calls were traced, and suggested that the call-attendants were overanxious themselves, overeager to “help,” or just not understanding. Delving into the policy, science, and call data, such misunderstandings seem not only possible but likely common.

The NSPL is managed by a nonprofit, Vibrant Emotional Health, under contract to the Substance Abuse and Mental Health Services Administration (SAMHSA). John Draper directs the NSPL along with hotlines for veterans, disaster victims, and the National Football League. About 180 community crisis centers are NSPL members, and comply with Vibrant/NSPL policies. Calls to the NSPL’s various 800 lines get routed to the geographically nearest member center, and other centers provide backup. Centers also take calls through their own local numbers. Call-attendants are often a mix of staff and volunteers.

The NSPL’s website and ads declare all calls to be “confidential,” and do not prominently disclose any limits to that. Member centers vary in whether, how forthrightly, or how often they might disclose. The practice of forcibly intervening is described in NSPL policy and in a journal article coauthored by Draper.

A caller is identified as being at “Imminent Risk” when the call-attendant believes that, in the relatively near future, the caller might take their own life. Actual “suicide attempts in progress” are just one, apparently rare, subcategory. To determine if other callers are at imminent risk, call-attendants secretly run callers through a risk-assessment questionnaire to determine if the caller has the *desire*, *intention*, and *means* to kill themselves.

“Active Rescue”—the euphemism for call tracing and interventions by police, ambulance, or mobile mental health crisis teams—is to be implemented as a “last resort.” But interventions can also be triggered simply when third parties call saying someone they know might be at risk, or if a call-attendant believes a caller’s mental state might lead to some undefined “harm to self or others.”

Certainly, US laws give latitude for breaches of confidentiality intended to help others in danger. But how many people who call a suicide line to talk about suicidal feelings *do not* have any desire or intention to kill themselves or access to any of the most common means such as pills, poisons, ropes, guns, jumps, or suffocation? So, with an average call duration of only ten minutes, is deciding which callers get a police visit basically a crapshoot?

Yes—according to all the research, including the NSPL’s.

A 2017 meta-analysis found that expert abilities to predict suicide barely beat random chance, and have “not improved across 50 years of research.” A 2018 review found that suicide risk-assessment methods all produce an “unacceptably high false positive rate.” A 2016 study of NSPL centers acknowledged that “an empirical foundation for warning signs of imminent suicide risk is lacking,” and that the whole concept of imminent risk “is fraught with problems such as lack of clarity and imprecision.” Internal SAMHSA and NSPL documents show a history of “inconsistent” assessments; one study of just four NSPL centers found that the number of times police were sent out ranged from 0.5 percent to 8.5 percent of calls.

So how many people is this happening to? And is it possible to protect oneself?

* * *

Christopher Parsons, senior research associate at the University of Toronto’s

Citizen Lab, which works at the intersection of digital technologies and human rights, had not heard of suicide-line call tracing. But his explanation of how it's likely done was confirmed in papers from the National Emergency Number Association and Federal Communications Commission (FCC).

With Caller ID and a landline, names and addresses can be found in widely available databases. With blocked Caller ID, mobile devices, and online chat, call-attendants contact 911 and get routed to a "Public Safety Answering Point" (PSAP)—usually police—for "Enhanced-911." Call-attendants give the call time or IP number. PSAP staff then obtain number, billing, and/or location information from telecommunications databases. They can also "triangulate" locations using cell towers, but most commonly today they covertly ping the GPS chip in mobile devices.

Can GPS-pinging be blocked? "This isn't an operating system feature," said Parsons. "This is baked right into the guts of the phone itself. It's going to bypass the controls that you may have set in place."

GPS-pinging can work even if the mobile is turned off or its main battery has recently died. This manufacturing standard was nobly intended—when we call 911, emergency responders can now quickly find us. With ever more devices, our personally identifying information and geolocation are transmitted automatically. However, Parsons said Canadian police have been evasive about other uses. The Electronic Frontier Foundation is fighting court cases where US police used it to track suspects without warrants.

Parsons said it's concerning that there are few legal rules and no public transparency surrounding Enhanced-911 usage. "I think that when novel policing technologies are being developed, or being deployed, or in use, there needs to be with it an explanation of the law and how that operates, as well as a mandatory reporting framework. That's the institutional bare minimum."

Electronic Frontier Foundation's Andrés Arrieta, too, was surprised by NSPL practices, and called for more transparency: "They should simplify and explain to people at the beginning what 'confidential' means. And how many times a day do they query for the location data? What was the reason? Was it reasonable? What was the result?"

* * *

SAMHSA and Vibrant/NSPL are anything but transparent.

Both refused to provide statistics. I initiated a freedom of information request, and, for months, SAMHSA alternately ignored it or claimed they had nothing.

SAMHSA finally handed over a survey. NSPL centers received 2.2 million calls in fiscal year 2017–18. Some call centers didn't complete the survey or answer certain questions, but out of 1,020,142 calls, 21,055 callers were subjected to Active Rescue. Extrapolating that 1-in-50 rate to all NSPL calls, that's 44,000 callers who got police visits that year. Some reportedly involved caller "collaboration," but that included callers who buckled to pressure.

This 2 percent rate is what the NSPL has occasionally admitted publicly. However, analyzing the data further, the number of interventions was much higher. Mobile mental health crisis teams were sent to visit an additional 108,386 callers. Across all NSPL call centers, the number was presumably twice that. These teams are often accompanied by police, and often forcibly hospitalize people; indeed, New York City mobile mental health teams specially trained to *reduce* hospitalizations still hospitalized 50 percent of the time. Furthermore, the survey did not ask NSPL centers how often they dispatched police in response to calls coming in through their own local numbers. That's eight million more calls and, assuming the same percentages, 160,000 more unwanted police interventions annually and possibly hundreds of thousands more interventions by mobile crisis teams.

These numbers suggested the National Suicide Prevention Lifeline was the biggest funnel into psychiatric detentions in America next to 911.

I stopped digging for more data when both SAMHSA and the NSPL's Draper promised me interviews, which they later reneged on. I asked Vibrant/NSPL media representative Frances Gonzalez what the NSPL had to say to people who've felt traumatized after they made a "confidential" call and got forcibly apprehended—Gonzalez didn't respond.

Meanwhile, in a promotional video, the NSPL's Draper actually criticizes how the mental health system forcibly intervenes on suicidal people, and repeatedly lauds how the NSPL is all about "empowering" callers to make their own decisions about "what kind of care they want, how they want it, and when they want it."

* * *

Many former call-attendants, crisis line operators, and suicidology and legal experts express concerns.

Megan Wildhood is a Seattle writer who identifies as autistic, and took NSPL training. It was two half-days, with just two hours devoted to making imminent risk assessments using a question-and-answer “decision tree.” Wildhood asked about people who’d had terrible experiences after their calls were traced. The trainer replied, “We help more people than we hurt.”

Katie Tastrom is a sex worker and disabled writer and activist who worked at an NSPL crisis center for several months. She pointed out that the police interventions are most dangerous for people who are poor, disabled, or otherwise marginalized—and more likely to rely on free support hotlines.

Call tracing was a daily occurrence in the center and Tastrom felt pressure to do it. The number of interventions sometimes went up, and then there’d be discussions and trainings to bring it down. “There’s definitely people who would call the police pretty quickly,” said Tastrom. “Some people just got really panicked; they felt like it would be their fault if the person killed themselves.”

Other biases also came into play. “People with a specific mental health disability, people with quote-unquote ‘psychosis,’ things like that, definitely would be at risk of having the police called on them way more,” said Tastrom. “They’re seen as not being able to make decisions for themselves.”

* * *

Even if there might sometimes be understandable reasons to intervene, why not at least honestly disclose to callers that it could happen?

Crisis Services Canada is a similar network to the NSPL, and similarly wouldn’t discuss its call-tracing practices. However, Stacy Ashton, director of the Crisis Centre of British Columbia, said they send out police in response to about 2 percent of calls.

Ashton said she dislikes how “boilerplate” disclosures can “maintain that impression that suicide cannot be talked about.” Disclosures can also make some people afraid to talk, she said, and isolate them further.

Of course, the fear could also make some callers seek out other hotlines that don’t trace calls—possibly partially explaining the evasiveness of the NSPL and Crisis Services Canada, who hinge their funding drives on their call volumes.

For her part, Ashton said that either letting people potentially kill themselves or sending police and forcibly hospitalizing them are “two really undesirable alternatives” and “not a decision that any one of us wants to be locked into.” Ashton said high-profile police shootings in America have had “ripple effects” in Canada. “The core assumptions of how we handle mental health crisis in our society is up for grabs. It’s an amazing opportunity to actually talk openly about it.” One roadblock, Ashton said, is the accreditation standards of the American Association of Suicidology (AAS): “They don’t support a completely anonymous crisis line.”

* * *

Bart Andrews sits on executive committees of the AAS and the NSPL, and is Chief Clinical Officer at a Missouri call center. He supports call tracing, and said call-attendants struggle with feelings of “moral liability.”

“You’ve got to ask yourself, which problem do you want to deal with? The person being dead, or them being angry that the police come out to make sure they’re safe?” said Andrews. And families sometimes try to sue. “You’re not answering to the person you didn’t call the police on. If they end up dead, you’re answering to their loved ones.”

Nevertheless, Andrews acknowledged mounting evidence that psychiatric hospitalization seems to be extremely suicidogenic. Numerous studies have shown that, after being psychiatrically hospitalized and treated, people become dozens or even hundreds of times *more* likely to kill themselves, even if they were never suicidal before. But Andrews believes more studies are needed to understand what this evidence truly means. “The lack of data is troubling. We hospitalize people at risk of suicide, even though we don’t have any evidence that hospitalizing them is particularly helpful.”

His center’s call-attendants usually disclose the possibility of call tracing and interventions; Andrews said he believes this openness builds trust, prevents people from feeling betrayed, and creates “an aggregate good.” So, shouldn’t all crisis centers accredited by AAS disclose that the police could be called? “It’s a fair question,” he answered. “That’s something that AAS as an agency needs to discuss and get input on.”

Draper’s paper hinted at backroom politicking heading in the opposite direction, though. “While two Samaritans centers in the network had historically resisted active rescue on philosophical grounds, they too agreed to adopt the Lifeline [Imminent Risk] Policy,” the paper stated, explaining that Samaritans finally understood the “compelling research.”

Samaritans characterized what happened differently. And they warned that the Vibrant/NSPL mission could ultimately reshape how all crisis lines across

America operate.

* * *

The New York Samaritans advertise that their hotline is “completely confidential” and that, “unlike some other hotline services,” they never conduct “any form of call tracing.”

Director Alan Ross said he understands the motives of call tracing, but some people want absolute anonymity no matter what. “You need diverse forms of access to reach the majority of people. And the greatest gap is confidentiality. People are hesitant to seek help, because they’re scared. They don’t want people to know their business, or they’re ashamed.”

Ross pointed to people questioning their sexuality or gender, illegal immigrants, politicians, parents in custody battles, and many others who might be seeking help in sensitive circumstances. “I can come up with one hundred reasons why you wouldn’t want to take a chance of someone being able to identify you.”

But many Samaritans crisis lines have moved away from protecting people’s privacy and autonomy. “In New York City, we’re the dinosaur. We’re the last bastion of what were the original practices and principles.”

Ross was a formal adviser on the NSPL’s development twenty years ago. He described a diverse collection of community-based centers collaborating to create round-the-clock support, with call tracing not required. Several years in, though, the nonprofit that later became Vibrant Emotional Health won the SAMHSA bid to assume control.

At the same time, there was an expanding psychiatric-industry movement to recast suicidal feelings as mental disorders requiring treatment. SAMHSA, the American Association of Suicidology, and Vibrant/NSPL began to push call tracing and hospitalization.

* * *

No one knows how many community-based hotlines around the country remain outside the NSPL and don’t trace calls. Yet when the federal legislation establishing 988 is fully implemented, all 988 calls—and the associated state tax funding allowed by the legislation—are slated to go solely to NSPL centers.

“This is one of the things that sticks in the craw of those of us who run independent community hotlines,” said Ross. “The NSPL gets all the marketing, all the promotion, all the funding. And now that they've created this three-digit number, it appears that things will only get worse. The NSPL could have a perfect monopoly."

So why have any Samaritans gone along?

Ron White, Chief Program Officer for Boston Samaritans, said his center joined the NSPL to be part of national research, best practices development, and funding access. Their center didn't trace calls. But around 2012, said White, "the NSPL finally, kind of, if you will, drew a line in the sand that said, if you want to be a member of this network, you need to adopt our intervention policies."

Does he believe 988 implementation could put pressure on other crisis lines to join the NSPL? "The more people are aware of 988, the less likely they are to call non-Lifeline centers," said White. "And if 988 comes with funding, I think these small nonprofit centers are going to take a hard look at that."

* * *

I later obtained internal meeting minutes showing that, even as I'd been seeking answers from the NSPL, internally, the NSPL's own advisory committee of people with lived experience—suicide-attempt survivors, hotline users, and family members—had long been passionately criticizing call tracing. They'd been telling NSPL leaders that subjecting unwitting people to forced interventions created "dangers of brutalization, violence, and criminalization," especially for "populations that have been historically marginalized and/or victimized by law enforcement and mental health systems, including LGBTQ and BIPOC communities."

In response, Vibrant/NSPL leaders had pledged to reduce unnecessary call tracing. However, in 2021, SAMHSA formally awarded them control of 988. Vibrant/NSPL representatives then asked the FCC to give them direct control over cutting-edge "NG911" surveillance capabilities, to enable NSPL call-attendants themselves to directly see the personal information and three-dimensional geolocation to within three meters of everyone who calls, texts, or chats through 988. Vibrant/NSPL leaders assured the FCC that call tracing "only" occurs "in rare but urgent circumstances" when it's "required to save a caller's life." So, in 2021, Congress instructed the Government Accountability Office to investigate the feasibility. (In late 2022, Canada announced plans to implement 988 as well, and during hearings its major national hotline services also lobbied government for NG911 call-tracing powers.)

Megan Iorio, senior counsel with the Washington-based Electronic Privacy Information Center (EPIC), called the prospect “disturbing.”

“It’s not clear if there’s any legal authority to do this,” said Iorio, pointing out that Vibrant/NSPL wants information on all callers for which even police normally must get individual warrants. Apart from the call tracing, what might happen when the NSPL is gathering such information on a vast pool of Americans? “In the moment, they might be referring you to the right [call] center or the mental health services that are closest to you,” she said. “But what happens to that data afterwards?”

* * *

Attorney Susan Stefan, author of *Emergency Department Treatment of the Psychiatric Patient* and *Rational Suicide, Irrational Laws*, was not surprised by experiences like those of David and Holly, and called it “unforgivable” that some suicide lines don’t disclose that they trace calls. “It’s so traumatizing to be trustingly talking to somebody and all of a sudden have the cops show up.”

Many hotline operators express fears about legal liability, but Stefan said courts don’t usually equate hotline interactions with doctor-patient relationships. Her research suggests that, to date, it’s been “extraordinarily rare” for hotline volunteers or staff to be successfully sued for a caller’s suicide.

Stefan described call tracing as a “short-sighted” policy, especially since many people she’s interviewed said they’d never again feel safe calling. Stefan pointed to an air force anti-suicide program that was successfully groundbreaking. The emphasis was less on intervening at the crisis point and more on helping people with practical daily challenges and marital, financial, or other problems that might lead to suicidal feelings.

Stefan also praised Massachusetts-based Wildflower Alliance’s “Alternatives to Suicide” training, which helps people become better at allowing an accepting space for talking with each other about suicide, and whose peer-run hotline attendants never trace calls.

Generally, peer-run hotlines appear to be less likely to trace calls, but Wildflower Alliance director Sera Davidow said that’s not guaranteed. “In my experience, all that they accomplish [by tracing calls and forcibly hospitalizing people] is to continue to send this message that whatever you’re struggling with, the things that have happened to you, are so dark and so terrible that nobody can handle hearing about them.” By contrast, “the whole ‘Alternatives to Suicide’ approach is rooted in this idea that if we make the taboo topics okay to talk about, then people often don't end up getting stuck in them."

Davidow asked which route ultimately leads society to more loss: "Is it the path where everyone is so terrified to talk about suicide because of consequences, like having the cops called on you even by confidential hotlines? Or is it the path where we know that we're going to lose people, and we create as much space as we possibly can to be with people in darkness and talk openly about this and support people?"

Indeed, promoting the suicide line may actually be reinforcing social isolation. Wildhood said that, due to her autism, she's had to teach herself how to build "connection," and she now believes everyone could benefit from some relearning. "We are all so disconnected from the people actually in our lives that we feel safer talking to a stranger," said Wildhood. "If you don't want people to be alone, you show up."

CHAPTER 11

FAMILY CONFLICTS WHERE PSYCHIATRISTS TAKE A SIDE

"I was a little wary when I got your email," said Luciene Parsley, the legal director for Disability Rights Maryland, when we finally connected by phone. "Are you familiar with the Treatment Advocacy Center?"

A TAC report had given Maryland's mental health system a grade of F, and since 2019 the state government and media commentators had gotten swept up in TAC's proposals to expand civil commitment powers. The public consultations were tense; lobbying alongside TAC were some family members of people labeled with mental disorders. Parsley wondered what my agenda was.

In Maryland, said Parsley, "it's typically very wealthy parents, who unfortunately had a son or daughter who has been super promising, Ivy League colleges, very accomplished, and then developed schizophrenia or another type of thought disorder and has reluctance to take their medications consistently or is otherwise resistant to some aspect of their treatment that's been recommended for them. And the parents feel that they should be able to make the treatment decisions for them."

Parsley was sympathetic. "I had a [relative] like this as well. But we see the other side of it, which is people who have been severely traumatized because decisions were made for them about their treatment."

I'd intended to ask Parsley about incomplete detention numbers the state government had given me. But more effectively than numbers could, her impromptu observations exposed a cultural nerve: opinions on forced treatment are polarized, and this polarization often plays out most intensely within families. These dynamics get reinforced by many treatment providers and government agencies that tend to assist those family members who want to employ civil commitment powers, and work against those who resist.

Ultimately, family conflicts form another major funnel into psychiatric detentions and forced treatment. And in many ways, Cindi Fisher gives an articulate face to both sides of the polarization within families.

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Cindi Fisher's child has never expressed interest in speaking publicly, so I've used the pseudonym Pat; in any case, this is really Cindi's story, not her child's. It's Cindi's version of events, and her journey as a mother from worried advocate of forced treatment to passionate activist protesting against it; from valued ally of treatment providers to target of their attacks.

Of African American descent, Fisher was an elementary school teacher married to a pharmacist. They raised their children in the 1980s in a middle-class, mostly white neighborhood in a city in Washington state.

Pat was an independent thinker, sensitive, bright, and adventurous, Fisher said. Though he didn't show much interest in school, he read profusely, taught himself guitar and hip-hop, and was among the top 5 percent statewide after taking the SAT at age twelve. But for other reasons, Pat's twelfth year was pivotal. Fisher later regretted that she and her husband were preoccupied with turmoil in their marriage that led to their separation.

Pat, the only Black child at a white school, came home one day carrying a girl's coat. Pat said schoolmates had taken it from her, and he'd wrangled it from them to return it. The next morning, Pat brought the coat to the principal's office, but refused to reveal who'd originally taken it.

"The police came to the school and handcuffed a twelve-year-old boy," said Fisher. "A young man who had never been in trouble in his life."

After a brief stay in juvenile detention, Pat's school attendance dropped precipitously. "I started losing [Pat] to the streets," said Fisher.

Pat became engaged in street life and was often moody, depressed, or reacting to recreational drugs. At seventeen, there was a sudden shift, as Pat became verbally aggressive, began talking to people who weren't there, and had several blackouts.

Fisher became anxious. "It got to where he would be walking in circles in his bedroom for three hours, talking about the dead coming up."

With a mystical dimension to her own views, Fisher thought perhaps Pat was "walking in two worlds" and struggling to find a balanced path between them. However, after another minor run-in with the law, Pat was ordered to see a psychiatrist.

Fisher took Pat to the appointment herself. "I was really desperate to find answers." Within thirty minutes, Pat had a diagnosis of schizophrenia and a prescription for antipsychotics. "This is what kicks off his career in the mental health system," said Fisher.

Pat took the drugs, but his condition worsened. Pat cut and burned himself deliberately, saying that he "wanted to feel something," and frequently complained about inexplicable agitation inside his body. Pat felt afraid of suicidal thoughts that were emerging.

Like so many confused, worried parents, Fisher ensured that Pat continued taking the medications. Early on, Pat never refused. "He desperately wanted help, and I think he hoped that the medications were the answer."

As the years passed, though, Pat's behavior became stranger and at times more physically threatening, and tensions between them heightened. Sometimes Fisher called 911 to forcibly hospitalize Pat. "I wouldn't be in fear, I'd just be angry," said Fisher. "I just wouldn't know what to do." Pat was prescribed more drugs, and increasingly Fisher had to help pressure him to take them. "I was all for the medications. I had working relationships with the doctors," she said.

Fisher believed the medications were helping—a little. Was she ascribing negative developments to Pat's illness, and any positive developments to the drugs? "Yeah, that was it exactly," she replied.

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"A great deal of the political advocacy in this country is driven by parents who have anxiety about the safety of their loved ones," said Debbie Plotnick, vice president for state and federal advocacy for Mental Health America (MHA). Like many others, she pointed to TAC and some branches of, or "factions" within, the National Alliance on Mental Illness (NAMI) as the main organizers of pro-force parents. (In Canada, the Schizophrenia Society nonprofits similarly organize pro-force family members.)

MHA has two hundred affiliates in forty-one states and, Plotnick said, different branches have differing views on civil commitment. But MHA's official national policy advocates for laws that abide by the standards set out by the Supreme Court: detention only when a person presents an immediate “serious risk of physical harm” and involuntary drugging only after other therapeutic options have been offered.

Plotnick’s own daughter was once suicidal. “I understand the perspective of parents who end up in that situation.” Plotnick said parents can be vital supporters and she resisted “blaming” them; nevertheless, she said that in some cases parents do need to more deeply question their roles. “Sometimes there are underlying issues in families. Sometimes there’s conflict, or abuse, or substance use.” Some parents become so worried, said Plotnick, that they end up more concerned with alleviating their own fears or stress than with doing what’s truly best for their child.

And family members may simply be misinformed. While medications can be a “useful tool,” said Plotnick, mental health professionals often tell family members that adverse drug effects are minimal, that withdrawal reactions are instead mental illness reemerging, and that the only reason their loved one wouldn’t want medications is due to mental illness impairing their understanding. Consequently, said Plotnick, some parents “undermine, rather than assist, their children’s efforts to safely taper off medications.”

Indeed, many psychiatrists say family members often pressure them to detain someone longer, and many family members talk—and have published popular memoirs—about how challenging it is when a loved one has serious troubles.

“Some families are just pushed to their limits, and they want the respite,” said the Texas psychiatrist James. He also often sees unrealistic expectations. “They think that if they send you to the hospital, we’re going to do something that’s going to be really helpful. But we’re limited in what we can do in an inpatient unit. It’s just drugs.”

Of course, the mental health industry has inflated people’s expectations through its own self-promotion—leading in turn to grief-stricken families sometimes criticizing hospitals in the media or trying to sue them for “failing” to help their loved ones.

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After years of treatments, Pat wasn’t improving. Pat gave Fisher power of attorney, and she began combing the medical records, and researching mental illness, medications, and alternatives. Gradually, a new narrative emerged.

During his first involuntary admission to Washington’s Western State

Hospital (WSH) at age eighteen, Pat was asked what he thought had caused his troubles. According to physician notes, Pat described being charged with stealing the girl's coat, the turmoil between his parents, and being victimized, at seventeen shortly before the dramatic worsening of his condition, in a brutal event that Fisher had never known about. Yet there were no indications that Pat's care providers ever developed therapeutic strategies for helping process these traumas; rather, Pat's problem was identified as "schizophrenia," and the treatment was psychotropics.

Fisher read books about psychiatric medications and their harms, and attended conferences of critical mental health researchers and practitioners. For the first time, Fisher heard experts suggesting that schizophrenia can be an expression of deep, unhealed inner wounds, and that psychiatric drugging can numb the psyche and prevent those underlying issues from being dealt with. She learned that the anesthetizing effects of antipsychotics can cause people to harm themselves trying to feel something, as Pat had done. The intense bodily agitation Pat experienced was identified even in Pat's medical records as drug-induced akathisia. And Fisher identified other known drug side effects that she'd long assumed were caused by Pat's mental illness and lifestyle—sluggish verbal responses, dampened motivation, and a distended neck caused by thyroid problems.

Learning all this led to some dark, difficult times for Fisher. "When I pieced things together, that was a feeling of terror and outrage. 'May God forgive me. I sent my boy to hell, thinking I was helping him.'"

But Fisher also had an "aha!" feeling. "I'd been searching for answers, trying to understand why he didn't get well, why didn't he stay well. Finally, I'm finding the answer." And it gave her hope to learn that some people could get off the drugs, work through their issues, and do better.

Fisher began speaking to her son's treatment providers differently. "At first, it wasn't really strong advocacy." She'd suggest fewer drugs, lower doses, vitamins, African American specialists, or psychotherapy. But none of this was tried. She became more insistent. She gave the psychiatrists books, asked for second opinions, and used an International Society for Ethical Psychology and Psychiatry guide with questions such as, "What is your diagnosis and what is the underlying cause? What is the rationale for using this drug? Discuss the science."

"When I started doing that," Fisher said, "I started getting shut up, shut down, shut out."

Hospital staff showed Fisher a brief handwritten note by Pat, revoking her power of attorney; Pat told her they'd promised a quicker discharge. Pat was moved to a floor where there was no patient phone, and was forcibly drugged more heavily. The staff used privacy laws to justify cutting Fisher out.

Fisher sought guardianship over Pat. The hospital intervened and backed a professional guardian. The judge sided with the treatment providers.

As conflicts intensified, a new guardian applied for a Vulnerable Adult Protection Order (VAPO) against Fisher. Under Washington law, a VAPO is intended to prevent the "abandonment, abuse, financial exploitation, or neglect" of vulnerable adults. So how was Fisher supposedly abusing Pat? The guardian's application stated that, "Ms. Fisher encourages Mr. Fisher to stop taking medications," which was "mental abuse." The judge banned Cindi from seeing Pat for at least six months because "there has been some interference of medication protocol by Ms. Fisher."

A new CEO of Western State Hospital around this time, psychologist Ron Adler, told me it was sometimes necessary to ban family members "if we think something is potentially disruptive to the patient, to the patient's treatment, or the treatment milieu." I asked if he was aware that differing perspectives on psychiatric drugs are increasingly the issue of conflict. "Very much so," he replied.

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The dubious VAPO got expunged by a judge, but the guardian and hospital discharged Pat into a group home and refused to tell Fisher where.

"I was frantic," said Fisher. She went on a hunger strike, and demonstrated outside the hospital. She called adult group homes randomly. She contacted mental health and civil rights organizations and politicians; few knowledgeable people were surprised, and none knew of anything that could be done.

Eventually, she and Pat were reunited. By this time, Fisher had begun connecting with other parents in similar situations and advocating for other patients.

I asked her if it was surprising to discover the broad legal powers mental health authorities have. "Holy smoley, that's one of my biggest shout-outs to all of America," Fisher replied. "If people had any idea of the tyrannical power that the psychiatric profession has over people on the outside, but especially inside the institutions, and they knew how they exercised that power . . . they would probably shut the hospitals down tomorrow.”

* * *

Many family members have had experiences like Fisher’s; if they stop agreeing that their children need to be forcibly medicated, treatment providers will often turn against them. The differences harden into power struggles—sometimes parents are cut out altogether, or even labeled as mentally ill themselves.

When Ann Fuller tried to protect her twenty-two-year-old autistic son Charles from forced electroconvulsive therapy at a Minnesota hospital in 2021, Fuller was described in a court submission as suffering from “lack of insight” herself.

Steven Epperson, a former Brigham Young University (BYU) scholar and recently retired minister of the nondenominational Unitarian Church of Vancouver in British Columbia, said the more he and his wife supported their son’s desire to taper off psychotropics, the harsher the mental health system’s responses became. They were told the drugs couldn’t possibly cause the adverse effects they saw, scolded for trying to “vicariously accomplish their own goals” through their son, and advised that police could be called. Epperson, dismissed from BYU years earlier for challenging Mormon orthodoxy, said he encountered similar rigidity among psychiatric professionals. “When you call these psychiatrists on stuff, they go into high-octane defense mode. They just want you to comply. They want you to be submissive. These guys are at least as dogmatic and patronizing, as condescending and defensive as the Mormon Church officials who eventually kicked me out.”

In a 2013 *Atlantic* article, psychologist, author, and *DSM-5* critic Gary Greenberg encapsulated this, arguing that the weak scientific foundations underlying psychiatric diagnoses and treatments lead to extreme emotional “defensiveness” among many practitioners: “It’s the universal paranoia of psychiatry that everybody who disagrees with them is pathological. You can’t disagree with a psychiatrist without getting a diagnosis.”

James said that even he as a psychiatrist-in-training frequently “got into trouble” if he suggested to a supervisor that a patient’s agitation or cognitive problems might be caused by a psychiatric drug. “It’s like I’m saying, ‘You’re causing this. You’re making this person unwell.’”

A telling case that gained national notoriety was that of Justina Pelletier. In 2013, at age fourteen, Pelletier was being treated at Tufts Medical Center for mitochondrial disease—a defect in cell energy production that can broadly affect body and brain functioning. But one day Pelletier landed in Boston Children’s Hospital, and a doctor there speculated that her symptoms were actually caused by an untreated mental disorder. When Justina’s parents objected, they were labeled as likely having mental disorders themselves and charged with medical negligence and child abuse. Justina was placed in state custody and forcibly treated with psychiatric drugs instead. Her health worsened and, sixteen months later, a court returned Justina to her parents. Still, in 2020, Justina and her parents lost their lawsuit against the psychiatrists and Boston Children’s Hospital.

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Despite the growing number of parents who’ve witnessed their children worsening, there’s no prominent organization giving them public voice in the way that TAC and NAMI organize pro-force family members. But Oregon-based MindFreedom International wants to change that.

MindFreedom has for decades been one of the most visible nonprofits working to unite organizations run by consumers and survivors who stand against forced treatment. According to office manager Sarah Smith, MindFreedom fields thousands of contacts per year, about half of which come from people who’ve been committed—or from family members like Fisher—seeking guidance on fighting back against psychiatric powers. She said the constant incoming calls feel like blood flowing from an open wound. “This is a really widespread problem, and we’re not being honest, our society, about this problem,” said Smith.

MindFreedom director Ron Bassman is a psychologist who has worked in a state hospital, run a large mental health center, and served on the American Psychological Association’s Expert Task Force on Serious Mental Illness. He was also labeled with paranoid schizophrenia and, in his twenties, forcibly treated with drugs, electroshock, and insulin-coma shock. Bassman is hoping MindFreedom can start its own educational groups. “NAMI does a family-to-family approach, which is very mainstream; it’s [a] drug-oriented, medical model: ‘You never recover from these things; you just stabilize people with medication.’ What I want to do is have a counterpoint to that.”

But Bassman intimated that it could be an uphill struggle. The notion that their child’s distress is caused by biochemical imbalances—rather than influenced at all by anything they themselves may have done or not done—is compelling to many parents. Furthermore, Bassman added, it's challenging for anyone to change their views if they've once helped force treatment on someone they love. "It's hard to confront this. To get people to recognize, when they've tried all they can, and have done damage. They don't want to give up those beliefs. It's very, very hard to change a person who feels guilty." Indeed, rallying psychiatric powers against loved ones often tears families apart, further entrenching polarized views while deepening trauma, distrust, and fear that may never truly go away.

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NAMI policy argues for expanded civil commitment criteria, since many people "lack insight or good judgment about their need for medical treatment." And NAMI advises all judges to accept whatever a psychiatrist recommends: "The role of the court does not include making medical decisions."

NAMI's national office declined my requests for an interview. Kimberly Comer, though, former director of NAMI Greater Indianapolis and currently managing the Peer Mentor Program for NAMI Palm Beach County in Florida, told me that NAMI branches are not always in alignment with the national office on forced treatment.

"I don't agree that anyone should ever be forced," said Comer. "While I think the system is well intentioned, if we're looking at recovery, and we're looking at someone being empowered to live their healthiest quality of life, that will never be achieved by disempowering them."

Comer's own experiences highlight some of the complex issues in families that can lead to one member getting forcibly treated.

Comer described growing up in a deeply troubled Texas military family, then moving to Chicago at age sixteen to marry an older man with whom she soon had a "toxic," conflict-ridden relationship. "I left one unhealthy home environment and subsequently moved into another," she said.

Giving birth to her first child left her feeling trapped and suicidal amid flashbacks to her own childhood. Comer's pediatrician helped force her into a psychiatric hospital. Other than "a multitude of medications," said Comer, she got no help, and no one showed interest in her family history or current circumstances. "They looked at the symptoms; they medicated accordingly." She still vividly remembers her psychiatrist, unaware of anything about their home life, turning to her husband and saying to him, “You need to plan on her being in an institution the rest of her life, and you taking her child.”

Comer did get discharged, get out of the relationship, and raise her child—but not without more troubles over the years, including another partner with whom she had conflicts helping to get her locked up. She eventually got inspired by meeting peers who’d been through similar experiences, and empowered herself by learning coping skills and how to manage her medications. But in all, Comer said her own experiences and those of others have made her recognize that “there’s always one person that has a diagnosis, but they’re not the only one in that family with an issue.” Comer agreed that many family members get loved ones forcibly hospitalized because they want respite themselves. “But if they were the ones getting hospitalized, they’d think twice about that.”

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I first met Cindi Fisher in 2014. Her emotions and life have continued to fluctuate with Pat’s journeys in and out of hospitals and medically coercive group homes.

Western State Hospital went through various scandals surrounding poor patient care. Washington State governor Jay Inslee fired Adler in 2016. In 2018, a WSH psychiatrist publicly stated that the hospital operates with “a systemic culture of retaliation, discrimination, and bullying,” while outspoken patients and concerned staff alike get “ignored, shamed, and intimidated into silence.” WSH lost tens of millions of dollars in federal funding “after failing to achieve basic health and safety standards,” and finally lost its accreditation. Nevertheless, it’s still operating.

Fisher saw this not as vindication, but as sad testimony to what Pat has been, and continues to be, forcibly subjected to.

In 2021, Fisher told me Pat’s condition had generally worsened. Recently, she went through her own crisis. “I saw myself spiraling down, into a very deep depression. It’s been seven more years fighting the system, and nothing has really changed.”

For a time, Fisher lived in a van next to what was once a Washington fruit orchard. Gradually, she said, the van transformed from “a chasm of despair” into “a cave of prayer and contemplation.” She enjoyed walking amid the re-wilding grasses and flowers by a creek, developed friendships with dog-walkers, and became a Zen rock builder. “I felt like I was going from the cave into a cocoon, and gradually the cocoon was thinning and the light was coming in.”

Eventually, she found renewed energy, and the next time I spoke with Fisher, Pat was living with her in a small apartment. Fisher felt optimistic about how they were learning to accommodate each other’s needs. Pat had begun asking to be referred to as “she”; Fisher was supportive, but also had fear for Pat being Black and transgender in a community with high rates of police violence. “It raises her level of vulnerability and targeting.”

Seven years earlier, Fisher herself had warned that “when they give us our kids back, and they’re now much more harmed than they were before, after the drugs and after the inhumane and cruel institutionalization, they can be dangerous.” So Pat needs to be with people trained in keeping themselves and others safe, she said. Fisher wants to find a house to transform into a culturally sensitive, therapeutic group home. Working with an established nonprofit, Fisher’s other daughter recently obtained a substantial government grant toward purchasing a building to seed such a facility.

Fisher also wants to nurture a broader family, a whole community of support for other people coming out of the hospital. “I’m working towards that,” she said.

CHAPTER 12

PRISONS WITHOUT WALLS

Kingsley reported to police that he was assaulted on the street by his girlfriend's ex-lover. Several nights later, the investigating officer returned to Kingsley's apartment with two plain-clothed women. The women sat on Kingsley's couch. The officer stood by the door.

One of the women began asking Kingsley questions. The other watched and took notes.

"Are you suffering from stress?" the woman asked. "Do you take medication?"

At first Kingsley answered casually. But when he was asked about his relationship with his mother and his sexual history, he felt uncomfortable. Kingsley wondered aloud why he was being asked these questions. The woman said: "Do you have a problem with it?"

The police officer said that the women were mental health professionals, and they were concerned he might be suffering trauma from the assault.

Kingsley thanked them for their concern. But he was stunned by the questions that followed.

"What is today's date?" asked the woman. "What's the similarity between a canoe and a bicycle? What's the relationship between an apple and a banana?"

Kingsley said he sensed they were trying to decide if he was "a nutcase"; he had urges to give answers like, "I can throw them both at you." He asked again what was going on.

The police officer explained that his assailant had acknowledged that an altercation had occurred, but claimed he was defending himself because

Kingsley was mentally unstable. The women were here to determine whether Kingsley needed further evaluation in a psychiatric hospital.

Kingsley suggested that the accusation was just another way for his assailant to lash out at him. This remark was greeted with silence.

"What does it mean that people who live in glass houses shouldn't throw rocks?" asked the woman.

"It's like you're walking on a razor's edge," commented Kingsley to me. "Your normal reaction as a citizen, or a human being, is to get angry with this bullshit, and tell them to get the hell out of your apartment. But you're afraid to actually get angry, because you're sure they'll use that against you. It's degrading. I felt intimidated, and afraid. It was the fact that they could just come like that at any time, bang on your door, charge in, and possibly haul you away."

Twenty minutes after their arrival, the two women stood to leave, indicating that they'd "check out" some of Kingsley's answers.

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I learned that Kingsley's visitors were a social worker and psychiatric nurse on a community-based mental health team. Going by names like "mobile mental health crisis responders" or "psychiatric emergency response teams," they're increasingly common in cities moving away from reliance on police as the sole responders to emotional-distress calls. Sometimes they help de-escalate situations; sometimes they order hospitalizations. The questions Kingsley was asked came from common assessment tools, including the Mental Status Exam and Montreal Cognitive Assessment, that score people on factors like whether they exhibit confusion or anger, have an "unkempt" appearance, or laugh at "inappropriate" times. Higher scores indicate "Triage to hospital."

Kingsley's particular case was part of an even bigger, continent-wide trend to provide situation-responsive and mobile mental health services: the New York State Office of Victim Services, for example, funds organizations that provide victims of crimes with financial, legal, and other help—such as "emotional support." The contracted emotional-support providers include many that also routinely get people committed. And that, in turn, is part of a still broader movement: social workers have become a widely dispersed, powerful funneling system into civil commitment. They even operate mobile prisons.

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A veritable army of social workers—more than 650,000—patrol America’s communities, working in schools, nursing homes, hospitals, family and social services, disability support, corrections, employment assistance, immigration, and more.

The US National Association of Social Workers declined to discuss civil commitment. They directed me to the Clinical Social Work Association, who didn’t respond. I submitted a few questions about psychiatric detention decision-making to a Reddit group with thirty thousand social workers; the moderators banned me within minutes.

Maureen Clark wasn’t surprised that major social work organizations didn’t want to talk. Clark started working in mental health crisis response services in 2006 in Massachusetts, eventually becoming a clinical director and team manager. Today, she teaches at Westfield State University, and is completing a PhD on civil commitment. She became interested in civil commitment when, in 2009, Massachusetts suddenly gave all social workers authority to commit people. “In my training, and in general from what I’ve observed, social workers get about twenty minutes of talk about suicide and significant mental health issues and risk,” she said. The topic isn’t often discussed in academic journals, either. “I found no research on involuntary commitment in the social work literature in the US.”

There are deep tensions, she said, between the field’s grand vision of itself as an instrument for improving society, versus the daily reality of the job. “Social workers are employed in many institutions where the function is more as an agent of social control rather than as an agent of social change.” This reality can be difficult for social workers to admit to themselves, she said, let alone discuss publicly.

Crisis-response social workers are routinely called in to do psychiatric evaluations by families, employers, landlords, homeless shelters, schools, and more. Referrals also come from therapists, outpatient services, and substance use treatment providers—ironically, practitioners who are supposed to be helping reduce hospitalizations. Clark said the overwhelming majority of these “emergencies” don’t involve people presenting immediate physical dangers, and if they do, police usually take charge. In her experience, fewer than one in fifty cases even involves people that might be labeled “severely mentally ill.” More typically, she said, people experiencing relatively ordinary levels of emotional distress are simply engaged in behaviors someone else finds disruptive. “You get into certain arenas where there’s just no tolerance for any kind of abnormality or behavior that they can't manage."

Clark said she was called to evaluate a teen who tried to leave school early. The girl, it turned out, was simply excited on her birthday, but was caught by administrators with a zero-tolerance policy on truancy. Such situations, she said, often make her wonder which person truly has "the mental problem."

And such seemingly innocuous situations aren't without risk. There's constant pressure to label people, she said, because insurers generally require a mental disorder diagnosis for an interaction to be reimbursable. "I could have given her an adjustment disorder or something like that," said Clark, but a diagnostic label also starts a documented psychiatric history that becomes widely accessible in social service systems and makes people more vulnerable to forced hospitalizing forever after. "If you started a fire at any point in your life, you're always potentially going to start a fire," said Clark. So, what happened with the birthday girl? Clark let her go, undiagnosed. "We ate the cost of the assessment."

As she gained more responsibility, Clark became increasingly concerned about the personal, cultural, and institutional biases built into how civil commitment powers often get used. "I was starting to do a lot of training with staff, and seeing people's reasonings for committing or pushing for a hospitalization. For some people, their own fears were driving it." Some social workers become anxious witnessing strange behaviors or emotional outpourings, or feel overwhelmed themselves by people's difficult life circumstances, she said. "It's quicker to hospitalize. It's the easy route."

In addition, Clark said social workers are taught that mental health is ultimately a "medical" issue; consequently, they can feel inadequate and assume someone's safest in a hospital.

And confirming Kingsley's concerns, Clark said it's risky to display anger, fear, or resistance when a social worker is evaluating you. "If you're too vocal, if you're not vocal enough, if you cry, if you don't cry, if you say you're getting lawyers, if you ask to read the paperwork too much—any of it confirms your mental health diagnosis. You're crazy, you're wrong, you're misinterpreting, you're overreacting. There's a lot of room for things to be recontextualized as symptoms of mental disorders."

Clark said she left social work for teaching in part because she was becoming increasingly disturbed by the coercive practices occurring "without critical reflection on how it can be done differently."

Clark pointed me to a popular website with practice exams for social worker licensing. Various scenarios described people who open up about unusual experiences or violent feelings. Rather than encouraging social workers to foster a connection and try to better understand the person and situation, the “correct” responses are frequently, “Call the police,” and “Facilitate hospitalization immediately.”

* * *

Paula is a social worker with twelve years’ experience. Over several months of regularly speaking with her, I saw how countless situations that she dealt with every day could either get creatively solved or end up with someone forcibly hospitalized. Paula often worked extra, unpaid hours trying to problem-solve with clients, because she’d seen forced drugging harm people. But by doing so, she said, she was frequently breaking protocol and risking her license and career.

For example, a woman asked Paula for help dealing with neighbors who were stealing things like her turkey baster, clothing, hairbrush, and tape measure. The woman explained that she’d called the police many times, and they’d been no help. She’d bought security cameras, but they never recorded anyone—she believed the security company was in on the thefts.

Paula said she encountered such people virtually every day. “A lot of people have strange beliefs, or very different cultural beliefs. Is that mental illness? They can still be very functional.” With regard to this woman, she added, “Now I have to be super vague in how I document our meeting. If I reveal what I told you, I’ll be considered to be ‘not doing my job’ if I don’t get the ball rolling to have her taken to a psychiatric hospital. She is eating and paying her bills. She is not a risk to anyone or herself. She is going to piss away a bunch of money on security stuff, which is ‘harmful,’ but I have many clients who will buy dope and beer before they buy their heart medications, and we don’t send them to the psychiatric hospital.”

A building manager called Paula to evaluate an eighty-nine-year-old man who’d stopped paying his rent. When Paula arrived, the manager said how great it was that she could help because the man was mentally disturbed and had never been easy to get along with. Could Paula assess his mental health right away and get him moved to a hospital or nursing home?

Paula determined that the man would benefit from some simple assistance at home. But she eventually uncovered that, for twenty years, the manager had been inappropriately charging the man much more than he was required to pay in the government-subsidized building, and had drained his bank account.

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The most invasive way in which social workers get involved in civil commitments and coercive drugging is through wraparound community-based programs like Assisted Outpatient Treatment (AOT, or outpatient commitment) and Assertive Community Treatment (ACT).

AOT is court-ordered forced drugging for people living in the community (in Canada called “extended leave” or “community treatment order”). Enrolment in ACT is officially voluntary—though ACT teams often also manage people on AOTs. But according to David Boyer, managing attorney for community integration with the US National Disability Rights Network (NDRN), some states like Florida now require that virtually everyone who’s been involuntarily hospitalized gets discharged only after “voluntarily” accepting an ACT team.

Originally pitched to legislators and the public as tools to let the most severely ill people out of hospitals, ideally, both AOT and ACT programs provide assistance with housing, daily tasks, vocational training, and treatments. In practice, critics say these programs often do little more than build high-surveillance “chemical prisons” or “prisons without walls” in our communities—and have primarily allowed far more people to be coercively drugged and controlled, because inpatient beds aren’t needed. Indeed, one of the primary tools has become long-acting antipsychotic injections—a single one of which can keep a person tranquilized for weeks to months at a time. Many of the other “services” can be coercive, too; Maureen Clark explained that, between required trips to outpatient clinics, daily drugging at home, counseling sessions, meeting goals set by providers, and so on, people can become “really overwhelmed by having to basically become professional mental health patients.”

Francesca Simpson is one of the critics. From 2010 to 2020, Simpson was almost continuously involuntarily treated in her British Columbia home by an ACT team. During a period of crisis, she’d repeatedly sought help at a hospital and been turned away. When she started breaking the law, though—smoking in a nonsmoking pub, emptying salt and pepper shakers in a restaurant, rearranging shelves in a store—she was detained and drugged.

She began willingly taking medications, she said, but the team often forced higher dosages until she felt like “a vegetable.” Simpson described ACT as “intrusive,” “humiliating,” and “demeaning.” She had to wait for several hours every day to have her meds “witnessed.” For the injections, she had to pull her pants down. She preferred women team members but couldn’t refuse the "strange men" entering her home. Team members probed her personal life and gave her unsolicited advice, all the while weighing her reactions for any hint of a need to re-hospitalize her. "Everything that I did was pathologized," said Simpson.

One day she'd had a few drinks and was in a "foul mood" when an ACT team member arrived. "I screamed at him, drunkenly. The next day my counselor came and told me I could voluntarily go to the hospital or I would be arrested. And I was completely calm when she told me this." Simpson commented dryly that she'd been reduced to "fighting for the right to be a drunken asshole in my own home." In the end, the hospital psychiatrist decided that using "curt" and "cruel" words to an ACT team member was not sufficient grounds to detain Simpson.

Simpson said she generally gains more rights and freedoms by expressing gratitude for the team's help. "The more you pretend to go along, the easier it is for you."

As of 2021, she was officially no longer court-ordered, and was visiting the team in their office. "I'm halfway to being free." Though she's not entirely against forced treatment in some circumstances, Simpson believes community-based coercion has become far too easy and common—the fact that she was stable for years was repeatedly used as a rationale to extend the court order. "If everybody who was controlled by an ACT team was in the hospital, the hospitals would be overflowing, and there'd be public outrage." But what's happening to people like her, she said, is "invisible."

It's the same in New York. Amanda voluntarily took psychotropics, but a chronic pain condition made her attempt suicide. She was put onto court-ordered AOT and prescribed more psychotropics. A team visited regularly to ensure she took them. "It's not about helping me," said Amanda. "It's about controlling me."

One time the team threatened her with hospitalization, so before they arrived, Amanda fled to the stairwell of another open apartment building. The police came searching for her with dogs. "I was like, 'What am I, a fucking criminal?'" Another time, Amanda moved upstate to get away; she was declared a missing person and tracked down.

* * *

Every state now has such programs. In 2021, there were 3,000 people on court-ordered AOTs in New York State, and another 7,000 under monitoring by ACT teams. In California, where there's been organized political and legal resistance to AOTs, there were just 900 people on AOTs—but 30,000 children and 41,000 adults monitored under ACT and similar wraparound programs. In Canada, the same story. For example, British Columbia, at four times New York's rate, has among the highest per capita rates of forced outpatient treatment in the world. Continent-wide, then, there are likely hundreds of thousands of people in these prisons without walls—on any given day, more than are detained in all psychiatric hospitals.

And the vast majority are not formally identified anywhere as de facto prisoners—yet a paper in the *Journal of the American Psychiatric Nurses Association* listed numerous surveys where ACT team members themselves confirmed how coercive even their "voluntary" programs are. Studies found that 90 percent of ACT teams frequently or always delivered medications to their clients, and 85 percent made sure the client swallowed the medications. ACT teams regularly used tactics such as "told consumer that they would have to stop working with the consumer if he or she did not take medications," and "threatened to report consumer noncompliance to legal authorities." In one survey, the most telling tactics were the most common: 71 percent "firmly directed consumer to take medications," 44 percent "threatened to hospitalize if no medication is taken," and 32 percent "involuntarily committed consumer."

According to NDRN's Boyer, housing managers also often work closely with ACT teams, or may themselves pressure people to take tranquilizing psychotropics to prevent behaviors that staff or other tenants don't like. Many group and assisted living homes for people labeled with mental disorders operate essentially as locked facilities and with around-the-clock monitoring of every aspect of residents' lives. "If you can keep a person doped up, they're a lot easier to manage," said Boyer.

Additionally, if the Social Security Administration deems someone incapable of managing their money, the SSA allows a "Representative Payee" to take over. ACT teams often become people's Representative Payees, and can withhold their money to enforce medication compliance. In some states, the SSA itself orders clients to comply with psychiatric treatments or lose their benefits. Eight million Americans have Representative Payees, and complaints have been so widespread that, in 2018, new federal legislation gave NDRN organizations auditing powers. They've found "lots and lots of bad cases" of coercion and exploitation, said Boyer.

Meanwhile, in the only study of its kind, across five US cities researchers found more than half of people who were accessing “voluntary” outpatient mental health services had experienced threats to remain treatment-compliant, with their housing, income, or another “leverage” held over them.

Does all of this rising community coercion help people? Marvin Swartz, a Duke University psychiatrist, coauthored a study that found the vast majority of people required to participate in AOT felt they didn’t benefit (see chapter twenty-one). Swartz also coauthored an American Psychiatric Association position statement acknowledging that “there is no broad consensus” about AOT’s effectiveness. Any apparent benefits could be due to the positive impacts from the housing, training, or practical supports sometimes provided, rather than from forced treatments.

Generally, Swartz told me, studies suggest AOT can reduce police interactions, hospitalizations, minor conflicts or “non-injurious violence,” and financial costs to society. However, he added, “We think the effect of these [court] orders are not only on the individual, but on the system around them, and how people respond to them.”

So, could these positive impacts simply be due to the fact that, since the person is already being forcibly drugged, the people around them become less likely to call police to hospitalize them, and more likely to help problem-solve? “It’s possible,” said Swartz. “In the studies we’ve done, we don’t have data on that.”

* * *

If social workers are conscripts into the community security patrols of psychiatric coercion, Maria Liegghio was a child soldier. Today, she’s outraged by coercive practices creeping ever deeper into our lives, because she’s witnessed how they can pollute even the love between a mother and child.

Now teaching social work at a Canadian university, Liegghio said her late mother often had unusual ways of acting, and saw and heard things others didn’t. But the family loved and accommodated her, and the most “dangerous” thing her mother ever did was sometimes simply wander away and be difficult to find.

Liegghio remembered a story her father once shared. She and her little brother were looking at a picture showing the earth from the moon. Their father said that when their mother was acting strange, it was because she had special powers. “One of her special powers was to transport herself to the moon, and to look down on to us, and to love us from the moon," recalled Liegghio. "He said, 'If you had Mommy's special power to transport yourself to the moon, you would see the earth differently, too.'" Consequently, said Liegghio, "We didn't experience her as scary. We just experienced her as magical."

The family did all they could to keep her mother at home, but had frequent anxiety during her wandering periods. Finally, one day, they sought help. "My father couldn't take the weeks of sleeplessness," said Liegghio.

They found resources available to lock her mother up, forcibly drug her, and put her in a facility or group home—but no resources to help them out in their own home. Though such in-home supports were available when a family member had dementia, there was nothing similar accompanying a psychiatric diagnosis. "I don't know of any services like that even now," commented Liegghio.

Once her mother got entangled in the mental health system, for the rest of her life she'd be forcibly treated and in and out of the hospital. On those occasions when her father resisted the forced treatment, he was told he was "enabling" his wife's illness.

From childhood, Liegghio herself was coached by medical staff and social workers to help with the involuntary interventions. "I was coerced to be an arm of the system." Liegghio was told that her mother wasn't magical, quirky, or eccentric, but instead "really sick and disturbed." Liegghio was trained to constantly monitor and report to the professionals about her mother's activities. She was instructed to use threatening ultimatums to help compel her mother to take psychiatric drugs.

Previously, the family only vigilantly monitored during her mother's wandering periods, but now they were warned if anything untoward ever happened, her mother could be permanently taken away or the children themselves put into government care. "We couldn't leave her unsupervised. My training to accept this started when I was eight, to do this surveillance, of us and by us."

She also learned that her mother was a kind of nonperson. The psychiatrist would ask her mother about her eating, sleeping, and general status, said Liegghio, "and then he would still turn to us children and ask us the exact same questions, as if my mother's answers could not be trusted." One day, Liegghio was doing her schoolwork on the floor next to the hospital bed where her mother was restrained. A nurse said to Liegghio, "You can't be here without a parent."

Liegghio went into professional social work hoping to effect change, but transitioned into academia when she became too uncomfortable with how often her job involved coercing individuals onto drugs when what needed addressing were issues such as poverty, racism, or impediments to employment.

And the memories of what happened to her mother still today at times overwhelm her. Liegghio said there were periods when her mother was so drugged she could barely stand, would slur incomprehensibly, and wouldn’t know where she was. Liegghio found it especially hard as a child to see her mother tied in restraints sobbing, and pleading to be let free. “Those are the ones that I can’t get over,” said Liegghio. “How much more do you have to beat down somebody’s soul so that they will comply with your medication regimes?”

CHAPTER 13

“AN ASSEMBLY LINE OF FRAUD”

Audrey told me that, when she was a teenager, she was essentially sold and shipped across the border from Canada and, for a year, was detained in an American private hospital as a kind of psychiatric billing-slave.

I found the story difficult to comprehend or believe. But the US Department of Justice set me straight.

* * *

Reviewing the picture that’s emerging of the contemporary face of civil psychiatric commitment, a logical question can arise.

If virtually anyone can be labeled as having a mental disorder and as at risk, and there are so many vast, community-based funneling systems into psychiatric detention, and courts mainly just follow psychiatrists’ recommendations, and medical professionals and psychiatric facilities are weakly regulated, and governments have been expanding civil commitment powers, and patients generate billions of dollars in revenues . . . then isn’t there a terrible risk of some corporations and institutions rounding up masses of random people, locking them away, and drugging them into submission, simply to exploit civil commitment powers for power, profit, or social control?

And the answer is: Yes. Exactly.

* * *

Mass-scale, fraudulent civil commitment practices have occurred for decades across North America. They appear to be in a resurgence.

Audrey and her mother, I learned, were wheels in what US psychiatric hospital administrators and accountants once called “the Canadian gravy train.”

According to legal documents I obtained through freedom of information requests to the Ontario government, in the 1980s and early ’90s, some of America’s largest hospital chains ran enticing ads in Canada promoting therapeutic retreats in warm, sunny climes—all paid for by Canada’s generous public health insurance. The hospitals hired local representatives to offer free return flights to people at meetings of mental health and addiction support groups, health clinics, and halfway houses.

Upon arrival in the US, many of these people were promptly declared by psychiatrists to be mentally ill and in danger. Instead of a brief Sun Belt therapy retreat, they were incarcerated in hospitals and held as long as Canadian public insurance kept paying.

There’s never been a full international accounting of how many Canadians’ lives got derailed before the financial taps were shut off—but as a direct consequence, to this day, Canadian provincial health insurers severely limit how much they’ll reimburse for care in the US.

A CBC report at the time suggested a few substance-using patients got some version of the sunny vacation they were promised; but court documents give a glimpse into the damages for others. For example, in 1997, the Ontario government sued (and ultimately settled with) twenty-nine US psychiatric hospitals in a dozen states for about $130 million—suggesting there were at least hundreds if not thousands of patient-victims. The affidavit stated that the hospitals hired “headhunters” who targeted Canadians, detained these people “who did not suffer from any condition requiring hospitalization or treatment,” and then “misconstrued, misdiagnosed, and exaggerated” their mental problems. The US hospitals compelled them to stay “for excessive lengths of time” and forced them to undergo “excessive and unnecessary treatment.”

Audrey told me that her own year at an upscale hospital wasn’t so bad, but she found her mother’s role frightening. Audrey—now a working single mother who has never again been psychiatrically incarcerated—directed me to evidence of her mother lobbying legislators to expand civil commitment laws, and speaking to news media as simply a worried parent of a child with serious mental illness. Audrey had no documentation to prove it, but said as a teenager she’d seen many hints that, all the while, her mother had been secretly doubling as one of those paid-by-commission civil commitment headhunters. The court documents I obtained did not identify personally any of the patient brokers.

Yet the Canadian gravy train was just one feeder-route for a much vaster buffet. The 1994 book *Bedlam: Greed, Profiteering and Fraud in a Mental Health System Gone Crazy* by former *New York Times* journalist Joe Sharkey documented these halcyon years of psychiatric fraud in America. The easy profits delivered by forcibly detaining mental patients launched a gold rush, and the number of private psychiatric hospital beds in America tripled in a decade. News media and state and federal regulators eventually recognized what was happening, and lawsuits against many of America's top hospital chains led to billions of dollars in settlements. Hundreds of private psychiatric hospitals shut down. A 1991 *New York Times* article quoted a prominent hospital-industry investment analyst about the end of an era: "The psychiatric hospitals used to be like a kid in the candy store. They could keep patients as long as they wanted and charge anything they liked."

However, the aggressive investigations, lawsuits, and regulations by governments soon waned. And since the 2010s, there have been many telling signs that mass-scale civil commitment fraud is making a comeback.

For one, the beds have returned. According to the National Association of State Mental Health Program Directors' study (discussed in chapter seven), in the wake of the crackdowns in the 1990s, the number of private psychiatric hospital inpatient beds in America dropped by 50 percent but, since 2000, bed numbers have rebounded to 1990s levels. In addition, private psychiatric beds in general hospitals, community mental health centers, residential treatment centers, and other settings have also increased. The authors explained that inpatient psychiatric beds have become lucrative again, in part due to changes in health insurance to improve mental health "parity" with common medical conditions.

Simultaneously, media scandals and government lawsuits are starting to emerge.

For example, in 2016, *BuzzFeed* published a series of articles about Universal Health Services (UHS) with introductions like, "Lock them in. Bill their insurer. Kick them out. How scores of employees and patients say America's largest psychiatric chain turns patients into profits." UHS has two hundred psychiatric facilities generating billions of dollars in revenues, and *BuzzFeed* interviewed 175 current and former UHS staff, including eighteen senior executives, along with many patients.

One woman recounted going to a Texas hospital for their advertised "free mental health assessment.” She was asked if she’d ever had suicidal thoughts. She answered, “Well, who hasn’t had suicidal thoughts?” and joked, “It’s Texas—it isn’t that hard to get a gun.” She was forcibly detained as someone with a suicide plan. A former UHS administrator said each facility had its “conversion rate” tracked: the percentage of people who came for free mental health assessments and then became inpatients. “People don’t understand,” explained a former intake worker. “Our goal is to admit them to the hospital.”

UHS clinical staff said they were trained to write medical records that emphasized only patients’ worst feelings and behaviors, and to routinely keep patients until their insurance ran out. One UHS psychiatrist complained in writing to his superior, “Doctors are publicly shamed by asking them to justify discharging a patient ‘early’ before the end of their insurance authorization.”

UHS isn’t alone. The *Tampa Bay Times* ran a 2019 article headlined, “You’re Trapped. They’re Cashing In. How one Florida psychiatric hospital makes millions off patients who have no choice.” Journalist Neil Bedi described unqualified staff, unsafe conditions, families barred from visiting, and patients at North Tampa Behavioral Health Hospital being threatened and coerced into longer stays. Advocates said patients were “held hostage” for profit.

Cut to Colorado. Also in 2019, Tony Kovaleski began a series of reports on Clear View Behavioral Health hospital for Denver7, an ABC television network affiliate.

Kovaleski’s sources recounted innocently seeking mental health support and getting locked up, years of complaints from patients and families, fraudulent billing, falsified medical records, a confirmed cover-up of at least one death from overdrugging, and “a culture of pressuring and intimidating patients to sign paperwork that would extend stays.” A former therapist, Kovaleski reported, “claims she was regularly told to deviate from the truth to keep patients longer.”

* * *

In 2021, I contacted the Medicare Fraud Strike Force to get their assessment of the state of psychiatric civil commitment fraud in America. The Strike Force is an interagency collaboration across twenty-four federal districts involving the US Department of Justice (DOJ), Office of Inspector General (OIG), Department of Health and Human Services, and state attorneys general.

Though our interview was arranged through the DOJ media relations office, the spokesperson preferred to remain unidentified; however, he was obviously extremely knowledgeable and passionate.

I asked if mental health care fraud was a major focus for the Strike Force. “Absolutely,” he answered. “There’s a lot of work to be done. It is a priority.”

The DOJ spokesperson described three “tenets” common to how psychiatric fraud operates.

The first one, he said, is getting patients. “Fraud schemes need patients. How do you get patients? There is a massive network of patient recruiters.” He said these were variously called marketers, community liaisons, or body brokers. “These individuals are usually not medical professionals. They just have connections where they hit the streets.” They seek people with Medicare, Medicaid, or private insurance registrations.

The second tenet is conscripting medical professionals. “You need doctors and nurse practitioners and others who oftentimes are getting kickbacks and bribes. Professionals who will sign on the dotted line, who will routinely falsify records to make things appear legitimate.”

And those records constitute the third essential element. The body brokers, the facility staff, the psychiatrists, and the owners will “obfuscate their roles” and activities through bogus titles, sham contracts, and falsified patient progress reports, he said. “In order for any of these types of schemes to work, I’ve told juries, it’s an assembly line of fraud.”

In many cases, the would-be “patients” targeted are elderly, poor, or homeless, or have a mental or physical disability, or have some other kind of “vulnerability,” he said. Recruiters often work homeless encampments, halfway houses, assisted living facilities, and support groups for people with drug, alcohol, or mental health issues. In a small minority of cases, patients themselves are paid small kickbacks, but more typically, he said, people are tricked, threatened, coerced, or forced. For example, housing providers take kickbacks and then threaten to kick tenants out if they don’t go with the body broker.

Would some try to escape and get held against their will under mental health laws? “Yes, absolutely,” he said. “People are bought and sold like cattle. Literally. To make these schemes work. And that’s not hyperbole.” He said the victims might be forcibly drugged with either or both of legal psychotropics or illicit drugs to help control them. “Oftentimes, they are drugged so that they’re docile.”

He pointed to the case of American Therapeutics Corporation (ATC) in Florida. “It was multiple psychiatric facilities, with individuals coming from halfway houses and from assisted living facilities,” he said. Some victims had such severe Alzheimer’s they’d be completely disoriented. “They don’t know where they are, they get put in a van. It’s extremely sad.” Taken to a day-treatment facility, the “treatment” they got involved anything from staff showing them videos to drugging them into submission. “So it’s all a façade. And it went on for a long time.” Thirty administrative, medical, and mental health professionals were convicted in the scheme involving $200 million in Medicare billing.

Then there was Healthcare Solutions Network (HCSN), where psychiatrist Roger Rousseau ran a similar partial hospitalization program for people snatched from assisted living facilities. “Same conduct: buying and selling patients,” the DOJ spokesperson said. “Same formula: Dementia, Alzheimer’s patients, with substance abusers. Routine falsified records.”

And psychiatric fraud is so easy, the perpetrators are often brazen. Even as auditors were investigating HCSN’s Miami facility, Rousseau and others opened up a new facility in North Carolina. This happens frequently, the DOJ spokesperson said: “Networks” of corrupt mental health professionals move from one scam to the next. “Some of the therapists who were prosecuted at HCSN had also worked at ATC.” Rousseau was sentenced to sixteen years in prison, but many others have been convicted of fraud and did not get imprisoned or even lose their medical licenses.

Mass-scale fraud also happens in other kinds of mental health facilities. For example, two Houston physicians who owned a community mental health center (CMHC) paid kickbacks to group home operators to push unwitting victims to them. After several similar cases, a 2012 review by the OIG found that half of CMHCs in America were engaged in “unusually high billing” and “questionable billing,” and 90 percent of these “were located in States that do not require CMHCs to be licensed or certified.”

The DOJ spokesperson said the latest trend is in “sober homes.” Substance use disorders were previously excluded from most civil commitment laws, but as more states authorize forced treatment for substance use, the fraudulent detox business is soaring.

In one case the DOJ prosecuted, several Florida treatment centers gathered and detained substance users and homeless people from around the country. Most were drugged with either or both of illicit narcotics and psychotropics, and some were forced into prostitution. Urine testing alone is “liquid gold” in the sober homes industry, said the DOJ spokesperson. A 2017 *Kaiser Health News* investigation found that urine tests previously costing a pittance now cost public and private insurers hundreds or even thousands of dollars, and US urinalysis industry revenues quadrupled in four years to $8.5 billion. A single incarcerated patient getting routinely tested three times weekly could potentially generate hundreds of thousands of dollars in revenue a year. The testing labs, the DOJ spokesperson explained, also sometimes falsify results and take kickbacks from the sober homes detaining the patients.

One might assume private health insurance companies would be helping fight such fraud. But shockingly, kickbacks and bribes in the private health insurance industry weren’t even illegal until 2018, when Congress finally passed the Eliminating Kickbacks in Recovery Act specifically to try to get fraud in the substance use treatment industry under control. This was a phenomenon Sharkey also unearthed when he was researching *Bedlam*, and that *ProPublica* described again in a 2019 series of articles with titles like, “We Asked Prosecutors if Health Insurance Companies Care About Fraud. They Laughed at Us.” Basically, health insurers see fraud like credit card companies do—as just a cost of doing business. On the whole, it’s ultimately more profitable for them to just allow easy money to keep flowing, and pass rising costs onto insurance payers. Moreover, efforts by mental health organizations and treatment providers to promote health insurance parity for people labeled with psychiatric conditions puts pressure on even responsible private insurers to ignore possible fraud and keep opening the taps further.

That it took so long for government to pass an anti-kickback law also raises questions about how high the corruption goes. Just one provocative example: current Florida Republican senator Rick Scott was previously founder and CEO of Columbia/HCA Healthcare Corp., and departed shortly before the company began negotiating toward a $1.7 billion settlement in 2003 for fraud and kickback schemes involving its hospitals.

* * *

The DOJ spokesperson was reluctant to opine on how widespread psychiatric detention fraud in America is today. But this led me to a different question. Amid fuzzy diagnosing, flexible commitment criteria, routine use of chemical and physical restraints, and often unhelpful treatments, how did DOJ investigators distinguish fraudulent, abusive detentions from legitimate and well-meaning detentions?

“Some of these schemes last for decades, and you often wonder why,” he said. “Well, because they make things appear legitimate. To not just the community, but even to Medicare and other auditors.”

I asked if he had any advice for the public. “Ask questions. The patients who I see in these vulnerable situations, their family members thought they were being taken care of. So, ask questions, and don’t make any assumptions. Because sometimes these patients can’t fight for themselves and speak up for themselves.”

* * *

The DOJ spokesperson’s advice—or warning—is telling. In the recent cases of UHS, North Tampa Behavioral, and Clear View, the companies generally did not deny the specifics of what was reported about their practices, but all three denied that these activities were illegal or abusive. For example, UHS stated that many patients with mental disorders were “unable to make the same judgements regarding clinical care and appropriateness of admission and discharge” as ordinary people, while detaining them until their insurance expired was a medically validated way to “keep patients safe.”

Meanwhile, in the wake of the media coverage, federal and state regulators did launch investigations into all three companies—investigations that dragged on for years. For example, regulators identified eighty-five violations and upheld seventeen formal complaints at Colorado’s Clear View hospital. The Colorado attorney general initiated a criminal investigation. The state health department downgraded the hospital’s license to “conditional.” The Centers for Medicare & Medicaid Services placed Clear View on a ninety-day termination track. And then . . . the hospital simply continued operating. Kovaleski wrote that one clean inspection apparently “cleared up more than two years of what the state had described as unprecedented failures.”

A Reddit chat with journalist Bedi about North Tampa Behavioral was similarly revealing. Many commenters described corrupt practices elsewhere:

“This happened to me as well but in Louisiana . . .”

“I personally worked in a facility like this in a different state . . .”

“This happened to me in Georgia . . .”

“I am a psychiatric nurse in CA who has worked for facilities that illegally extend holds to fill beds . . .”

“I work in mental health and every time I try to report serious abuses nothing gets done . . .”

“I experienced this in a Virginia psychiatric hospital . . .”

One identified himself as a physician regularly handling civil commitment cases, and said Bedi’s article did not convince him the psychiatrists were “maliciously” detaining people. He said sidesitters regularly tell him he’s “wrong for keeping the patient, wrong for discharging them.” American psychiatrists Dinah Miller and Annette Hanson gave a similar perspective in their 2016 book, *Committed: The Battle over Involuntary Psychiatric Care*. They wrote that, “Even within the mainstream psychiatric community, we don’t always agree on what’s best for our patients, what’s best for society, and what the standard for involuntary hospitalization should be. We likely capture many patients who don’t need hospitalization in the name of being on the safe side.”

So when does “being on the safe side” become fraudulent, blatantly abusive incarceration? And who decides?

* * *

One provocative answer: in 2020, the OIG found high rates of noncompliance with the law at US psychiatric hospitals.

CMS requires facilities to keep some basic records about psychiatric inpatients—most importantly, a “certification” form from a physician or psychiatrist stating that the patient did in fact need to be hospitalized for psychiatric reasons.

The OIG reviewed a random national sampling of inpatient cases where claims for reimbursement to CMS included claims beyond the base rate—so, cases that would more often involve someone labeled as more seriously ill, needing extra services, or involuntary. The OIG found that 71 percent of these cases were missing the required certifications that the person actually needed to be hospitalized.

I asked OIG media officer Donald White, “Is it accurate to say that the purpose of the physician certifications was to help prevent people from being fraudulently hospitalized?”

“Yes, that is accurate,” he answered. “They are very important.” White said the certification requirement was instituted by the federal government precisely to help curb fraud and abuse in psychiatric care and, as the OIG report stated, “protect and promote each patient’s rights.” White added, “Often I hear, and our auditors hear, ‘Well, that’s just paperwork.’ It’s not just paperwork!”

It’s the same in Canada’s public system. For example, a 2019 provincewide investigation by British Columbia's ombudsperson found "significant levels of non-compliance" with civil commitment laws at hospitals, finding legal forms not completed, forms "that did not provide anything close to adequate reasons," and physicians who "failed to explain why a person met the criteria for involuntary admission." In all, the ombudsperson found, civil commitments in the province were legal only 28 percent of the time.

So again, where's the line between routinely ignoring the "paperwork" of medical assessments and legal rights—and illegally, abusively incarcerating and forcibly drugging thousands of random people?

* * *

I wanted to ask Tony Kovaleski for his perspective. Kovaleski is a national duPont Columbia and forty-one-time Emmy Award–winning investigative journalist who's outed domestic terrorists, crooked judges, and financial criminals. What did this veteran corruption reporter think as he delved for the first time into civil commitment practices?

"We stand by everything we reported," said Kovaleski to me, declining to elaborate or opine beyond the established facts. Kovaleski's cautiousness was likely due to the fact that Clear View's ownership had sent Denver7 a letter with an implied lawsuit. Denver7's reporting nevertheless had persisted and, in the end, Clear View's own medical director turned whistleblower and state regulators shut the hospital down. Discussing related topics, though, Kovaleski was friendly and engaged, so I circled back. I said I was investigating widespread, often inappropriate uses of civil commitment powers. In light of how long it took regulators to shut down Clear View despite the overwhelming, ongoing evidence of abuses, I said I was curious if he believed Clear View was an unusual case of criminal profiteering, or instead indicative of a worrisome norm where complaints about psychiatric hospitals are routinely regarded as mere mutterings from crazy people.

Kovaleski said, "I encourage you to continue your look at a very important issue."

* * *

In 2020, Universal Health Services paid $117 million in a fraud settlement with the Department of Justice. The media release stated that UHS hospitals in multiple states forcibly detained people who "did not require" or "no longer required” hospitalization, “improperly used physical and chemical restraints and seclusion,” and “billed for improper and excessive lengths of stay.”

Investors welcomed the settlement; UHS’s stock price soared. An expert in health fraud cases told *Modern Healthcare*, “We often see companies make up what they have to pay the government and then some in increased stock price.”

PART FOUR

INSTITUTIONAL MANAGEMENT, PROFITEERING, AND POLITICAL OPPRESSION

CHAPTER 14

MENTAL HEALTH AND THE LIMITS OF ACCEPTABLE SPEECH

Jon Elizarraras, a twenty-year-old living in Pocatello, Idaho, posted a celebratory forty-seven-second video on Twitter in April of 2019 about having successfully withdrawn from five psychiatric drugs. Saying the drugs had made him feel “like a zombie,” Elizarraras suggested that others who wished to could withdraw as well.

The video got millions of views within a week. But Elizarraras was deluged with commenters calling it “dangerous,” “incredibly dangerous,” and “fucking dangerous.”

In ensuing news coverage, Columbia University psychiatrist Philip Muskin called Elizarraras “irresponsible.” Muskin said psychiatric medications were as “essential” as drugs for physical ailments, comparing them to medications for people dying of heart disease.

Several Twitter users figured out where Elizarraras lived and contacted the police.

Two years later, I reached out to Elizarraras to find out what happened next.

An officer tracked Elizarraras down at the bagel shop where he worked. Elizarraras and the police officer knew each other from high school soccer. Elizarraras relayed his whole story and assured him, “Dude, I’ve never felt better!” He and the officer laughed together about the wackiness of social media.

“I had never thought that it was going to go viral and be this huge statement,” Elizarraras told me. “I just thought it was kind of a cool accomplishment for myself.”

The overwhelming majority of reactions to his video were hostile, Elizarraras said, but privately, many people are still reaching out to him for inspiration, encouragement, and tips on safe withdrawal. Some people tell him they thought that if they had a mental disorder, psychiatric drugs were impossible to live without. Elizarraras has been happy to share his learnings. “If people won’t stand up and help others—people who have the audacity to spread the message—how do you know if there are other options?” he said.

Elizarraras told me he was continuing to feel better on his own journey to discovering who he could be without the drugs. Still, the backlash he experienced for speaking out publicly, he admitted, made him a little scared. “I felt like I was being silenced.”

* * *

The uses of psychiatric detention and forced treatment powers for institutional management, social control, profiteering, or political ends are penetrating ever further into our culture—and becoming increasingly difficult to discern from “well-intentioned” forced treatment. In this section, we’ll look at a diverse array of such situations from workplaces to nursing homes, and among soldiers, whistleblowers, dissidents, and more.

Elizarraras’s case points to an overarching political trend: psychiatric detention powers are being used to establish limits on otherwise constitutionally protected speech, and to constrain legal behaviors.

Such boundaries are explicitly drawn, for example, in “duty to report” laws and policies that impose varying degrees of responsibility on licensed mental health professionals to commit people who intend to harm themselves—despite the impossibility in most cases of separating the tiny minority who are actually going to harm from the vaster numbers who sometimes experience feelings of intent and a need to express them.

Jameel is one of countless victims.

I’d already been interviewing Jameel about a run-in he’d had with hotline call tracing, so I knew how innately and irrepressibly critical, erudite, sardonic, and existentially philosophical he could be. Jameel then told me that he’d been psychiatrically incarcerated once before, a few years earlier, purely for those reasons—for being who he was. And indeed, the medical records verified it. For having dared to express his existentialist perspectives, Jameel became a psychiatric political prisoner. And the more he defended his right to simply speak openly, the worse his predicament became.

◆

After completing his undergrad in math and physics, Jameel came across a mental health study at Columbia University offering weekly psychotherapy, and payment for participating. The inclusion criteria were broad.

He needed the money, but the psychotherapy also appealed to him, as he was struggling with his identity. Jameel's family was from a conservative Middle Eastern background and, though in his mid-twenties, he'd not yet dared come out as a transgender man. Opening up to his family "would be considered tantamount to suicide," he told me. But not opening up felt like a form of suicide, too.

So suicide was a theme on his mind, and Jameel enjoyed the sessions with a therapist who shared his interest in existential questions. "I felt I could be completely honest with him," said Jameel.

As Jameel described their conversations to me, he cited Albert Camus and Jean-Paul Sartre. "We're born into this world without asking to be born. Life has all of these unpleasantries, vicissitudes, uncertainties. We're going to drop dead—all of us are going to drop dead sooner or later. Why not commit suicide? Why live? Isn't there a certain degree of dignity, if you will, in eliminating one's own existence by one's own hand, by one's own free will, through one's own self-determination? Isn't there a certain, what is the word, 'appeal' to mastering this biological urge to survive?"

The therapist left for another job midway through the study, and Jameel was assigned a new one. The first day Jameel launched into philosophizing about suicide, she brought out the Columbia Suicide Severity Rating Scale: Did he have suicidal thoughts? How often? Did he have a plan?

Jameel answered that of course he thought about suicide. Didn't any rational thinking person? And in living vitally, shouldn't the possibility—or the option—of death be constantly in the background of our minds? He listed different methods by which he could kill himself in short order: the subway tracks nearby, the George Washington Bridge just minutes away . . .

Jameel said the therapist's eyes darkened. "She does this fake saccharin voice of concern, almost like a bad actress: 'Oh, I'm very concerned about you.'"

Within minutes, the study's lead psychiatrist and two security guards were ushering Jameel across the grounds toward Columbia University's hospital. Jameel had never been to a psychiatric hospital, but didn't like the prospect of getting forced into one. "My heart is racing. I'm sweating. I'm just shocked. I asked the psychiatrist, 'Sir, why are you doing this?'"

The psychiatrist didn't respond. Left with a security guard at the hospital, Jameel tried to explain that what was happening was "ridiculous" and "preposterous." The guard ordered him to hand over all his possessions and remove his clothes. Jameel pleaded that he was profoundly shy about his gender, and that undressing in front of others would feel like assault. He was told that, if he didn't strip, more guards would come and he'd be forcibly disrobed.

"This was like no hospital admission that I had ever experienced," said Jameel.

Next, a nurse interviewed Jameel. She asked a common question for assessing insight: "Why do you think you're here?"

Jameel said, "Miscommunication with a therapist." He again explained his belief that everyone should be free to seriously consider and discuss suicidal feelings. Jameel was assigned a person to monitor him at all times.

Another nurse ordered Jameel to provide a urine sample. He said he didn't need to pee. The nurse threatened to force in a catheter.

Jameel responded, "So basically, if a person cannot urinate, because they might be dehydrated, your first course of action, rather than offering the person water, is to threaten them with sexual assault? How very professional. I am very impressed by your level of clinical care."

He said the nurse didn't respond. Medical records stated that Jameel "has been noted to make provocative statements as a way to communicate her [sic] disagreement with unit rules or procedures."

Jameel then said to this nurse, "I am not suicidal. If there was some miscommunication with a psychotherapist, let me say this very, very, very clearly. And very unambiguously. If I was actively suicidal, I wouldn't be wasting time seeing the therapist."

It didn't help. Only hours before, Jameel's words had been taken so literally and seriously, they'd landed him in hospital. But now, he observed, all his words were seemingly dismissed as mere mad babbling. "I was quite flabbergasted. Basically, my feeling is that, while there, you're a nonperson. You are subhuman."

The attending doctor was a psychiatric resident-student, just a little older than Jameel. "I say hello, I shake his hand, I try to appear as quote-unquote normal as possible,” recounted Jameel. “Essentially your sanity is being placed upon a tribunal. You gotta show some Ivy Leaguer fuckface that you’re no crazier than he or she is.”

The psychiatric-resident, “Harold,” gave Jameel a Mini-Mental State Examination, asking him to count down by sevens, recall three objects, name the US president . . . Jameel seethed, but kept thinking, “Be calm. Hopefully, God willing, you’ll be out of here by morning.”

Harold asked, “Why do you think you’re here?”

Jameel explained what had happened one more time. And he declared, “I believe suicide is a fundamental human right. Is a life worth living? To me this is a strictly philosophical question. A religious question. This to me is not a question that has any place in medicine. The role of medicine is to diagnose and treat diseases.”

Medical notes stated that Jameel “expressed her [sic] suicidal thoughts in highly intellectualized ways.”

Harold held a “poker face” throughout the interview, and Jameel recalled at one point becoming irate and saying, “If a person is feeling suicidal because they feel entrapped, because they see no way forward, because they feel they have limited control over their life or their state of affairs, I’m not sure how further taking away things as basic as their socks, undershirt, and electronic devices, detaining them, threatening them with the use of force, threatening them with forcible catheterization, and treating them as essentially a prisoner would be considered to be curative or therapeutic in any reasonable or rational way.”

Medical notes stated that Jameel had admitted to having a “tendency to act ‘rebellious’ when feeling ‘oppressed.’”

Two days later, a slip of paper on Jameel’s bed notified him that he’d be involuntarily committed for up to sixty days. Staff warned him that if he requested a court hearing, he’d likely be detained longer.

Jameel spent his days pacing the hallways, talking with patients, getting no therapy, and being allowed ten minutes of internet access every second day. “And at night, in your dreams, you do not get escape from that place. Because every fifteen minutes someone comes in and shines the flashlight in your face.”

During this period, he said, “I went from feeling shocked, flabbergasted, and incensed to just numb and angered. Horrified that such things can take place in a quote-unquote democracy.”

Staff asked Jameel about his suicidal thoughts daily. He now politely sidestepped. In the medical records, staff identified only one behavior as a symptom of a mental disorder: “repeated ongoing hand washing.” Jameel told me he washed his hands after using the toilet, before eating, and after using communal objects such as newspapers and pens. But, exemplifying how mental disorder symptoms may suddenly transform into culturally endorsed behaviors and vice versa, Jameel was incarcerated pre-Covid-19.

Even before the pandemic, though, more than half a million Americans contracted infections in hospitals each year—ironically, more dying of those infections than by suicide—and studies often identify the worst spreaders as doctors, because they tend to not wash their hands *enough*. Nevertheless, staff stated that a core objective was to get Jameel to “recognize that frequent hand washing is a response to anxiety.” Staff instructed Jameel to keep a log and try to reduce his hand washing.

After two weeks, Jameel was abruptly discharged. He never learned why. “Everything is just as opaque and as clear as it was from the very start.” The closing medical record stated that Jameel “remained somehow unchanged throughout hospital stay.”

* * *

Upon exiting the hospital, Jameel said he felt more humiliated than he’d ever felt in his life—and more actively suicidal than he’d ever felt, too.

He walked toward the George Washington Bridge. “I hadn’t smelled the air in my face in over two weeks . . . What difference does it make if it’s today or forty years from now? Your sense of dignity, your sense of honor has been destroyed. I come to the George Washington Bridge, the sun has set, it’s quite beautiful. I think, this is a pretty sight to have been my last memory.”

There’d been a car accident, and police and stalled traffic clogged the bridge. Jameel would have to act quickly. He suspected he’d hesitate.

Jameel went home and had a bath. “I tried to wash away this trauma from my body.” For the next several weeks, he said, “I was just feeling completely numb. No feeling, no emotion, just nothing.” His willpower and energy were “sucked out,” and he had many nightmares.

* * *

Amnesty International describes a “prisoner of conscience” as a person who “has not used or advocated violence or hatred but is imprisoned because of who they are . . . or what they believe.”

Countless psychiatric detainees are, in some senses, political prisoners. Many people who have not been violent, advocated violence, or broken laws, are psychiatrically detained primarily on the basis of the allegedly “crazy” things that they believe, think, feel, or express.

Furthermore, many of these people believe that, not only them, but no law-abiding, nonviolent citizens should ever be subjected to indefinite incarceration and medical interventions against their will. But when they express this belief in court—boldly proclaiming a basic human right to refuse mind-altering drugs in defiance of a law that they believe is wrong and unjust—they often get hauled back into detention like civil rights protesters of 1950s America.

But just as racism hurts us all, so, too, does this kind of sanism—bigotry toward people who appear unduly strange or different to us. A society’s chosen prejudices ultimately entrap all its citizens, and erode everyone’s opportunities for genuine human connection. In many conversations, Jameel expressed to me how profoundly wounded he felt to have become the target of such bigoted beliefs, and to now be wearing the label of certified mental patient.

* * *

One day, more than a year later, Jameel entered a mosque he often walked past; he’d heard it was LGBTQ-friendly. It was Ramadan, so the mosque was crowded. Almost immediately, across the room, he saw Harold, the hospital psychiatrist. “I’m not religious,” Jameel told me, “but the profundity seemed inescapable. To see this person who dehumanized me, in a place where we’re equals, where your status and position in life doesn’t matter.”

Jameel later found himself next to Harold, who didn’t seem to recognize him. But standing shoulder to shoulder, said Jameel, both ordinary people in ordinary street clothes, felt “healing.”

Jameel started visiting the mosque regularly. Three weeks later, he deliberately approached Harold.

Jameel recounted to me what he said: “Sir, it’s very interesting that we should meet here. We met about a year and a half ago under some very unfortunate circumstances. And what transpired that one evening has really traumatized me. I have nightmares about what happened. Flashbacks. I feel very violated, very dirty. I don’t know if you remember me. But I remember you like it was yesterday.”

Jameel said Harold stared intensely and recognized him. Harold then said, “We were doing the best that we could, given the circumstances. I’m sorry the experience was less than positive.”

Jameel kept pressing for deeper connection, outside their previous enforced roles of doctor and patient in relation to one another, reaching for shared understanding. “Here, we’re equal. Here, we prostrate upon the same ground. But what occurred there really harmed my soul . . .”

Harold said, “I would advise you to see a therapist.”

CHAPTER 15

“A ‘BEHAVIOR’ IS NOT BEING QUIET”: FORCE-TREATING THE ELDERLY

Denise Herrenbruck was teaching special education at UCLA when her eighty-five-year-old father, Gene, fell and fractured his shinbone. Herrenbruck flew to North Carolina to help out.

Gene had been experiencing some early dementia, having trouble finding his keys or glasses, or losing his train of thought. But he was living comfortably at home with Herrenbruck’s mother. A retired college administrator, he walked to the recreation center and entertained friends with his jazz piano.

Gene’s tibia was treated at a nursing home. However, one morning he apparently experienced delirium—not uncommon for elderly people recovering in unfamiliar inpatient settings. He became temporarily confused and, with his leg immobilized, swung his cane to prevent staff from approaching. No one was hurt and he later apologized, but staff transferred Gene to a hospital for evaluation.

According to an American Association for Emergency Psychiatry report, delirium can cause disorientation and hallucinations, and be triggered by a variety of factors including medications, urinary tract infections, vitamin deficiencies, dehydration, or recent surgery. Delirium usually goes away on its own. Yet in a focused study, average emergency physicians and psychiatrists failed to identify short-term delirium in 76 percent of cases.

At the hospital, the psychiatrist diagnosed Gene with severe dementia and psychosis, and prescribed an antipsychotic. He then committed Gene to the psychiatric ward and prescribed more psychotropics. Gene’s mental state deteriorated.

Herrenbruck said she tried to explain that her father's dementia was actually not severe and that he seemed to be going through a sudden and qualitatively different state than his recent norm. But she said hospital staff saw him as "just a difficult-to-manage, old, demented man."

Over the next ten days, Gene's condition continued deteriorating dramatically. He lost his ability to take care of himself, was unstable on his feet, at times was barely able to pull himself up in bed due to spinal and muscular rigidity, and was frequently thrashing his limbs around while pleading to Herrenbruck, "Why do I keep moving? Why can't I stop?" His cognitive capacity intermittently diminished, and he suffered aphasia, struggling to find or mixing up words. On several occasions, Herrenbruck witnessed her father's head droop for a few seconds while he mumbled; one time a physician in the room reacted with alarm and, after testing, suspected Gene may have had a mini-stroke.

Eleven days after his detention in the psychiatric ward, Herrenbruck said, her previously functional father was discharged "in diapers on a gurney." Herrenbruck was horrified and confused, but knew for certain that her elderly mother was not capable of taking care of her father in this state.

The nursing home would only admit Gene under the hospital's approved discharge conditions. So, though Gene was no longer committed, the psychiatric drugs had to continue. Over the ensuing months, her father failed to return to normal. His leg healed, but he was unsteady walking, and still complained frequently about feeling agitated and needing to move. Herrenbruck tried to figure out what was going on, researching dementia, Alzheimer's, mental disorders, and other conditions, but nothing accounted for his sudden and ongoing array of symptoms.

"Eventually, I got to, 'What about these psychiatric drugs—what do they do? What are the side effects of those?'" said Herrenbruck. "And then it was just like, 'Oh. My. God.'"

The hospital psychiatrist had prescribed Gene the antidepressants Trazodone and Celexa, and the antipsychotic Risperdal. All three of their manufacturers' drug labels warned of possible adverse effects, often heightened in the elderly, that listed virtually all of Gene's symptoms over and over: aphasia, psychosis, cognitive impairment, muscular rigidity, incoordination and unsteadiness, strokes, and akathisia. As with all antipsychotics, Risperdal additionally had a black-box warning that the drug should not be given to elderly people with dementia, and that it nearly doubled death rates within months.

Herrenbruck’s breakthrough, though, came too late for her father. By then he’d been suffering for a year, especially from the akathisia and motor instability, and one day he fell and broke his hip. His doctors said Gene wouldn’t survive hip surgery, and recommended palliative medications. “That was it,” said Herrenbruck. “He basically died of morphine.”

Today, Herrenbruck is convinced that, along with a brief bout of delirium that started it all, her father suffered from severe adverse reactions to psychiatric drugs from the day he entered the hospital until his death. “I have a lot of grief that I couldn’t save my dad from that,” she said. “That’s just profoundly painful.”

Part of the reason it took so long for her to consider the drugs as a problem, she said, was because she’d witnessed them at least briefly “working.” After he took them, her father would often become calmer—for a time. Herrenbruck said she’s aghast that not a single medical staff person at the hospital or nursing home ever suggested the possibility that her father could be experiencing adverse drug effects. “How could this be so globally missed? It’s just beyond belief.”

In retrospect, she feels immense regret about not taking her father seriously enough when he said staff were disrespectful of his views, such as when he insisted he was not faking the muscular rigidity he was experiencing. “That’s what bothers me the most, even more than my father’s death,” said Herrenbruck. “The violation of his agency, his integrity. The more he tried to assert his rights, the more he was accused of not making sense.”

* * *

In elderly care across North America, many ordinary families are increasingly brushing against mental health laws, and encountering the blurring lines between responsible care, poor or abusive care, and fraud and profiteering. Every body in a bed is a source of income for long-term-care (LTC) facilities where tranquilizing psychotropics are widely used as tools to help with managing people—and when a client or family protests, mental health laws often get invoked.

Over the past two decades there have been pushes by governments in both the US and Canada to reduce the use of antipsychotics in seniors’ care. However, the drugs continue to be routinely prescribed for “behavior control.”

Yet the phrase *behavior control* can be misleading. In a 2018 report, “*They*

Want Docile: How Nursing Homes in the United States Overmedicate People with Dementia," Human Rights Watch (HRW) investigations didn't turn up cases of dementia patients running hallways and fistfighting staff. "In the words of a long-term care ombudsman in Kansas," the HRW report stated, "a 'behavior' is not being quiet." An ombudsman in Texas said, "A resident is 'disruptive' if she's outspoken: if she's not happy with what they're doing . . . Basically, 'disruptive' means a person knows her rights." While severe dementia can certainly at times prompt anxiety, wandering, or other unpredictable behaviors, there are many strategies for intervening, calming, or assisting someone without drugging them. But one of the report authors recounted that many staff members "frankly admitted giving residents these medicines for their own convenience" and considered it "a perfectly acceptable practice."

Efforts to reduce antipsychotic use have had mixed success.

An investigation by the federal Health and Human Services Office of Inspector General (OIG) found that, as of 2007, about 14 percent of elderly nursing home residents nationally were being prescribed antipsychotics, and 88 percent of those were people with dementia—doctors were directly flouting the FDA's black-box warning. The OIG noted that the practices resulted partly from financial corruption; for instance, from 2009 to 2013 the DOJ settled a number of lawsuits worth hundreds of millions of dollars with Omnicare, America's largest nursing home pharmacy, and Johnson & Johnson, the manufacturer of Risperdal, for using bribes and kickbacks to promote the antipsychotics for inappropriate uses in seniors. It was but one settlement of this kind involving innumerable companies, often involving kickbacks to physicians as well.

By 2011, the percentage of residents in nursing homes (a subset of LTC facilities) on antipsychotics had risen to 23.9 percent. So, in 2012, the Centers for Medicare & Medicaid Services (CMS) partnered with federal and state agencies, LTC providers, and others through the National Partnership to Improve Dementia Care in Nursing Homes, with a goal to reduce antipsychotic use. LTC facilities completed regular surveys and, according to those surveys, by 2019 the percentage of elderly nursing home residents taking antipsychotics had decreased back to 14 percent.

However, there was a loophole: if residents were diagnosed with schizophrenia, then prescribing an antipsychotic was considered appropriate, and so these weren't included in the numbers. In 2021, a follow-up OIG report and a separate *New York Times* investigation found that diagnoses of schizophrenia had been climbing tremendously in LTC facilities. "This finding raises concerns," stated the OIG. The *Times* calculated that at least 21 percent of nursing home residents were taking antipsychotics—apparently, no actual decreases had occurred since 2011.

Professionals themselves acknowledge this dubious "diagnosing." In 2017, the American Association for Geriatric Psychiatry, American Association of Nurse Practitioners, American Psychiatric Association, and others issued a statement cautioning their members that "the development of schizophrenia is uncommon in older adults" and "clinicians need to be mindful of and avoid labeling patients with other diagnoses to justify the use of medications."

A 2016 report from the Canadian Institute for Health Information reported even higher rates of antipsychotic use in Canadian LTC facilities—an average of 39 percent of clients. Then Covid-19 lockdowns led to further rising rates in both countries.

And none of this addresses other sedating or numbing psychotropics; in many LTC facilities in both countries, 70 to 80 percent of residents are being given at least one psychotropic.

When elderly people resist such treatments, Mia's case illustrates how hard it can be to wrest free.

* * *

When I arrived at the prearranged location, Michelle met me at the door.

"Sorry, I didn't want to tell you on the phone," she said. "Now we're going to go to where Mia really is."

In a small convoy, Michelle, her husband, Russel, their children, a nanny, a seniors advocate, and I drove in deliberately roundabout ways through the winding roads, regularly checking for anyone following. It felt like I was being ushered into remote mountains to meet *el Comandante de los guerrilleros*. I was actually in a quaint, wealthy suburb, on my way to interview an eighty-two-year-old woman named Mia, described by friends and family as quiet, sophisticated, and loving. How did we all get on this road together? Mia hadn't threatened anyone or broken any laws, but she was on the run—from the local public health authority.

Mia had resided in an assisted living facility in Canada for several years, where she was given various antipsychotics and antidepressants. She frequently expressed her dislike of the facility and the drugs, and eventually Michelle and Russel brought her to live with their family. But Mia injured her hip and, while recovering in the hospital, a psychiatrist diagnosed her with depression. He committed Mia to the psychiatric ward and scheduled electroconvulsive therapy (ECT).

Mia saw the effects of ECT on other patients, and was frightened by their memory loss. She didn’t want ECT, and her family supported her in requesting a formal hearing.

That’s when I first heard from Mia’s granddaughter Michelle, and went to the hospital to meet Mia, who invited me to the hearing. They hoped the presence of a journalist shining a light on patients’ rights could help them.

At the hearing, no rules of process were explained and few were evident; instead, right away, Mia was grilled by the tribunal chair with questions like, “Ma’am, do you understand why we’re here today?” and her every misunderstanding, confusion, or moment of forgetfulness was a strike against her competence.

After I was recognized by the psychiatrist, and it became clear the family had enlisted not one but three attorneys, the tribunal panel met with the psychiatrist and hospital attorney alone for fifteen minutes—leaving the rest of us stunned by the blatant bias.

When they returned, the tribunal chair summarily kicked out the seniors advocate, the nanny, and me. I obtained a covert recording of the rest. When the family’s attorneys started questioning the relevance and fairness of what was happening, the chair threatened to throw them out, too.

The psychiatrist portrayed Mia as extremely at risk, and Michelle as inappropriately scaring Mia off ECT. Mostly, the tribunal interrogated Michelle and Russel, assessing them as caregivers against unstated standards.

Russel described the hearing process to me later as, “like a wood chipper, like a steam roller.” Mia was so heavily force-drugged, she frequently dozed off. Michelle was astounded at how much information the psychiatrist had been able to selectively cull and cunningly use against them from virtually every point of contact the family had had with the health care system, from records and interactions they’d assumed were confidential with social workers, support groups, pharmacists, family physicians, and private home care companies. Health privacy protections are much more porous once a person is labeled as potentially dangerous to self or others.

Despite all this, Mia won. The panel declared, “The patient is a member of a close and loving family, which has always caringly attended to her personal, as well as medical care and supervision.” The panel wrote that Mia did not need to be electroshocked. She did not need to be committed. She was not in danger. She could go home immediately.

I was relieved for Mia, but it was also unnerving. This complete reversal just further highlighted the pseudoscientific, unfair process that had deprived Mia of her liberty.

The psychiatrist on the panel dissented, saying Michelle and Russel were “obviously caring people,” but they didn’t have “appropriate expertise.” He believed Mia was “committable.” It was a foreboding warning.

* * *

Shortly after Mia’s discharge from the hospital, social workers and community nurses from the local health authority began calling Michelle’s home multiple times per day, and dropping by unannounced several times per week.

“They asked us a ton of questions, trying to find out what we were doing, where we were going,” said Michelle. “They asked Grandma who her new doctor was, how’s her therapy going . . .”

The health department’s lawyer sent a letter with demands: Mia must visit a physician monthly, continue taking all prescribed psychotropics, submit regularly to psychiatric assessments, and always give them her current whereabouts.

The Public Guardian’s office sent Michelle and Russel cryptic warnings: “We are in receipt of a referral with respect to [Mia] and will be assessing the situation to determine if the services of our office are required.”

Michelle and Russel were shocked. Would the health authority really go so far as to try to get Mia taken from them?

They all went underground. Calls were screened, daily schedules were closely guarded, and Mia moved between friends’ and relatives’ homes. Michelle and Russel adapted their work situations and started homeschooling their children to allow family mobility.

When I was escorted to meet with Mia in person the final time, she seemed quiet, but clearly relished her freedom. She described having mainly felt “frightened” and like she’d been “going nuts” in the hospital. She was now seeing a physician who’d agreed to work covertly. She was not taking any psychotropics, and felt better. “I had the feeling I was overdrugged,” Mia said. “Terrible. I felt very tired.”

She still felt depressed sometimes. I asked what made her feel better. “I like to be with my family. I'm very glad I have Michelle and Russel."

Russel asked me, "What do they want? Why do they want to do these things to us? What are their motivations? Is it money? Is it something darker?"

A local psychiatrist who was aware of the case said to me, "From our end, we really are doing our best to help our patients and our best to promote good practice and good care." He described "a really intense caring attitude"—his tone one of determined protectiveness, as if he'd found an abandoned baby on his doorstep.

Michelle and Russel were at a loss as to what advice to give others, because they'd had everything in order with Mia, including powers of attorney, representation agreements, home support, and more—yet still, simply helping their grandmother fulfill her clearly stated wishes had become an ongoing battle on multiple fronts.

"I felt that this was a great country, and we had a good Charter of Rights, and that we were protected here, and we were free people," said Russel. "But we're not. We're all in danger. No matter what legal documents you have that you think are expressing your desires and wishes. None of that is worth anything once the hospitals and doctors decide that they want you."

"This has ruined our lives," said Michelle. "It's been a year of hell for us. Financially, it's insane. Just our time, our family, everything. It's been overwhelming."

"I'm scared," said Russel. "The legislation absolutely does need to change. And people need to know what's going on because they're hiding it. And these stories are so impossible to believe. The only way that this can change is in the public eye."

Eight months later, the health department attorney sent a more threatening letter to one of the family's attorneys, demanding to know Mia's location and for "evidence" that Mia was undergoing "treatment of her medical conditions." Otherwise, mental health and guardianship laws would be invoked. "If we do not hear from you," concluded the letter, "we will pursue assistance from the police in locating [Mia] as a missing person."

The family's attorney advised them to hold their ground. The health department contacted the police. The police tracked the family down. Satisfied that Mia was fine, the police agreed not to divulge their whereabouts.

The "missing person" told me over the phone that she was feeling better, and a therapist was helping with her frightening memories from the hospital. After I hung up, I felt a stab of worry again: Might health authorities really go so far as to put Mia under a guardianship, just to forcibly treat her? I assumed Mia’s case must be rare, though, for the extremes to which the practitioners had gone. But then I started learning more about guardianships.

CHAPTER 16

“IT’S NEARLY IMPOSSIBLE TO ESCAPE A GUARDIANSHIP EXCEPT IN A COFFIN”

Anyone who doubts that the nets of involuntary treatment laws have expanded enormously need only look to Britney Spears. The international pop music star has for many years been regularly acting on television, touring, maintaining a social media presence, and performing a successful residency in Las Vegas. Yet only in late 2021 was she finally freed after more than a decade subjected to the nuclear option of forced treatment: conservatorship.

Under conservatorship laws, also called guardianships, a court declares a person incapable of making reasonable decisions, and gives all day-to-day decision-making authority to someone else, such as a family member or professional guardian. Guardianships were designed to help isolated children and the most incapable adults—such as those with dementia so severe they can’t comprehend who or where they are. Increasingly, though, adults who’ve been labeled with relatively ordinary mental disorders are being put under guardianships and forcibly drugged.

Spears’s story has been extensively reported and her own book, due out after this one went to press, will undoubtedly bring new revelations. But a brief look back is instructive, because many of her experiences appeared typical of this new wave of guardianships—except she got freed.

Spears first got put under the guardianship of her father, Jamie, after several incidents where she got into conflicts with her ex-partner or aggressive paparazzi and was briefly psychiatrically hospitalized. According to a *New Yorker* investigation, after two successive psychiatrists did not determine that the twenty-seven-year-old busy mother, singer, and actress was “mentally incapable,” a third psychiatrist was contracted and did. The guardianship was granted in a brief court proceeding without Spears present.

Shortly afterwards, Spears hired lawyer Adam Streisand to challenge the guardianship. When Streisand arrived in court, the judge cited the psychiatric evaluation indicating that Spears was allegedly not even mentally competent enough to hire her own lawyer, and reprimanded and disqualified Streisand.

So the guardianship became entrenched. Many in the public surmised Spears became comfortable with the situation, since she wasn’t shouting from all rooftops demanding her freedom; it turned out her communications, relationships, and social media were now controlled by her father. On several occasions, like others I’ve interviewed in similar situations, Spears desperately called 911 and went to police to complain, and was seemingly discounted as mentally ill.

Finally, in testimony to a judge in 2021 that Spears asked to be made public amid mounting media attention on her plight, Spears described herself as a “slave” to her father and others who were paying themselves millions of dollars off her labors, while they kept her under constant pressure to keep taking psychotropics. Spears said the psychiatrist “abused” her by the “treatment” he gave her.

The judge told Spears if she wanted to end the guardianship, she’d have to undergo another psychiatric evaluation. Spears, though, repeatedly emphasized that she’d lost all trust in psychiatric evaluations. “I don’t feel like I should even be in a room with anyone to offend me by trying to question my capacity of intelligence,” she said. “I want to end the conservatorship without having to be evaluated.” Due to Spears’s prominence, her obviously lucid testimony alone caused enormous public embarrassment to those orchestrating her guardianship, and they one by one stepped down.

Most victims, though, remain trapped by psychiatrists’ evaluations.

* * *

The National Council on Disability (NCD) issued two reports in 2018 and 2019, where they identified “serious problems” in how guardianships operate in the United States. The NCD pointed to a dearth of monitoring and oversight, frequent denial of due process, and entrenched prejudices against people labeled with disabilities. And, they wrote, the way that mental capacity or competency evaluations are typically done is “deeply problematic.”

Many court guardianship decisions, the NCD said, hinge on opinions from ordinary physicians and psychiatrists who typically don’t have “any specialized knowledge that would aid in making a capacity determination” and whose testimonies are “rarely subjected to rules of evidence.” And psychiatrists’ opinions, the NCD noted, are frequently based on unreliable tests or broad, prejudicial generalities about diagnoses. For example, anyone labeled with bipolar disorder or schizophrenia often gets presumed to be permanently ill, probably lacking insight, and potentially violent.

The Mini-Mental State Examination (MMSE) screening tool is one common capacity test. It asks people to identify the exact date, name the president, recall random listed objects, and spell and count backwards. Perfect scores and nil scores certainly indicate something. But many people score in the middle ranges where answers can be influenced by poor literacy, having mild short-term memory problems, being drugged on psychotropics, or just feeling anxious as one’s freedom hangs in the balance of a five-minute trivia game.

The NCD, like most disability groups, has long lobbied for fulsome assessment processes presided over by multidisciplinary teams that assess different abilities and capacities, and for limited guardianships that set up supported decision-making instead of needlessly stripping people completely of all of their rights. But that model is rarely followed. Tests like the MMSE and the subjective opinions of psychiatrists, wrote NCD, are “usually given tremendous weight by the court,” and judges’ decisions are absolute and practically irreversible.

Sam Sugar said all this makes guardianships ripe for abuses.

* * *

Sugar is a doctor of internal medicine who moved to Florida “to enjoy the weather and to plan for retirement.” Things didn’t work out that way, he told me. “Instead, I got entangled in this unholy mess and corruption.” He’s published a book about it titled, *Guardianships and the Elderly*: *The Perfect Crime.*

It all started when Sugar’s wife and her siblings, among whom there was existing animosity, got into a court battle over guardianship of their aging mother. Instead of weighing the true merits of each side’s case, the judge simply appointed a professional guardian to take over. Sugar was aghast at how easily their mother was stripped of her assets while her daily life was subjected to the control of a stranger.

"I had never heard the term *guardianship* before," said Sugar. He began to research guardianships and created a website and nonprofit to educate others. "The reason I wrote the book is because I was getting so many phone calls with the exact same problems from people around the country."

Sugar believes guardianships instituted by genuinely loving family members are usually appropriate and helpful, but said a rising tide of corrupt professional guardians, probate lawyers, and institutions are making financial fortunes, often from well-to-do, vulnerable elderly people.

"One thousand or more people a day are moving to Florida. They're bringing their money with them. They are leaving family and friends behind. And some of them are going to fall and break their hips or have a stroke or otherwise become vulnerable. This is like serving these people on a silver platter." He added, "In 2003, there were exactly twenty-three professional guardians in the state of Florida. Today there are over 650."

According to the DOJ's Elder Justice Initiative, there are approximately 1.3 million adult guardianships nationally controlling at least $50 billion in assets. "Which is an incredible understatement. That information is two decades old," commented Sugar. "No one knows the true extent of the problem." A 2021 *BuzzFeed* investigation estimated two hundred thousand new guardianship applications are now filed *every year*. Some states have public guardians, but an industry of private guardians has also sprung up, largely unmonitored and unregulated, and shrouded behind health privacy laws and sequestered courts.

In 2010, the federal Government Accountability Office (GAO) declared that even they could not penetrate the walls of secrecy enough to reach definitive conclusions; however, they "identified hundreds of allegations of physical abuse, neglect and financial exploitation by guardians in 45 states." In 158 cases that they unraveled, involving millions of dollars in stolen assets, the GAO identified "common themes": courts failed to screen guardians, appointed guardians who had histories of criminality, corruption, and financial problems, and failed to provide oversight. The GAO also found cases where not only the guardians but the probate lawyers and judges were on the take in shared conspiracies.

Sugar said the first step in a guardianship is often that an elderly person gets reported to a court or the police as in some way vulnerable or a danger to themselves. Sometimes this could be a legitimate concern, and sometimes an invented one from someone with an exploitative agenda. In either case, having any genuine vulnerability, such as being socially isolated, having no close family or having dysfunction or disagreements within one’s family, having suffered a serious injury, or being labeled with a mental disorder, makes the situation especially hazardous.

Much like mental health hearings, guardianship proceedings happen in secretive courts, said Sugar. “There are never juries. Rules of evidence are very loosely applied or ignored, as are rules of due process.” Often, the person who’s going to be subjected to the guardianship—the potential “ward”—isn’t even notified, as the testimony of a health professional is usually enough to persuade a judge that a person is incompetent. Essentially, said Sugar, guardianship proceedings involve one judge with “godlike powers” and “no checks, no balances, no monitoring, no supervision.”

The close intertwining of guardianship laws and psychiatric forced treatment, he said, is central to how abusive guardianships work. “Nearly all of these abused wards are intentionally overmedicated,” said Sugar. “They take people who might forget their keys a couple of times, forgot to pay their mortgage once or twice, and declare that they’re incapacitated. Next thing you know, they’re on [antipsychotics] Haldol and Seroquel and [sleep drug] Ambien.”

Psychotropics, said Sugar, are often referred to by rights advocates as “handler” drugs. “Handling,” he emphasized. “They’re designed to keep the ward quiet. And to make everyone around believe that everything’s just fine, because no one’s complained. You can’t complain when you’re a zombie.”

Sugar said there are now many “insider” lawyers, guardians, and health professionals conspiring together “who understand how this system is supposed to work, and precisely how to profit from it in a very big way.”

Sugar pointed to the case of Rebecca Fierle.

* * *

Fierle was a professional guardian arrested in Florida in 2020 for allegedly ordering that one of her wards have his feeding tube capped against his own express wishes, resulting in his death.

According to a 2019 report by the Orange County Comptroller, Fierle had more than a hundred wards simultaneously—far more than is typically considered safe—whose finances she paid herself from and whose daily lives and medical and psychiatric care she controlled. Yet the oversight was so shoddy that the Comptroller could in many cases not even determine if Fierle had actually followed guardianship laws, let alone managed the wards and their assets well. This wasn't uncommon. A 2021 follow-up audit found that the director of the county's whole guardianship program couldn't identify how many guardianships there were, and efforts to prevent abusive guardians were nearly nonexistent.

Many of Fierle's nearly 700 wards over a decade were patients with a single health care provider, AdventHealth, who'd also—seemingly inscrutably—paid Fierle close to $4 million in fees related to the same patients. Fierle often moved the patients out of AdventHealth hospitals. While these moves were ostensibly for the good of the patients, health care facilities and corporations may have their own financial interests in getting patients transferred. This was an issue raised in a similar situation exposed in Virginia.

In 2019, the *Richmond Times-Dispatch* analyzed 250 cases and found that the VCU Health System "has taken hundreds of low-income patients to court over the past decade to remove their rights to make decisions about their medical care." The *Times-Dispatch* found that three lawyers at one firm had been paid over a million dollars by VCU to help get these patients—most labeled with mental disorders—stripped of their rights. The same lawyers then got themselves appointed as their guardians and started mining the wards' assets for their own gain. The lawyers would also then move the patients from the VCU hospital into lower-cost, lower-quality LTC facilities. "This process," reported the *Times-Dispatch*, "frees up hospital beds at VCU Health System and saves thousands in uncompensated costs." During this process, the new guardians would be able to circumvent any resistance of these poorer patients and their family members to the changes.

How did all of these obvious conflicts of interest so easily pass through the courts? A Virginia guardianship court case, reported the paper, "regularly takes 15 minutes," and neither the targeted person nor a defense attorney were typically notified.

BuzzFeed also turned up innumerable shocking stories, from a ward getting abused and secretly buried in concrete to a guardianship "nonprofit" draining the accounts of more than eight hundred people.

* * *

The patterns in abusive cases are so similar, Sugar said, that he calls it a Guardian Playbook. “It’s like somebody actually published a playbook of how to get your hooks into a vulnerable individual, drain them dry, and then kill them off and get them out of the way,” he said. “The mantra is litigate, overmedicate, take the estate, cremate the remains. It’s nearly impossible to escape a guardianship except in a coffin.”

Notably, in commenting on the Britney Spears case, a prominent disability rights attorney conveyed the same “mantra” to the *New Yorker*: “The strategy is isolate, medicate, liquidate.”

“From a layman’s perspective, looking in on this, it looks for all the world like multiple laws are being broken,” said Sugar. “Laws about conversion and exploitation and elder abuse and state trafficking and human trafficking. But because everything is done through a judge’s order, it is not illegal. Wrong? Sure. But technically legal, and therefore almost impossible to challenge.”

Sugar said one of the few people he’s seen get released from a guardianship is Janice Garwood. But she had no psychiatric history, was highly capable, and wasn’t drugged—and still needed a lucky bit of help from Sugar.

* * *

In 2017, the sixty-seven-year-old Garwood was watching television in her house in Longwood, Florida, when the doorbell rang. A woman Garwood didn’t know said, “Give me the keys to your house and your car. You’re coming with me.” The woman was Rebecca Fierle.

It remains a mystery how Fierle knew who Garwood was. Garwood told me she’d recently suffered injuries in a car accident that caused periodic seizures, and has reason to suspect a distant cousin thought a guardian could help her with daily activities—or was angling for control of a substantial family trust fund Garwood had inherited.

Fierle had submitted a court petition that barely filled two pages, stating that the whereabouts of Garwood’s two sons were “unknown”—though Garwood was in contact with both. Providing no evidence, Fierle wrote that Garwood had “poor insight and judgment,” and checked boxes declaring that Garwood was too incompetent to make legal, financial, or medical decisions, or marry, vote, travel, or socialize. Without meeting Garwood, a judge granted Fierle guardianship.

Garwood lost control of her own finances, and after Fierle was charged with aggravated abuse and neglect of a different ward in an unrelated matter, the subsequent guardian forced Garwood into a locked assisted living facility. Visits were monitored and she was drugged with psychotropics. “I used to stand and look at the sun rise and set through the blinds,” said Garwood.

However, on a floor populated by people with severe dementia, staff knew Garwood didn’t belong. They turned a blind eye when she started flushing the psychotropics down the toilet. And when the guardian sold Garwood’s furniture, artwork, and jewelry—and her house to one of the facility’s employees—that prompted some staff to switch allegiances.

A nurse sneaked in a cell phone from Garwood’s son, and Garwood pleaded for her freedom to anyone she could. She’d been detained for over a year when she reached a volunteer with the nonprofit Center for Estate Administration Reform (CEAR).

CEAR contacted Sugar, who collaborated with the facility’s doctor in a new evaluation for the court that concluded, “Janice Garwood is not incapacitated.”

Garwood was freed. Today she rents a small apartment and survives on social security. “I have learned how to count every nickel,” she said. “I don’t think guardians should be given the type of privileges they are, without having family and three or four other people double-check everything they do.”

Rick Black, CEAR’s codirector, said CEAR has been involved in about four thousand guardianship cases nationwide, and he’s seen only a hundred people regain freedom.

Generally, he sees a lot of financial corruption. For example, conducting a mental capacity evaluation can net as little as $150 from public coffers, said Black, but if a person is successfully put under guardianship, retroactive fees come from the ward’s money and are typically $3,000. “The psychiatrists learned very early: give the attorneys what they want, and you’ll get a lot more of these $3,000, thirty-minute evaluation requests. The biggest beneficiaries are the litigators. A big part of what [CEAR does] is educate the public that the bar association in each state, and the guardians who benefit, will not tell you the truth about the risks of entering into this environment.”

Even destitute wards can be profitable. Black said he’s seen cases where facilities billed Medicaid as much as $20,000 a month for a ward’s bogus “treatments.” State governments have little motive to investigate such fraud because it’s valuable federal funding flowing into their state.

Black said that CEAR has seen many cases of people as lucid as Britney

Spears. “Yet they died in a guardianship, completely unable to protect themselves and begging for help.”

* * *

Many times, guardianships aren’t so much about forcibly drugging people for profit, though, as just about forcibly drugging them. As in the cases of Mia and Pat, many mental health professionals have deep-seated beliefs that people labeled with mental disorders should be medicated—and this can make them want to assume control. For example, Rosemary Weaver, formerly a peer-support specialist in a state psychiatric hospital in North Carolina, saw many involuntary and “voluntary” patients alike admitted by their guardians.

“The hospital themselves would initiate guardianships,” Weaver told me. “If the patient had had repeated admissions, then they would just say, ‘Well, this person obviously can’t handle their lives.’”

A 2018 report from the University of North Carolina at Chapel Hill found that the demographics of guardianships in the state has indeed been changing—from elderly people with dementia to predominantly younger people with intellectual disabilities or labeled with mental disorders. Refusals of psychotropics were central in their case studies. *BuzzFeed* also found a trend of struggling young people getting sucked into a “school-to-guardianship pipeline.”

Similarly, the state of California—even as the Britney Spears scandal was unfolding—moved toward *expanding* guardianship laws to make it easier to seize control of the lives of people who are homeless and labeled with mental illness or substance use disorders, for the explicit purpose of detaining them in long-term facilities and involuntarily treating them.

And similar practices occur in Canada’s public health care system. After I wrote for a Canadian magazine about Lois Sampson’s fight for her mother’s freedom from a guardianship, nursing home, and psychotropic drugging, Sampson started getting calls from across the country. She launched a website and became a volunteer advocate. In ten years, she estimated she’s been in contact with thousands of people, and has gotten extensively involved in about one hundred cases.

While earning money off patients is a core element of every LTC facility’s business model, Sampson doesn’t believe money is always the “root” evil. “We often hear that private care homes are the worst, but in my experience, some of the worst are actually public facilities. The nature of the economic model really makes no difference. The main driver is professionals and institutions actively defending their powers to do whatever they want to do. And the lack of meaningful consequences for any wrongdoing is at the heart of the problem."

For many, the Canadian LTC system works fine, said Sampson. Problems usually emerge when someone starts challenging authority. Often, the flashpoint is psychotropic overdrugging, and mental health laws get invoked. "An isolated elderly person usually doesn't stand a chance; their protests are regarded as symptoms of their dementia or mental illness that justify more sedating. And if they have close family or supporters who rally to their side, then the institution will try to seize control."

Sampson showed me documents from a Toronto case. A sixty-seven-year-old man suffered a stroke, but a medical neurologist said he was a good candidate for full recovery with appropriate therapies, and explicitly cautioned against antipsychotics. Nevertheless, hospital doctors and psychiatrists prescribed the man antipsychotics, antidepressants, and sedatives—and his condition worsened.

His wife launched legal action. The hospital doctors in response tried to get the public guardian put in charge. The doctors argued that the wife's desire to reduce the psychotropics proved she was ignoring the "principles" of responsible substitute decision-making. "We feel strongly that any decision other than to consent to the proposed plan of treatment is not a decision made in accordance with these principles," the doctors wrote.

The man's condition continued worsening. "His prognosis for any recovery is nil," his doctors concluded, planning palliative care ahead of imminent death.

Desperate, the wife orchestrated a ruse with the help of Sampson and basically kidnapped her own husband from the hospital. She took him directly to another hospital, where doctors expressed shock at his condition and took him off all the psychotropics. The man was soon discharged, and the couple enjoyed seven more years together at home.

Like Black and Sugar, Sampson emphasized that even hiring your own lawyer in such situations can be risky, because many attorneys work regularly with health providers, and they routinely reach their own decisions together "under a cloak of superiority and entitlement." By way of example, she sent me documents that emerged years later surrounding her own case. Several attorneys specializing in elder law who'd thwarted her efforts to stop the forced drugging of her mother were advertising their services to purportedly help elderly people, while simultaneously sitting on boards of LTC facilities, working with health providers and government on revisions to guardianship laws, and training judges in administering the laws.

Sampson said her best advice for people is to be aware that the health care system is extremely powerful—and act at all times as if someday you could end up in court fighting for your or a loved one's rights. "Document, photograph, video everything," she said. "If you don't have any records of such events or occurrences, it will be their word against yours, and their word will always be believed. There will be such egregious things done, and that may never see the light of day, because nobody believes them. Bring witnesses."

* * *

A 2018 report from the US Senate Special Committee on Aging found "few states are able to report accurate or detailed guardianship data" and that "there are few safeguards" to protect people from abuse. And as the Spears story stayed in news cycles and rights advocates used the opportunity to pressure governments, by late 2021, Sugar told me he'd been observing changes stirring. For example, citing Britney Spears, the two ranking senators on the Committee on Aging proposed a "Guardianship Accountability Act" to require data collecting and oversight, and less restrictive, supported decision-making.

Sugar added, "There are leaders in the Civil Rights Division of the DOJ who have become involved in efforts to investigate and even possibly prosecute the most severe abuses. It gives us hope for the future."

CHAPTER 17

CAREERS DESTROYED: ENFORCING WORKPLACE WELLNESS

There'd be some dispute later about exactly what got said during the call when Vince Geisler was laid off. Geisler was a field technician for a Vancouver wireless communications company, and he and the human resources director never got along.

After hanging up, Geisler went into his home workshop. "I started to do some welding," he told me. "Just to kind of focus my attention on something else so I'm not sitting there brooding." A couple hours later, he decided to go to his neighborhood shopping mall for lunch. But as he went outside, he stopped mid-step. He saw a van and police officers with guns drawn.

According to police records, the street had been cordoned off by about ten officers, including an emergency tactical team with assault rifles and a sniper. They called Geisler out. He walked over, perplexed. Geisler was "calm and cooperative," stated police records. Police told Geisler that he was being arrested under mental health laws, slapped handcuffs on him, and loaded him into the van.

"I'm like, 'What in the hell?'" described Geisler. He said this was when he uttered the first of many requests to contact a lawyer.

At the hospital, a psychiatrist asked Geisler how he was feeling.

"I said I'm feeling a little stressed out because I've just been laid off and I've been basically kidnapped and hauled off here and I'm being denied a lawyer," recounted Geisler.

Geisler learned that the human resources director had called the police, alleging that Geisler had said to her, “I may as well walk off, put a gun in my mouth, and blow my brains out.”

By his recollection, Geisler believed he said, “I feel like I’ve been shot.”

His wife told me Geisler sometimes used dramatic language when upset.

Police had discovered that Geisler, a hunter who also sometimes worked in bear territory, had five registered rifles and shotguns, and a handgun. When Geisler hadn’t answered his door—his workshop was in the basement and he didn’t hear knocking—police suspected Geisler had barricaded himself.

Misinterpretations escalated further at the hospital.

The psychiatrist suggestively asked if Geisler had been feeling excessively “under stress” lately. Geisler said no, and said he didn’t understand why the police had arrested him.

The psychiatrist made notes that Geisler appeared “limited” in his “insight” about police concerns and perhaps “not totally truthful” about his stress level.

Asked about medications he was taking, Geisler said he took medication for ADHD and for chronic pain from an old injury. But he forgot to mention his antidepressant. When the psychiatrist noticed the prescription in his medical records and suggested Geisler might be dangerously depressed, Geisler said he’d been prescribed the antidepressant for his ADHD. (It’s a common practice, though not approved by health regulators.)

The psychiatrist wrote, “It certainly would appear from his prescription of an antidepressant that he has been on for some time that he has been depressed and which he has denied. Given his lack of honesty and forthrightness, for his safety he is being detained.”

Geisler was locked in seclusion and ordered to change into a hospital gown, and his wife was prevented from seeing him. His psychiatric record was stamped “incapable of appreciating the nature of treatment and/or his or her need for it.”

Geisler continued to express outrage and persistent requests to talk to a lawyer until security guards entered his room led by a nurse carrying a paper cup with pills. Geisler was told the drugs would calm his nerves—and if he didn’t take them, they’d force him to.

Geisler woke up sixteen hours later. “For about five minutes, I didn’t even know where I was,” described Geisler. “I’m groggy, I can barely stand up.” Geisler had been dosed with four different antipsychotics and a sedative.

Geisler said he was still “looped” when another psychiatrist interviewed him that morning. This psychiatrist wrote that Geisler had “no suicidal or homicidal ideation” and there was “no evidence” of him having any serious mental disorder. Geisler was discharged, still wobbly and disoriented.

"I don't want to belittle rape, but I felt like I had been mentally raped," said Geisler. "Cattle have more rights being transported to the abattoir than a person does under the Mental Health Act. Seriously. It's ridiculous."

Geisler next discovered that police had applied for a ban on him owning guns. The reason? Because Geisler had threatened suicide and been incarcerated in a psychiatric hospital.

Geisler fought back, and won. The judge demanded that the police clarify their records so the event wouldn't be a "lifetime millstone" that could cause similar miscues again. "I want such an entry [in police records] to very clearly articulate the fact that the court has found that there are no issues related to the public safety or Mr. Geisler's safety in relation to firearms," the judge wrote. "I want that in very bold and express terms."

It was small vindication for Geisler. He began suffering anxiety about returning to work. "It traumatized him," his wife told me. "There's still in him a sense of fear in an employment setting."

Geisler eventually got back working; however, at one workplace, he reported concerning levels of lead fumes to regulators, and his employer portrayed Geisler as not credible. "He used your article to try to prove I was mentally unstable," Geisler told me.

Geisler now works mostly as an independent contractor. He's hypervigilant around any hints of disagreement in workplaces—even as he tells himself it's probably just "an innocent interaction."

* * *

Benjamin Cruz, a designer in Google's Los Angeles Cloud division, complained to the human resources department about a colleague's racist remark. Cruz was pressured to get mental health help. In a 2021 NBC News report, a parade of other former and current Google employees said their complaints about racism, sexism, lack of diversity, or other workplace problems were routinely handled this way. "Each time, human resource personnel recommended the employees seek therapy or take medical leave to address their mental health," reported NBC News, "despite their mental well-being having nothing to do with their complaints."

This trend reaches far beyond Google. There's a continent-wide movement underway to train employers and employees to apply mental health approaches in workplaces, “recognize signs and symptoms,” and call 911 whenever concerned for another’s well-being. These initiatives are sold to employers as ways to save money on absenteeism and low productivity caused by workers’ mental health issues—though evidence that treatments increase productivity is flimsy. For example, a much-touted 2016 World Health Organization–led review in *Lancet Psychiatry* proclaimed that investment in mental health treatments produces fourfold financial benefits in productivity; however, deep in their analysis, the authors admitted “very few trials” anywhere in the world had ever actually examined this issue at all and weren’t very compelling. So, amid this “paucity of evidence,” the authors had simply done “projection modeling” and *imagined* that treatments would measurably and substantially increase everyone’s productivity.

Nevertheless, the Mental Health First Aid (MHFA) program, mainly offered in workplaces, has produced 15,000 instructors and millions of trainees. Psychological First Aid is also widely used.

Both programs are medicalized and coercive. For example, the MHFA handbook advises that, whenever you spot anxiety, depressed feelings, mood shifts, or unusual behavior in a colleague, you should first “assess the risk,” and immediately call 911 if you’re at all concerned. If you aren’t worried, then “listen non-judgmentally” and “give reassurance.” Then, Action Item 4 is always, “Encourage the person to get appropriate professional help” for their “real medical condition.” The handbook gives scores of three happy faces to antidepressants and electroshock.

MHFA’s website touts that the program is proven to increase the number of “signs” and “risk factors” people will spot. Yet the program includes no warnings about any possible Geisler-ish harms from executing Action Items 1 and 4. On the contrary, like its Youth MHFA counterpart, Mental Health First Aid is licensed and operated in the US by the National Council on Mental Wellbeing, the lobby group for 3,500 psychiatric treatment providers—so they bring some profiteering self-interest.

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I collaborated with Mount Royal University nursing professor Sonya Jakubec to interview people employed in workplace mental health who agreed to talk anonymously under academic study protocols. Everyone described the programs as inherently coercive. Because employers are told that mental health problems cause worker underperformance, employers often pressure workers to get psychiatric evaluations and comply with treatments.

Additionally, as at Google, mental health approaches are increasingly replacing traditional conflict resolution processes. A senior executive at a medical exam company that adjudicates mental disability claims and requests for accommodation said, “Often, we’ve found that the issue is related to conflict in the workplace—an employee having a conflict with their manager or supervisor. The way it gets dealt with is, unfortunately, through the medical system. Which is how the current systems are set up . . . to push people to medicalize issues.”

Christine, a human resources professional with twenty years of experience in mid- and large-sized organizations, similarly said that senior leaders were often “untouchable” in situations of workplace conflict. Therefore, the focus would shift to helping lower-level workers adapt and manage their emotional distress, which usually meant encouraging or pressuring them to seek treatment.

It happened to Christine herself. “I was being effectively bullied by a senior leader who was very connected and powerful.” She couldn’t bring this manager into conflict resolution discussions, and she started suffering emotional distress. “I was having significant symptoms related to anxiety,” she said. “I was requiring [sedative] medication to go from my car to my office in the morning. I was having panic attacks. I was having severe insomnia.”

Christine utilized her understanding of employment law, and collaborated with a doctor to get a mild mental disorder diagnosis she felt comfortable having on her record. This diagnosis instantly transformed her from an ordinary person getting pushed around at work to someone with a mental disability who was not getting appropriately accommodated under disability laws. Christine then negotiated a good severance package. However, that only worked because she could also demonstrate that she was complying with the recommended treatments for her newfound disability.

* * *

I discovered that the most aggressive workplace mental health programs occur in the medical field. These give a foreboding view into the possible future of all workplaces since, here, psychiatrists have unfettered control.

The Massachusetts Physician Health Program (PHP) describes itself as “a confidential resource for physicians and medical students who may benefit from help addressing stress, burnout, work-life balance issues, and a variety of physical and behavioral health concerns that sometimes arise in today's hectic health care environment." Michael Langan voluntarily sought help in 2007—and in 2021 was still battling for his rights and license to practice.

Langan worked for fifteen years as a physician and instructor at Massachusetts General Hospital and Harvard Medical School and, he told me, never had a patient complaint. In 2007, Langan developed shingles, and took Vicodin for the pain. "I was taking one-half a pill a night." When he decided it was time to quit, he contacted the Massachusetts PHP. "I went to them just for advice on what's the best way to wean off of it."

Langan was immediately pressured into a formal psychiatric evaluation, and got diagnosed with substance use disorder. He was told he'd have to attend a four-month inpatient treatment program in Georgia at a cost of $80,000, or risk losing his license to practice.

Langan balked, and sought independent assessments at Massachusetts General Hospital and Harvard Medical School. Langan was repeatedly found to not have a substance use disorder, but the PHP only accepted evaluations from their own recommended psychiatrists. The PHP also wouldn't allow Langan to get treatment anywhere but their recommended facility, which would not accept payment by insurance.

Langan surrendered and paid the $80,000. The treatment involved months of Alcoholics Anonymous–style discussion groups with other physicians, 90 percent of whom, Langan said, "also did not need to be there." There were also some therapy sessions run by unskilled counselors. "I made the best of it. But it was just a waste of time."

"It was coercive treatment," summarized Langan. "Under threat of loss of licensure."

Afterwards, the PHP required Langan to get multiple urine tests per week for five years. "Cash only," said Langan. "Sometimes it was $2,000 a month."

As the five years neared its end, Langan was suddenly told he'd tested positive for alcohol addiction—he'd have to continue in the program. Langan knew he barely drank, and he ultimately managed to show the test was unreliable and likely fraudulent (an increasingly common occurrence in the profiteering drug-testing industry, as discussed in chapter thirteen). Nevertheless, the PHP reported him to the Board of Medicine as "noncompliant with treatment."

J. Wesley Boyd believes PHPs are unfairly derailing the careers and lives of potentially thousands of physicians every year, compelling them to pay huge sums for treatment against their will.

Boyd is a psychiatry professor at Harvard Medical School, and for six years was associate director of a state PHP himself. “Because I know a lot about those kinds of programs, probably as much as anyone in the country, I feel like I have a duty to speak out,” Boyd told me.

Most PHPs began as ad hoc peer-run support groups for doctors, said Boyd. Since then, they’ve incorporated and morphed into profit-making entities and de facto wings of state boards of medicine (and of Canadian provincial colleges of physicians). PHPs portray themselves as offering “non-disciplinary” mental health assistance, but Boyd said in practice the boards defer to the recommendations of PHPs, so they have the power to strip licenses.

Typically, a distressed doctor will seek assistance, or an employer will report a doctor to a PHP. Physicians then have little choice but to obey the PHP’s edicts. Many get diagnosed with questionable mental disorders, Boyd said, “extorted” for enormous sums of money, discredited, and “deprived of a voice.”

Boyd described a case—that later became public—in which he was involved as an independent evaluator. Yolanda Ng, a pediatric physician in Spokane, Washington, had never had any complaints against her and was up for promotion at her hospital, which required a standard drug test. Marijuana is legal in Washington and Ng told her supervisors that she used a cannabis tincture at home a few times a month for menstrual cramps. She was assured it wouldn’t be a problem.

Tiny traces of marijuana were found. The Washington PHP got involved and ordered Ng into a four-day evaluation for substance abuse at a cost of $5,000. Ng immediately stopped using any marijuana, and by the time of the evaluation, she tested negative. Nevertheless, the PHP-recommended psychiatrist diagnosed her with a severe substance use disorder.

How was that diagnosis justified? In an interview with *420 Intel*, Ng said one pivotal diagnostic question was whether her substance use had ever led to her missing work, and she had to acknowledge that this four-day evaluation itself had made her miss work.

“The real way they got [to the diagnosis] was ka-ching ka-ching ka-ching,” commented Boyd. Treatment center representatives offered Ng their ninety-day program and, when she balked, they asked, “Isn’t your career worth $50,000?”

Ng was reported to the PHP as noncompliant with treatment, and the board demanded she stop practicing or they'd strip her license.

Boyd believes profit motivations are the major factor. The psychiatric evaluations alone typically cost $5,000 to $10,000, and the recommended treatments are usually thirty- to ninety-day inpatient programs costing $50,000 to $100,000.

A Washington PHP representative told *420 Intel*, "I feel compelled to point out that Dr. Ng finds herself in this situation due to her own choices."

Most PHPs say they don't need an appeal process since their programs are "voluntary." Boyd commented: "Someone puts a gun to my head and says, 'Give me your wallet.' Well, I suppose I could make the argument, I can voluntarily give the person my wallet or not."

* * *

Langan began researching PHPs as well and, through his blog, *Disrupted Physician*, started speaking out. He said he gets about five new contacts every week from other doctors going through similar experiences.

Langan described much of what PHPs do as "fraud," "extortion," and a "well-oiled racket." He's documented innumerable financial conflicts of interest as psychiatrists from state boards of medicine, PHPs, and preferred evaluators and treatment providers often play dual roles, switch roles, and sponsor, fund, and refer to each other.

But Langan allowed a more charitable interpretation might be that PHPs are just overly alarmist. He pointed to their increasing use of diagnostic labels "made up out of thin air" for disorders that don't exist yet. Federation of State Medical Board documents identify the importance of early identification and treatment for conditions such as "potentially impairing illness"—for doctors whose ability to work isn't impaired but might be in future. They also recommend treating "relapse without use" and "behavior without chemical use"—doctors who aren't actually using any substances, but are behaving similarly to people who do. The Medical Society of New York advises that doctors should consider referring colleagues to the PHP if they display signs of mental disorders such as "unkempt appearance," "irritability," "poor hygiene," or not returning calls.

Do some physicians also get forcibly drugged? "They commonly diagnose people with things such as bipolar disorder," said Langan. "And it doesn't matter how many experts say otherwise." Several psychiatrists told me they had physician-patients taking psychotropics as part of PHP requirements.

I asked Langan if doctors found it irritating and humiliating to be put through such programs, and he bristled, directing me to physicians' postings on his website about their dwindling financial resources and despair. Droves of similar comments appear on social media and in comment threads below news stories about PHPs. "These people are not just irritated. They're suicidal," said Langan. "I hear from medical students; they lose their careers because of these bastards. I hear from old doctors who are ruined at the end of their careers. It's a travesty."

By contrast, the handful of client testimonials on the Federation of State Physician Health Programs (FSPHP) website, all anonymous, are effusive, to say the least. "He gave me a phone number and said, 'You do not have to feel this way anymore.' And, he said, 'Life can be beyond your wildest dreams.' The phone number was for the Pennsylvania Physicians' Health Program . . . My story is a miracle."

Langan remains without a medical license as he battles his case in the courts. "I'm working as a landscape gardener right now," he said.

* * *

In response to criticisms, the FSPHP issues generic statements such as, "Physician Health Programs across the United States and Canada provide physicians and other health care professionals a resource to ensure they are healthy . . . Our goal is to restore physicians' lives and safely return them to patient care." Of FSPHP's twenty-eight directors, twenty-two are physicians, including seventeen psychiatrists, all connected to major academic and medical institutions.

Meanwhile, the stigmatizing power of psychiatric labeling effectively discredits even critics who are Harvard doctors. Boyd said the editor of a prominent medical journal contacted him about an article he'd submitted, and demanded to know if he or his coauthor had ever been patients in a PHP. Boyd said it was clear the editor was prepared to dismiss the article as mere "belly aching" coming from "addicts who are in denial of the fact that we're addicted."

How widespread are these problems? Langan and Boyd acknowledged they wouldn't likely get contacted by people who actually had serious problems and were helped by a PHP, so it's difficult to get a fully rounded assessment. The only PHP that's been independently audited was North Carolina's in 2014. The auditor found that abuses could potentially be rampant and never exposed because “the Program lacks objective, impartial due process procedures for physicians,” and was operating with no adequate oversight. There were also “no documented criteria” explaining how the PHP selected treatment providers, even as many financial “conflicts of interest” were evident. And there was no objective monitoring of the effectiveness of the coercive treatments.

It’s difficult to square the aggressive intervening by PHPs with licensing bodies’ notorious laxity on actual misconduct. But psychiatrist Kernan Manion, another critic of PHPs who’s spoken with hundreds of physicians, argued that, alongside the profits PHPs help rake in, many PHPs, medical boards, and treatment providers have “shared institutional agendas” of other kinds. Manion said many PHP cases involve physicians resisting productivity demands, advocating for patient care, or practicing less-mainstream therapies. “Physicians are being pulled into a ‘fitness for duty evaluation,’ but it turns out to be an involuntary civil commitment.” And that’s a powerful way, he said, for institutions to change, discredit, or get rid of physicians.

* * *

Jennifer Poole similarly believes many workplace mental health initiatives are used by institutions to help achieve their own management goals, often to the detriment of workers.

A social work and “Mad Studies” university professor in Toronto who identifies as mad, Poole has co-led surveys and studies of social workers and nurses that found many get unfairly targeted. Visibly crying or displaying intense emotions, complaining about workplace racism or sexism, or simply being a person of color were all linked with employers ordering psychiatric evaluations.

One of the most common triggers was requesting workplace accommodation, such as fewer clients or reduced hours. “The manager says, ‘Why and what for?’” described Poole. “The worker then has to give a little more information like, ‘I’m dealing with anxiety.’ And the manager says, ‘You’re going to have to prove it with documentation.’” Then, if an employer doesn’t want to accommodate, the employer refers the worker to that profession’s equivalent of a PHP or Employment Assistance Program. And much like in PHPs, Poole described social workers and nurses getting directed to specific, contracted treatment centers, and forced into repeated psychiatric evaluations, drug testing, and treatments at risk of losing their licenses.

Poole emphasized that, in their studies, they found no cases where members of the public had expressed concerns; the triggering complaint always came from a coworker or manager. “It was always a managerial technique to discipline that worker.”

In several cases, people’s careers and lives were destroyed. “They’d been kicked out of the [licensing] college, lost their work, lost their home, they had lost everything.” Nevertheless, Poole thinks many employers genuinely believe pressuring upset workers into treatment is good for them and couldn’t possibly cause harm. “It’s when managerialism really seeps into someone’s soul. They actually think that they’re doing the right thing by calling the authorities. It’s not even going to occur to them that reporting someone is a bad idea.”

CHAPTER 18

ORDERS FROM MILITARY COMMAND: REPORT TO BEHAVIORAL HEALTH

It was once difficult to serve in the US military while taking drugs for a mental disorder. By 2013, though, a *Military Times* investigation found one in six active duty service members were taking psychotropics, and in 2019 the Government Accountability Office reported that 740,000 veterans were.

Despite public hand-wringing about possible harms from overmedicating amid rising veteran suicide rates, it's usually presumed that these psychotropics are at least being taken willingly. But many insiders, like Commander Mary Neal Vieten (ret.), believe the vast majority of military users of psychotropics have been ill-informed, misled, pressured, or outright forced.

Vieten was a US Navy psychologist from 1998 to 2008, then served in the Reserves until retiring in 2020. She also founded Warfighter Advance, a free weeklong training program in Maryland in which active duty military and veterans learn about psychiatric diagnoses, drugs, and alternatives. Vieten told me that most who come to Warfighter Advance are taking large quantities of psychiatric drugs, forever hoping "the correct cocktail" will one day make them "wake up normal."

"The Department of Defense and Veterans Administration have swallowed the American Psychiatric Association whole," said Vieten. "They fully believe in the medical model. And nobody gets informed consent." During training, Vieten was specifically taught to use "little white lies" dubbed "techniques to increase patient compliance"—such as, whatever the drug dose, assure patients it's a "small" dose.

After seeing so many patients becoming worse rather than better, and valuable “military assets” and people’s skills and lives slipping away, in 2003, Vieten started studying psychiatric research with a more critical eye. She now spends six hours of each Warfighter Advance program lecturing on psychiatric science, diagnostic labels, pharmaceutical industry influences, and treatments and their risks (see chapter twenty-three)—and she considers six hours the bare minimum for a person to make an informed decision about a psychotropic.

Active service members and veterans are prompted to complete mental health screening questionnaires frequently. “I consider preventative screening tools to be coercive and disingenuous,” Vieten said. “Those questionnaires are intentionally set up like Zodiacs so that everyone will identify with all of it.”

Generally, soldiers are roped into treatment for run-of-the-mill problems. “It’s usually stress that is diagnosed as anxiety, or some sort of loss or trauma that’s diagnosed as depression. Psych meds are given away like breakfast cereal. And the more dramatic the presentation, the more heavy-handed the military is going to become.”

According to Department of Defense and Veterans Administration (VA) policies, service members have the same rights—or lack thereof—to refuse treatment as civilians. Government surveys suggest about 26 percent of patients in veterans hospitals have been involuntarily committed; the number of active duty soldiers committed each year is unclear. But Vieten said any numbers are misleading. “In the military, why would they even have to fill out paperwork? They can order you.”

Vieten, though friendly and frank, exuded the clipped self-possession of military authority even via video call. “The vast majority of people in the military are enlisted and young. And the people who are doing the work that I do in mental health . . .” She gestured to where her stripes would be. “Somebody comes into my office who’s a seaman apprentice, and I’m the commander, and I say, ‘Here’s what you’re going to do.’ They say, ‘Yes, ma’am.’”

Meanwhile, she said, other military officers can become as influential in treatment decisions as doctors. “If there’s something wrong with you that may jeopardize the mission, you’ve lost your right to confidentiality. And you can imagine how broadly that can be interpreted, when mental health has no actual parameters and no actual objectiveness.”

She believes many veterans end up on psychotropics simply as a result of behaviors deeply ingrained through military training. For example, she said, soldiers are taught that careless people get others killed, so, back at home, they may cause a scene when an inept retail worker triggers their “Threatcon” reaction or a child misplaces their keys. Instead of being coached in unlearning such behaviors, said Vieten, “they go talk to the psychiatrist, and the psychiatrist has never been to Afghanistan, so the psychiatrist says, ‘Let me get you some antidepressants or a sedative.’”

* * *

Jack joined the military in 2017 as a corpsman medic, and regularly administers the mental health screening questionnaires.

Even when people come in to the clinic complaining about ankle pain, he said, he’s required to get them to complete PHQ-9 and GAD-7 questionnaires. “If they score a seven or higher on either, it’s automatic: behavioral health referral.” It’s possible to score seven by answering “sometimes” to the handful of questions about feeling sad, anxious, sleepy, or unusually awake over the previous two weeks.

Jack said many soldiers have learned to lie to avoid consequences, so “only” about 10 to 20 percent score a seven. And during appointments with the doctor, which typically last less than five or ten minutes, virtually all leave with prescriptions for psychotropics.

Declining is risky. “When they reject treatment, it then gets forwarded to their chain of command,” said Jack. “It starts a judicial punishment for refusing treatment with the military.” Soldiers can get “administratively separated” from the military, leading to them and their families also getting cut off from life insurance, health care, and other military benefits. When soldiers actually learn their legal rights, Jack said, that can sometimes produce better outcomes for them, but it rarely happens.

His own brief experience with adverse effects from a psychotropic, and subsequent attendance at Warfighter Advance, has left Jack feeling troubled by his job. “I’m in the process of getting out of here. I personally cannot ask those screening questions anymore.” He has begun advising clinic visitors of the potential consequences of answering. Do his supervisors know he’s doing that? “They would immediately send me to judicial punishment for violating medical standards of care.”

* * *

Tony joined the US Navy in 1999 as a medical corpsman and psychiatric technician. During training, Tony said, he was taught that most mental disorders are caused by abnormal levels of serotonin or dopamine, while psychiatric drugs "bring you back in balance and make you a normal, happy, productive person again." Most military medics were, like him, young and not well educated, and already indoctrinated into obedience to authority. "Instead of evaluating what we were being told, it was just, 'This is the truth.' We'd nod our heads, 'Yes, this is the truth,' and go spread the word."

In his experience, commanding officers commonly just gave orders to soldiers exhibiting emotional distress: "You will go get seen. You will take their medication." Otherwise, orders to comply were issued directly by medical staff.

Tony already felt too many people without serious problems were getting "roped into the system," and this worsened after the military's high suicide rates got publicized. The military's "knee-jerk reaction," Tony said, was to identify and treat people more aggressively. Young soldiers feeling anxious, disobeying, saying they felt like "blowing away" an "asshole sergeant," or going AWOL and using the excuse that they felt depressed—all took on new auras of seriousness.

Tony became increasingly concerned about the adverse effects of psychotropics as he regularly saw soldiers becoming cognitively impaired during their stays in psychiatric wards. "You got a guy who's a network data systems operator, writing code for satellites and top-secret communication. The guy is not an idiot," he said. "Why can he not sit in front of me and make a complete sentence?"

Tony began independently researching psychiatric science and the relationships between the psychiatric establishment, military, and pharmaceutical industry, and he attended Warfighter Advance. "I was just livid," he said. "I knew something was wrong, but I didn't realize how wrong it was." This now fills him with regret. "For years, I was telling these young marines who trusted me, 'You need to take this medication; it's going to help you.' I was just lying to them. It's embarrassing that my ignorance injured people that I care about."

After medical retirement for PTSD in 2011, Tony admitted to having sleep problems, and his new VA doctor recommended the antipsychotic Seroquel. Tony declined.

The doctor explained that refusal would be regarded as evidence that Tony didn't actually have PTSD, and he'd lose about $2,000 of his $3,200 monthly disability pension. "Well, long story short, I left the VA after my five minutes with my doc, and six or seven minutes of arguing with them, with a prescription for Seroquel.”

The drugs come in the mail every month, and Tony discards them.

Tony’s regrets made me think of Sgt. Meeka McWilliams. She was once knocked out by a mortar in Iraq, but it was psychiatric medications that would nearly kill her.

* * *

As a young Black woman living in Chicago, Meeka McWilliams enjoyed being involved in her community, and was a member of Trinity Christian College’s soccer and basketball teams, and marching and concert bands. She’d always been health-focused, she told me, rarely eating fried or processed foods, never touching alcohol or street drugs, and avoiding most medications.

McWilliams left college in 2004 to join the US Army, and became an automated logistical specialist, overseeing warehouse inventories, vehicle movements, and financial transactions.

McWilliams was deployed to Iraq, where one day a mortar strike knocked her unconscious. She was diagnosed with a minor concussion and sent back to work. “But I started having really bad headaches and issues with light sensitivity and irritability,” said McWilliams.

Her last overseas mission was in 2011, and then she worked at bases in Texas and Kentucky, where she underwent mental health evaluations and was always determined to be doing fine.

Her work at Fort Knox was demanding. She often woke at 3 AM and returned home at 11 PM, including weekends. At one point, she’d gone four days without any sleep and was out walking her dog when something unusual happened.

Her neighbor, who’d recently had back surgery, fell in her garage. “I heard her screaming and yelling, ‘Help, help, help!’ But in my head, something clicked,” said McWilliams. “I was no longer in my neighborhood, walking my dog. And it wasn’t my neighbor screaming. In my head, I was in the desert. I could feel the heat, I could feel the sand, I could feel everything. I could hear helicopters. I heard a person yelling, and that was a person on the battlefield. So I cried to her, and the entire time, I was helping her as if I was helping a soldier on the battlefield.”

McWilliams got her neighbor inside and, moments later, the desert was gone, and home returned. “What the heck happened?” she asked herself.

McWilliams went to the base hospital but was reluctant to take the psychotropic medications the psychiatrists recommended, because she felt normal again after catching up on sleep. And when she did take the drugs, she didn’t like the feeling of sluggishness. But McWilliams said the doctors repeatedly told her, “If you don’t take these medications, we’re going to call your command and it’ll be in violation of a direct order.” When she contacted command, they said, “If you don’t do what the hospital says, then you could lose your rank.”

Thirty days later, McWilliams was taking five psychotropics, and had begun hearing voices and hallucinating—phenomena she’d never experienced before, other than that flashback. But by then she’d also learned that she’d never be allowed to leave the hospital unless she told the psychiatrists she was feeling better and promised to continue taking the drugs. So she did.

And by 2015, after years of treatments, she had a diagnosis of schizophrenia, her health had degenerated dramatically, and the voices in her head had become overwhelming. “It was like being in a football stadium, where you have so many people talking at the same time,” she said.

McWilliams was hospitalized many times, and each trip brought new diagnoses and drugs. She paced the hospital hallways for exercise, and got diagnosed with ADHD and anxiety. Concerned about her massive weight gain, she tried eating only salads, and got diagnosed with emerging anorexia. Her emotional ups and downs about her plight got her diagnosed with bipolar disorder.

“The doctors kept telling me, if you don’t keep taking the medications, then you can get a lot worse,” said McWilliams. Her daily medication regimen expanded to eight, ten, then thirteen different drugs. She was declared unfit for military service. She developed vision problems, and started having seizures. On one occasion she missed a weekly outpatient appointment, and the sheriff was dispatched to get her.

In her medical records, one psychiatrist expressed concern about McWilliams’s large numbers and dosages of antipsychotics, antidepressants, sedatives, mood stabilizers, and other psychotropics. Nevertheless, his attempt to optimize her drug regimen itself read like a bizarre chemistry experiment. Over the course of one two-week hospitalization, the psychiatrist decreased or discontinued sixteen drugs McWilliams was taking, and started or increased eleven; in some cases, the same drugs were alternately decreased and increased.

I forwarded an excerpt of these records to a psychiatrist who was also a critical drug researcher. He wrote back that he appreciated her psychiatrist's recognition that the polypharmacy was a problem, but was disturbed by the number and speed of the changes. "I think part of the issue is a simplistic regard of the role of meds. There is a common belief of needing to find the 'just right combo,' as opposed to seeing these as very crude tools with significant downsides." When I asked whether such staggering amounts and combinations were commonly prescribed, he replied, "I will say that, although this is worse than what I've normally seen, it's probably not that abnormal."

* * *

McWilliams's weight had ballooned from 138 pounds to over 250 pounds. She was constantly so out of breath, and her muscles shook and ached so much, that she just lay in bed most of the days. "It was so much easier to not have to move."

Three years after her first admission to a psychiatric hospital, at age thirty-two, McWilliams's liver and kidneys were failing; she was told she'd soon need dialysis. McWilliams's sister moved in with her to help feed and dress her.

"It got to the point where I could not speak. I literally could not form words. I would have to write things down in order for people to understand." McWilliams said she often asked herself, "How did I go from athlete to vegetable?"

One day, McWilliams saw a recent photo of herself at her father's funeral. They'd always been close. Yet she had no memory that her father had died. When she told her brother this, he joked bleakly, "I guess they gave you some really good drugs for that."

Her siblings had for years been suggesting that the medications might be making her worse. "They'd tried street drugs; they knew what drugs could do." She'd always respond, "You're not a doctor." But in that moment, McWilliams told me, "a switch turned on" in her head.

Coincidentally, she was scheduled for evaluation by an interdisciplinary team at Lone Survivor Foundation, a Texas nonprofit specializing in helping veterans. They diagnosed McWilliams with a traumatic brain injury (TBI) from the mortar blast. They explained that all her experiences prior to taking any psychiatric drugs, including the light sensitivity, headaches, irritability, and sleep-deprived flashback, were common TBI symptoms.

So, she wondered, did she even have schizophrenia?

McWilliams went home to Kentucky and, as an experiment, stopped seven of her sixteen medications. Her shaking diminished. “I was sitting with one of my friends, and she asked me something, and I was able to answer her. It was like real words that made sense to her.”

McWilliams attended Warfighter Advance, and then, in 2018, she got a referral to a doctor knowledgeable about the adverse effects of psychiatric medications. His prognosis was grim. On one hand, the doctor said, the massive drug regimen was bringing her to the brink of death. On the other hand, going off all the drugs abruptly could, literally, kill her.

McWilliams made her decision. She stopped all of her remaining psychiatric medications at once.

“As soon as I stopped taking the medication, the voices went away,” said McWilliams. That inspired her—and she needed inspiration to survive what came next. “I was in so much pain. My stomach felt like someone was ripping it out from the inside. I felt like somebody was stabbing me with needles all over my body. It felt like all the neurons in my body were flaring at the same time.” More than once she collapsed, and on one occasion her heart stopped, but her doctor had hooked her up to a medical-emergency monitoring system.

Though for some people withdrawal from psychotropics takes much longer, after about three months, McWilliams slowly started feeling better. She was losing weight, regaining her mental faculties, eating, and exercising. She was feeling like herself again, the person she remembered, the person who missed her father.

* * *

Off all medications, McWilliams avoided mental health professionals. She received her drugs in the mail, and threw them out.

But one day, an ear infection made her visit the military clinic. The doctor asked about her current medications. Eight hours later, McWilliams was still at the clinic. “They would not let me go until I agreed to take mental health medication.” A military officer was summoned to escort her to the pharmacy. But after the escort left, the pharmacist realized she’d already been dispatched her month’s allotment. McWilliams departed, elated.

A mental health warrant was issued for her arrest.

On the advice of veterans she’d met who’d been in similar straits, McWilliams fled Kentucky—and became one of a growing number of “psychiatric refugees” who flee across jurisdictions to evade forced treatment. In

Maryland, she got a new psychiatric assessment, and brought the evaluation back to a judge in Kentucky. He canceled the warrant.

“And that’s how I got out of the mental health system,” said McWilliams.

* * *

In the three years since, McWilliams has been doing well. “Things are so much better. I’m able to do normal things. My hands aren’t shaking. I’m not hearing any voices.”

Now thirty-nine, she’s almost back to her normal weight, has walked several marathons, and is progressing toward a master’s degree in sociology, hoping to advocate for foster children facing coercive mental health treatment.

After more research, she’s learned that virtually all the symptoms she experienced—weight gain, muscle pain, seizures, hallucinations, cognitive impairment, kidney and liver dysfunction—were known adverse effects of the drugs. “No one ever said these are the possible things that happen,” she said. “Looking back now, it doesn’t make sense. But back then, it made total sense, because I trusted the doctors, and I trusted the therapists.”

McWilliams believes profit played a role; all the hospitals and mental health professionals were making money off her. Nevertheless, she added, “I think they honestly believed that it would make me better.”

She also suspects racism was a factor; she never saw any Black medical staff, and doctors repeatedly assumed she’d done street drugs, had addiction issues, had bad genetics, and lived in a troubled neighborhood to which she couldn’t safely be discharged.

Does she now risk losing her military pension? McWilliams said a military doctor who recently evaluated her decided that her refusal to take psychiatric medications was a sign of her mental illness and lack of insight. The doctor urged the VA to continue providing McWilliams all of her benefits, since he believed she’d relapse soon.

CHAPTER 19

"THE PSYCHIATRIC EVALUATION ATTACK METHOD": MAKING WHISTLEBLOWERS CRAZY

The case of police officer Adrian Schoolcraft is one of the most thoroughly documented contemporary examples of an American whistleblower getting subjected to politically weaponized psychiatric retaliation.

Recounted in the 2013 book *The NYPD Tapes: A Shocking Story of Cops, Cover-Ups, and Courage* by former *Village Voice* journalist Graham Rayman, Schoolcraft was one of the first to blow the whistle on how senior NYPD officers routinely instructed beat cops like him to charge people for frivolous violations, and to minimize or ignore more serious crimes. Aggregated statistics then made it falsely appear that New York's police and political leadership were getting tough on crime and successfully reducing serious violence.

When Schoolcraft first complained internally about these practices, senior officers ordered him to see NYPD's in-house psychologist, who diagnosed "anger issues." Schoolcraft got consigned to a desk job. But Schoolcraft kept covertly recording and documenting evidence, and expressing concerns.

One day in 2009, NYPD officers ordered a wellness check on Schoolcraft. But not a typical one. According to Rayman, they sent numerous police cars to Schoolcraft's apartment carrying a dozen high-ranking officers, including a deputy chief, two deputy inspectors, a captain, several lieutenants, and sergeants from four different units, some in full tactical gear.

The officers let themselves in with a key they got from Schoolcraft's landlord. They discovered Schoolcraft resting in bed. Schoolcraft secretly activated a recording device as the officers showed how concerned they truly were for his “wellness” by harassing him, accusing him of having an “attitude,” and suspending him on the spot. Eventually, an officer told Schoolcraft he’d be treated as an irrational, emotionally disturbed person if he didn’t agree to go to a psychiatric hospital.

“We’re giving you a choice, Adrian,” said one officer. “Get up and walk out.”

Schoolcraft repeatedly, calmly asked, “How am I being irrational?” until one officer finally said, “All right, just take him. I can’t fucking stand him anymore.”

A group of NYPD officers are heard dragging Schoolcraft off his bed, slamming him to the floor, and handcuffing him. They then took Schoolcraft to Jamaica Hospital’s psychiatric unit.

Police records of the wellness check described Schoolcraft as irrational, unbalanced, confrontational, disheveled, disoriented, and agitated. Similar police lies were accepted unquestioningly by hospital staff and included in the medical records: Schoolcraft had been shouting and cursing at officers; he’d barricaded himself in his home; police had to break the door in to get to him; Schoolcraft had charged at police violently, then fled.

“They are all against me,” Schoolcraft told the doctors about the NYPD officers. This statement showed, the hospital psychiatrists wrote, that Schoolcraft—who otherwise seemed reasonably calm, “coherent,” “alert,” and “oriented”—lacked insight into his “paranoid” state, and likely had a “psychotic disorder.”

Six days later, the psychiatrists let Schoolcraft go, untreated for anything—but with a bill for $7,185 and a new, discrediting history of psychiatric hospitalization for paranoid psychosis.

Bizarre police surveillance and harassment tactics continued—enough to drive anyone crazy, or to make them sound crazy if they told anyone about it. Multiple NYPD cars parked outside Schoolcraft’s home for hours, reported Rayman. Officers made notes on seeing Schoolcraft’s curtains move, or about what he was wearing. They banged on his door a hundred times in fifteen minutes, and then said they were just making sure he was all right.

Schoolcraft concluded the best way to protect himself was to leak evidence to Rayman. And in 2019, the City of New York was still paying out tens of millions of dollars to victims of the corrupt practices Schoolcraft helped expose. Schoolcraft quit the NYPD, and sued and won $600,000 from the City of New York and an undisclosed amount from Jamaica Hospital.

The Schoolcraft case was not unique. For decades, American whistleblowers have been targeted with orchestrated psychiatric retaliation. And not surprisingly, it's most commonly implemented by the people who are the most familiar with how relatively easy it is to get practically anyone psychiatrically incarcerated: police, military, and medical professionals.

* * *

During public hearings leading up to the passing of the federal Whistleblower Protection Act in 1989, a parade of people testified to how they'd been forced into psychiatric evaluations and hospitalizations.

West Point graduate Major Peter Cole told Congress's House Armed Services Committee that he'd served sixteen years in the army, Reserves, and National Guard, including working as an operations research analyst for US Army Test Command at Fort Hood, Texas.

In 1969, Cole reported to his commander widespread illegal drug use by cadets. "Within days, the Commandant of Cadets, General Bernard Rogers, ordered me confined to Ward 41, the psychiatric ward, at Walter Reed Army Hospital," Cole testified.

He was detained for weeks, after which psychiatrists labeled Cole as "totally disabled" and recommended him discharged from service. Cole hired a lawyer, got a new psychiatric evaluation, and was welcomed back into military service.

But in 1976, Cole testified, he was the lead investigator into the disappearances of millions of dollars' worth of military equipment. When he was close to releasing his findings, which implicated some of his own commanding officers, Cole got relieved, then given meaningless assignments, damning evaluations, and threats of court-martial. Cole later uncovered documents showing that the Army Inspector General and other senior officers had considered again using what they dubbed "the psychiatric evaluation attack method" against him. But the Inspector General would ultimately acknowledge hundreds of millions of dollars of accounting discrepancies that had in part resulted in European terrorists walking off with US Army anti-tank weapons.

Cole gave more examples, and said that "psychiatric evaluations and confinements" were "the ultimate tool" the US military used against whistleblowers. He said psychiatric incarcerations were easier and faster than charging someone with misconduct. "The Army even to this very day orders military personnel and civil servants to undergo Soviet-style psychiatric evaluations and confinement without any form of due process. The threat that one can be arbitrarily sent to the Mental Hygiene Clinic is well known by Army personnel."

* * *

Next, retired Chief Petty Officer Michael Tufariello testified that in 1983 he was working at the Dallas Naval Air Station, supervising the payroll system for the Naval Reserves. He spotted "serious problems," he said, stemming from organized fraud. He reported his discoveries through the chain of command right up to the Inspector General. He was repeatedly warned, he said, to "back off."

Tufariello was called to an unexpected meeting with senior officers. "I took a seat but no one said anything," testified Tufariello. "I said, 'What the hell is going on here?' The response was a nod from the medical officer." Soldiers seized Tufariello and drove him 150 miles to the Sheppard Air Force Base psychiatric hospital. "My uniform was taken away and I was issued blue striped pajamas and slippers decorated with happy faces."

Tufariello was detained in the psychiatric hospital for several days until a doctor finally appeared and released him. "To this day I'm confused," testified Tufariello. "Who is the enemy? How many military personnel today, this moment, are locked away in a mental ward, wearing slippers with happy faces, asking the same questions?"

Tufariello said he hadn't gotten a full night's sleep since. But he did eventually receive a Navy Commendation for uncovering the "administrative oversight" that caused large financial payments "in violation of the regulations."

* * *

Similar testimonies kept coming. An alarmed House Armed Services Committee demanded a response from the Department of Defense (DoD).

In a brief letter, DoD psychiatrist William Mayer assured congressional leaders that all orders for psychiatric detentions were done with "sound discretion" by military officers based on their "best judgment," while involuntary treatment decisions were made by "competent medical authorities."

DoD lawyer Robert Gilliat told the committee that the stories of Cole, Tufariello, and others had not persuaded him that anything more problematic was going on than, occasionally, "a bit of bad judgment" in implementing forced psychiatric hospitalizations. "Now, was it handled perfectly?" said Gilliat.

"Probably not. But did the system eventually correct that? I think it did."

Congressional representatives suggested regulations clarifying appropriate versus inappropriate uses of psychiatric incarceration. "There are too many Department of Defense regulations already," responded Gilliat.

* * *

Tom Devine also testified at those hearings. Devine is the legal director of the Government Accountability Project (GAP), long the leading US nonprofit representing whistleblowers, from Daniel Ellsberg to Edward Snowden.

In conversation in 2020, Devine pointed out to me that Congress eventually passed United States Code 5-2302, "Prohibited personnel practices," stating that it's illegal to "order psychiatric testing or examination" as a form of retaliation against a complaining employee. But Devine said that forcing people into psychiatric evaluations and detentions nevertheless remains a "common, traditional form of retaliation against whistleblowers." Devine didn't want to name former clients, but it was easy to cross-reference some details he shared with publicly available information.

There was, for example, Phyllis McKelvey, who worked in the US Department of Agriculture (USDA) for four decades until 2010. McKelvey raised early alarms about waste and irresponsibility in the USDA's emergency planning programs. "This was before Hurricane Katrina," said Devine. "And a lot of her warnings ended up coming true." McKelvey also raised concerns about the lowering of health and safety standards with imported food. "She was a tenacious whistleblower. So the agency's response was to order her to take a psychiatric examination."

McKelvey's USDA bosses handpicked a psychiatrist to examine her. When he did not find her mentally ill, they hired a second psychiatrist, said Devine. Same result. They assigned their own medical officer to assess her, and then contracted a fourth psychiatrist. Same results.

What then happened with the fourth psychiatrist was uncovered later. "USDA told the shrink that, 'We're not going to pay you unless you modify your diagnosis,'" said Devine. "The shrink reversed the diagnosis and said the whistleblower was paranoid because she thought the government was out to get her, and therefore was psychiatrically unfit for federal service."

From his own perspective, Devine described her as soft spoken and shy, but with "a backbone of iron." McKelvey eventually won a financial settlement.

In another case, US Air Marshal Robert MacLean got fired by the Transportation Security Administration (TSA) after he leaked to MSNBC that the TSA was slashing budgets right in the middle of preparations for an identified possible 9/11-style series of airliner attacks. Shortly after winning his job back in 2016, MacLean was ordered by the TSA to submit to a psychiatric evaluation. MacLean wasn't diagnosed as mentally ill, just overly stressed, but TSA fired him again, anyway. MacLean's lawsuit was ongoing in 2021.

Devine said that some of the people who first reported on sexual assaults in the armed forces were also subjected to psychiatric retaliations.

One reason the method continues to be so widely used, Devine said, is because "the first principle of retaliation" is to shift the spotlight from the message to the messenger, and then discredit the messenger. "We call it the Smokescreen Syndrome. It's like what happens with rape victims, only uglier. Anything you can do to discredit the whistleblower so that people won't take their dissent seriously. And branding them as crazy is one of the most effective techniques there is."

Devine said that the Veterans Administration (VA) has been especially vindictive in branding internal whistleblowers as mentally ill because the VA often has their psychiatric histories already at its disposal. "A lot of the employees of the VA are veterans who have suffered from PTSD, or have overcome their own personal crises," explained Devine. "The VA has an active practice of scouring those [psychiatric] records in order to find a way to discredit the whistleblowers."

This practice, too, has become so common in government institutions that Congress passed a law in 2017 making it illegal to "access the medical record of another employee or an applicant for employment" as a form of retaliation.

In summary, said Devine, employing psychiatrists and mental health laws to help discredit whistleblowers is still "a bread-and-butter harassment tactic."

* * *

It happens in Canada, too. A fourteen-year veteran, Sean Bruyea retired from the Canadian Air Force after serving in the Gulf War. At home, he discovered how difficult it was for veterans to get the supports they needed, and he soon became a nationally prominent and influential critic of Veterans Affairs Canada (VAC).

One day Bruyea got a surprise invite to a meeting with senior VAC bureaucrats. But the meeting's proposed agenda seemed unclear, and something unsettled Bruyea. “I didn’t know what it was,” he told me, still disturbed about the events in 2020, a decade afterwards. “But I was shaking after I got off the phone. I was profusely sweating. I was crying.” Bruyea’s wife, a Mexican immigrant who’d seen activists get “disappeared,” encouraged him not to go. Bruyea called back and canceled.

In 2010, Bruyea’s freedom of information request uncovered a series of official ministerial Briefing Notes about that planned meeting. For pages, the notes interwove criticisms of Bruyea’s activism with information culled from his VAC psychiatric records. Much of this confidential health information was also distributed to ministry employees to discredit him. The final “Recommendation” of the senior bureaucrats was that they would attempt to extract specific political and personal concessions from Bruyea at the meeting, including ordering that Bruyea be “sent to Ste Anne’s Hospital” for a psychiatric evaluation. If Bruyea didn’t agree, VAC would cut his current supports.

Bruyea was shocked to see how far VAC would go—especially considering that the bureaucrats would also have known, Bruyea said, that his therapist believed disruption of his therapy at that time could make him suicidal.

He’s never fully recovered emotionally. “I feel completely disillusioned. I have nightmares about losing control of my destiny.” However, Bruyea added, it has helped him to persist with his activism. “I think one of the reasons I keep fighting is to combat that fear. Because otherwise, I’ll feel completely helpless.”

* * *

Psychiatrist Kernan Manion is still reeling from the repercussions of his own whistleblowing showdown with the US Navy that started in 2009. But the experience, he told me, has taught him about some of the most important aspects of what keeps anyone sane.

Manion got interested in psychiatry after reading thinkers from the “human potential movement,” like books by Abraham Maslow and M. Scott Peck’s self-reflective *The Road Less Traveled*. “I felt like this is the promise of what mental health is about,” said Manion.

During his residency at Tufts University, however, Manion said he witnessed psychiatry moving away from exploring self-actualization, and toward “psychopharmaceuticals and diagnoses and medicalizing of human experience.”

In his own practices he tried to focus on psychotherapeutic approaches, but became frustrated with how mental health care systems and funding were increasingly geared to just making quick diagnoses and prescribing drugs. In the 1990s, Manion began speaking publicly and consulting on physician burnout, and found others feeling similarly.

When an opportunity came up in 2009 to work at the Camp Lejeune Marine Corps base in North Carolina, Manion jumped at the opportunity, believing he'd be able to work with the soldiers stationed there over longer periods, developing relationships, and exploring issues of trauma and stress.

He was immediately shocked by conditions at the Camp Lejeune mental health clinic. "It was operating out of three rinky-dink trailers," said Manion, "and run by someone with no experience in high-risk mental health." The clinic was serving marines returning from Iraq and Afghanistan with brain injuries and severe trauma, but was unwelcoming, disorganized, and non-collaborative in many ways that, Manion believed, were potentially dangerous for patients, families, and staff alike.

Manion started making recommendations for improvement, but was met with disinterest and resistance from his superiors, he said. He was ordered into a new position with less responsibility. All of his patients were changed. Then, after he sent a formal letter of concern to the DoD Inspector General, Manion was fired. "Next thing I know," Manion said, "I'm escorted off the base under armed guard."

But with rising military suicides and a mass shooting at Fort Hood, Manion's concerns caught the attention of *Salon* and Associated Press journalists. A congressman started demanding answers. Marines reportedly "flooded" the congressman's office with calls verifying Manion's complaints. An admiral in charge of navy hospitals began investigating. The Joint Chiefs of Staff corresponded directly with Manion.

Camp Lejeune officers returned fire, trying to discredit Manion. In one of their more brazen retaliations, they deleted records of a glowing performance review and concocted a new one painting Manion as guilty of frequent absenteeism, exhibiting disrespectful and unethical conduct, and harming patients. The fake review was then sent to investigators, who repeated the condemnations of Manion to the news media as gospel.

That ruse was later publicly exposed by *Salon,* but these and other attacks wore on Manion emotionally. He was losing sleep, getting headaches, suffering physical cramping and pains. One Camp Lejeune officer accused him of fomenting "mutiny," and Manion worried about how much further these officers could go. Might they be sending soldiers to follow him, even if just to make him feel more paranoid? He read up on military non-lethal weapons, and his senses heightened for unusual behaviors, odors, and noises. Manion suspected some of his worries were “far-fetched,” and he’d ask those around him if they could help verify.

Manion became friends with famed FBI whistleblower Fred Whitehurst, who visited and assessed that Manion was indeed being targeted with surveillance and other harassment tactics that Whitehurst himself had once been subjected to. This reassured Manion that he wasn’t completely losing his mind, but also worried him still more.

Then Manion made a crucial mistake: he wasn’t paranoid enough. He turned to the local police department for help. He trusted them, and confided in them.

Manion told me that he hoped the Wilmington Police Department would put the military on notice that they were being watched themselves, and then help either verify or dispel some of his more worrying observations.

However, as is common in cities with both police departments and military bases, many Wilmington police officers had formerly served in the military, and Camp Lejeune and Wilmington police shared equipment and weapons and formally collaborated on many initiatives. So, Wilmington police had to be aware of the biggest public scandal to hit Camp Lejeune in years. But Manion didn’t know any of that when he walked into the Wilmington police station in 2010. He was just thrilled that he got to speak with the chief personally for a full hour. And pleased a detective interviewed him still further.

Not long afterwards, the North Carolina State Board of Medicine (NCMB) received “an anonymous concern from the police” about Manion’s mental stability.

Manion was ordered by its Physician Health Program (PHP) to report immediately for a psychiatric evaluation. The PHP ordered Manion to fly to their preferred treatment center in Kansas for a four-day evaluation, which would cost $5,000 to $10,000. Already out of work for months after getting fired, Manion chose a different, closer psychiatrist.

The PHP declared Manion guilty of “unprofessional conduct” for refusing to go to Kansas for evaluation.

Manion hired a lawyer. As disagreements mounted, the NCMB smeared Manion by publishing all of the unproven “allegations” against him on its public website, which mainly consisted of a list of the most odd-sounding concerns or fears Manion had purportedly expressed to the unnamed police officer—a list that Manion characterized to me as a mix of “distorted,” “false,” or “embellished” assertions.

Manion hired more independent psychiatrists to evaluate him, who all found his sanity intact. The PHP officials reframed these assessments, and insisted again on their own psychiatrists. Years were going by.

Finally, in 2013, one psychiatrist tagged Manion with a diagnoses of “Adult Onset Delusional Disorder.” The NCMB promptly told Manion he had twenty-four hours to either voluntarily inactivate his license or have it revoked by reason of his being mentally ill and dangerous to patient care.

In 2014, Manion got yet another psychiatric evaluation declaring he was not and likely never had been seriously delusional. But the NCMB insisted Manion undergo yet another evaluation with their preferred psychiatrist. At that point Manion said he decided, “This is bullshit. I just don’t need this.” Without a career, he at least wanted his life back.

* * *

As I got to know Manion over several months, I was intrigued by his descriptions of the altered state of mind that the never-ending stress had caused. I asked Tom Devine about it.

Devine said that another common method of psychiatric retaliation against whistleblowers is not just to “brand them as crazy” but to “drive them crazy.” The strategy is to subject whistleblowers to harassment, humiliation, fear, stress, and “emotional battery” until they appear mentally ill and get locked up, or at least appear much less credible.

Devine said he includes this warning in his standard introduction to new whistleblower clients: “Just defending yourself is an incredibly stressful, multi-year, marathon ordeal . . . They’re going to brand you as crazy. You’re liable to be ordered to take a psychiatric examination. They’re going to do everything they can to make your life hell . . . Can you handle the stress?”

Some people buckle. Devine said he currently has several clients who’ve become suicidal. One “surrendered” on the eve of winning his case. “He just couldn’t take it anymore, win or lose.”

There have also been clients “who snatched defeat from the jaws of victory” because, after everything they’d endured, they could no longer present themselves or testify credibly even in Devine’s eyes. “They just cracked,” he said. “They lost it.”

For a few, the descent into fear became so intense that they didn’t even trust

Devine, anymore. “Although I fought and won every battle for them and their legal rights, they had decided that I was conspiring with the government to sabotage them, and fired me, and filed bar complaints against me.” He commented without judgment, “That just comes with the territory.”

* * *

Manion began consulting for other physicians tangled up with PHPs. And like many whistleblowers, he still has fears about retaliation.

The worst part throughout, he said, has been the isolation—how most people don’t believe some of the things that were later verified had been done to him. Manion cited *Zersetzung*, or “decomposition,” the former East German Stasi’s name for psychological warfare techniques. Their goal was to undermine dissidents emotionally, socially isolate them, and render them politically ineffective through what was officially described as “a systematic degradation of reputation, image, and prestige on the basis of true, verifiable and discrediting information together with untrue, credible, irrefutable, and thus also discrediting information.”

Commented Manion: “A human being has a variety of connections, of moorings, that hold that human being in place. A marriage or significant other. Friends. Family. Community. Neighbors. Church. A job, income. In other words, all of this is the tapestry of one’s environment. And what the Stasi decided is that the way that you can annihilate someone is to cut those moorings, one at a time, cut them off from each of them.” And there was no quicker or more effective way for authorities to do that, said Manion, than to make everyone around you start suspecting you’ve gone mad.

* * *

Major Ian Fishback lost those connections. In 2005, Fishback went to Congress and exposed torture by the US Army in Iraq. He later taught at West Point and spoke widely about war, humanitarianism, and US foreign policy, and earned a PhD in philosophy. But, according to the *New York Times*, in recent years Fishback developed “paranoia” that he was being tracked and harassed by government agencies. He became increasingly “argumentative” and socially isolated, and he dodged forced psychiatric treatment. In 2021, he was committed. Fishback was put in a group home where he was so heavily drugged that he reportedly could barely walk or express himself, and two months later, at age forty-one, he died.

CHAPTER 20

DETAINING PROTESTERS AND PREGNANT WOMEN: OTHER POLITICAL USES OF PSYCHIATRY

The US Internal Revenue Service employee manual designates two special client categories: “Potentially Dangerous Taxpayer” (PDT) and “Caution Upon Contact” (CAU). PDTs are physically threatening, but the CAU designation more broadly flags people who may present some kind of risk that’s “less severe or immediate.” The manual is hazy about what happens next, though it’s clear that all cases get escalated to managers, and if any taxpayer seems especially despairing, employees must “contact the required local law enforcement or government suicide prevention authority.” Two audits identified thousands of PDT and CAU cases annually, and criticized IRS employees for not flagging still more people.

A victim of similar policies in Canada has been speaking out. Gordon Stewart had parked his truck outside Revenue Canada offices in Victoria, British Columbia, with a banner saying, “Canada’s Dishonest Tax Police.” To passersby, Stewart promoted his forthcoming self-published book about how Revenue Canada had leveraged money out of his small arborist business over a decade, before finally admitting they’d erred. Stewart wanted the world to know about the systemic corruption he’d uncovered.

But an “anonymous” caller contacted the police to do a wellness check on Stewart. Police records described Stewart as “rational and calm” and “does not want to hurt anyone or anything, just wants to protest.” Police records revealed it was definitely Revenue Canada that called about Stewart the second day. Again, Stewart was described as calm. Concerned about the harassment, Stewart tried to get a “peace bond”—a non-judicial restraining order—against Revenue Canada, but another wellness-check request went in, and this time police didn’t even interview Stewart but just took him straight to a psychiatric hospital.

Stewart’s partner, Rita Dutsch, had talked with him just an hour earlier, and told me the apprehension was perplexing. “Gordon’s a really calm guy. He doesn’t get upset. He’s never had mental health issues his entire life.”

Detained at the hospital, Stewart was prevented from contacting an attorney or Dutsch, and became confused and concerned. The medical records showed the emergency room doctor’s analysis of Stewart’s “agitated” but “in control” state of mind. “On one side, the story sounds [like] one of paranoia with Mr. Stewart saying Revenue Canada is out to get him, he is worried for the safety of his wife and children, he thinks Revenue Canada is going to do him away,” the doctor wrote. “On the other hand,” he continued, there was clear corroborating evidence that, in fact, “Revenue Canada has been out to get [Stewart], they admit to making some mistakes, it sounds like they have been very hard on him financially, and not having good reason to be so.”

The doctor then tried to reconcile these differing versions of reality: “[Stewart’s] insight seems reasonable up to the point where he says ‘Revenue Canada is going to blow away my wife and children.’”

“I never said that,” Stewart told me. The records didn’t state if the doctor heard those provocative words, if they came to him secondhand, or if they might have merely been dramatic vernacular for, say, “drive into poverty.” In any case, was fearing Revenue Canada’s wrath enough to commit someone who otherwise “seems reasonable”?

The doctor decided it would be “best” to detain Stewart longer.

Demanding to know his rights, Stewart was put into seclusion and forcibly drugged. “I was doped out and really weak,” said Stewart.

The next day he reached a lawyer and learned he could only appeal his incarceration after three weeks. After day one, Stewart was so outraged by this abrogation of basic civil rights that he refused to speak to medical staff. “I’m holding my ground,” he told me, “as a Canadian citizen.”

The psychiatrists held their ground, too, keeping Stewart locked up and drugged through days two, three, four . . . On day eleven, Stewart finally buckled and spoke with a psychiatrist, who promptly discharged him. Stewart described his reaction: “I said, ‘Just like that? Free to go?’ I felt like running, but I walked.”

Ever since, Stewart has campaigned to change mental health laws. “I don’t want to go public with this story; I don’t want anyone to know my business. But it needs to be told, so people can understand that, yes, this can happen in Canada.”

Yet Stewart also wouldn’t risk releasing his book until mental health laws changed. “Could somebody call police and give them misinformation again? I think I would be stupid if I wasn’t concerned.”

* * *

I came across similar cases at other institutions. Several people reported getting into disagreements at banks or trying to make large withdrawals and landing in psychiatric hospitals. I asked several national banks and the American Bankers Association if banks had written policies and staff training on when to call or not call for police wellness checks, but they did not respond. A former bank manager confirmed to me that it’s common practice. “Banks are super tentative with unusual requests,” he wrote in an email. “Demand for large cash (hostage or blackmail) or withdrawals on joint accounts etc . . . Drunk, drugged, or mental health signs raise flags, too.”

An executive for an international medical technology company and mother of two described in *Mad in America* how she was having an emotional day already and argued with airline staff in New York about whether she had appropriate travel documents. She wrote, “Imagine going to the airport to travel to London, a commute you had made dozens of times before, only to find yourself locked in a high-security psychiatric ward a few hours later, stunned and naked except for a gown and underwear, paralyzed by psychoactive drugs, and deprived of all of your belongings.”

I started to wonder if there were other blatantly politicized uses of psychiatric powers going on. Calling for psychiatric intervention seemed all too easy a way to get rid of complainers and protesters.

* * *

Contemporary Communist China provides a good comparator. A 2014 article in *Psychiatry, Psychology and Law* discussed a nongovernmental organization’s report to the Chinese government about “cases of abuse of involuntary hospitalisation.” In particular, the report criticized the rise of a psychiatric practice becoming so common that the general Chinese public had given it a catchy name: “Bei Jing Shen Bing,” or *getting mentally illed*—translated as the “involuntary diagnosis and treatment of a mentally sound person as a mentally disordered patient.” In response to family conflicts, sometimes over property or money, or a person repeatedly complaining or protesting at Communist government agencies, the report stated, “some persons with no evidence of mental disorder were involuntarily hospitalised and treated without due process, mainly on the application of family members and local governments.”

This seems to be the way it often works in North America, too. Essentially, psychiatric power operates less like a single central command issuing consistent instructions to unified armies and more like many decentralized groups with access to private militias, security teams, weapons caches, and guns, ready to take reactive action at any time in defense of local authorities in workplaces, schools, prisons, the military, long-term-care facilities, banks, tax offices, and so forth.

Another provocative example: In 2016, journalist Batya Ungar-Sargon reported in *Narratively* about collaborations between psychiatrists and leaders of orthodox religious Jewish communities in New York. Ungar-Sargon interviewed orthodox male and female Jews who felt compelled to obey the united authority of the religious leaders and psychiatrists, and “were prescribed anti-psychotics, hormones, or anti-depressants for masturbating, questioning the tenets of the community’s faith principles, experimenting with or even fantasizing about same-sex partners, or displaying ‘too high’ a sex drive.” Ungar-Sargon asked Richard Louis Price—himself both a psychiatrist and rabbi—if he prescribed SSRI antidepressants to youth who masturbated specifically to knock out their libidos. Price replied, “I’m not going to say *that*.” Price insisted he prescribed the drugs to lessen the anxiety that inappropriate masturbating caused these youth. “[B]ut the side effect of all the SSRIs . . . is that it reduces libido and delays ejaculation, which is really almost the primary benefit.”

* * *

One of the most explicitly, systemically political uses of mental health law powers in contemporary America involves seizing control of pregnant women.

Peer-support specialist Kimberly Comer told me she’s known a number of women who’ve gotten into battles with their psychiatrists over pregnancy. One time when she herself got pregnant, her psychiatrist ordered her to get an abortion. He was concerned that the psychiatric medications could damage the fetus, but also worried about what would happen to Comer if she went off the drugs.

Comer chose withdrawal, which was “like the worst case of flu I ever had. It was absolute hell.” Her psychiatrist? “He had discharged me as a patient. He did not want the liability.” Comer’s baby came eight weeks premature, but healthy. Many women, though, aren’t allowed to make their own decisions.

Over the past two decades, most states have passed laws promoting mental health screenings for pregnant women. These are presented as caring, helping initiatives, but Lynn Paltrow, director of the nonprofit National Advocates for Pregnant Women (NAPW), told me that pregnancy then becomes “the excuse for depriving pregnant people of any semblance of due process.” In these laws, which include mandated substance use screenings, there’s little pretense of intending to truly help the mother’s mental health. It’s all about the state seizing control of her fertilized egg—the mother is merely in the way.

Many such laws, said Paltrow, sprang out of the “crack-baby” myth that certain popular drugs, especially those used by poor Black women, were far more dangerous to the fetus than other widely used recreational and prescription drugs. A belated 2019 mea culpa in the *New York Times* admitted these myths were born of “bad science and racist stereotypes” fueled by news media. The politicians who crafted these laws also ignored demonstrably more hazardous impacts on maternal health such as poverty, domestic violence, and pollution.

The upshot? Paltrow said some states have expanded “danger to self or others” in mental health laws to include a fetus or fertilized egg as an “other.” Some states created specific “unborn child protection” laws that remove even the few due-process protections of civil commitment. These laws create a legal framework where eggs and fetuses have more rights than the women themselves—and the state claims to represent the egg.

Paltrow pointed to Wisconsin as an example. “When a woman is taken into custody under that law, her fetus is entitled to a lawyer, but she is not,” Paltrow said. The hearings are secret and pregnant women can be sentenced to ninety days or more of detention and forced treatment. The state gets ongoing access to the woman’s medical records; conversely, when the woman is later permitted a lawyer, she can’t give her lawyer copies of her own medical records, because that’s a breach of the fetus’s privacy rights. “Being able to challenge or even learn about what happens in those cases has been very difficult,” commented Paltrow.

NAPW has seen some women getting forced onto medications. Paltrow described a case of a pregnant woman who went to a hospital seeking help with opioid dependency, and a doctor recommended methadone. But some states regard using either opioids or medical opioid-withdrawal aids as child abuse or attempted murder. So, a different doctor got the woman incarcerated in a psychiatric hospital, where psychiatrists, ironically, put her on an addictive sedative.

However, much more often, Paltrow said, NAPW has seen women using narcotics or other substances get incarcerated in “abstinence-only” mental health treatment centers and forced into sudden, extreme withdrawal that can itself cause serious fetal distress, miscarriages, or stillbirths.

These risky, medically contradictory approaches are visibly embodied within the “supportive” position statements the NAPW has collected on its website. In these statements, many health professional associations declare that they’re against “criminalization” and “punitive approaches” to pregnant drug users, yet promote psychiatric detentions and forced treatment. The American Nurses Association “supports the fact that substance use disorders are diseases that require treatment.” The American Psychiatric Association pushes for “early intervention and treatment.” The American College of Obstetricians and Gynecologists states that “psychiatric consultation may justifiably be sought when a pregnant woman’s decision-making capacity . . . is in question.”

Asked about this, Paltrow said that early in NAPW’s advocacy work, NAPW used the banner “Treatment Not Punishment.” But after NAPW saw how quickly others interpreted that as an endorsement of forced mental health treatments, NAPW refined the messaging.

* * *

Adam Urato navigates these systemic contradictions daily. A maternal fetal medicine specialist in Massachusetts, Urato told me he testified as an expert witness in the case of a pregnant woman whom psychiatrists were trying to force to take antipsychotics. “She was thinking that she didn’t want to be taking this chemical into her body that would be crossing over and going into the baby. Her thoughts on this were entirely reasonable.”

Urato said the now dominant “conventional wisdom message” on psychotropics has been generated through “a big corporate marketing rollout” through pharmaceutical company-funded studies, advertising, paid medical spokespersons, and news promotional stories. “That message is that if you use these medications in pregnancy, they have a good effect on the mom’s mental health and so they improve the pregnancy outcomes.” Many young women are already taking psychotropics by the time they get pregnant, said Urato, and they’re often told that psychiatric drugs are “almost like a vitamin” and “there’s no downside” for fetuses. “We’re telling patients that these chemicals are going to have a profound impact on your brain. And yet, on the flip side, we’re telling them that these chemicals are going across into the baby’s developing brain, but there’s no proven impact there. It doesn’t make any sense.”

Urato finds it challenging to wade through the many pharmaceutical industry-influenced studies, but said there’s a lot of evidence pointing to potential harms from psychotropics. “I think there are significant downsides.” For example, he said, depending on which psychotropics, there are associations with increased rates of miscarriage, birth defects, pre-term births, and postpartum hemorrhage—and rates of newborn withdrawal syndrome averaging 25 to 40 percent, and as high as 85 percent with antidepressants.

But the rhetoric on this topic, said Urato, often gets taken to extremes where people suggest that if women don’t take psychotropics the result will surely be tragedy. In such a context, psychiatric coercion or force are easily justified. “When I give talks on this, where the conversation inevitably goes is, ‘But the women are going to be killing themselves.’ Nobody wants that more than me: women not killing themselves! [Yet] I can’t even start to make a reasonable argument if I’m portrayed as the guy who’s okay with pregnant women killing themselves.”

There are risks associated with taking psychotropics, and with suddenly withdrawing, and so in practice Urato said he always collaborates with women to help make decisions that are optimized for their circumstances and wishes.

NAPW’s position is similar. Paltrow said that the biggest risks to pregnancy outcomes are embedded in people’s “life circumstances,” so, helping women with challenges such as racism, poverty, nutrition, pollution exposure, and domestic violence, along with any mental health or substance use issues they may have, should be a cooperative, supportive process that optimizes harm reduction. “Forced treatment is not the thing that’s helping them and just makes everything so much worse,” said Paltrow.

Yet the use of these laws to control pregnant women, and to enforce either pregnancies, sterilizations, or abortions depending on each state government’s or psychiatrists’ biases, could increase dramatically after the US Supreme Court, in

2022, threw out federal protections for women’s own rights to choose. It also seems possible that, in anti-abortion states, licensed mental health practitioners and call-attendants of the 988 hotline will be required to report as “dangerous” any clients or callers considering abortions.

* * *

It’s enlightening to review the most well-known example of politicized mass pathologizing from modern history; it shows how psychiatry’s elastic diagnostic system is readily adaptable to declaring members of virtually any political movement to be mentally ill.

Psychiatrists in the former Union of Soviet Socialist Republics (USSR) routinely diagnosed political dissidents as mentally ill. International awareness became heightened with studies by Sidney Bloch and Peter Reddaway leading to their 1977 book, *Psychiatric Terror: How Soviet Psychiatry Is Used to Suppress Dissent*. Accounts of anti-Communist protesters getting forcibly treated in Soviet psychiatric hospitals were widely reported until the scandal reached international proportions.

Yet not so well known then or today is the fact that, behind the scenes, Western mainstream psychiatrists were reluctant to sanction their Soviet colleagues. In a 1983 article in *The Lancet*, Allan Wynn, the chairman of the World Psychiatric Association’s (WPA) Working Group on the Internment of Dissenters in Mental Hospitals, described debates in psychiatric journals, symposiums, investigative review committees, visits by Western psychiatrists to the USSR, and backroom negotiations. For years, no sanctions came.

Soviet psychiatrists, Wynn explained, insisted that the dissidents really were mentally ill. Wynn quoted A.V. Snezhnevsky, director of the USSR’s Institute of Psychiatry of the Academy of Medical Sciences, acknowledging that most of these dissidents did display “seeming clinical normality.” Yet, in fact, Snezhnevsky said, they had “latent” or slow-developing schizophrenia. These dissidents suffered moodiness, chronically complaining about life in the USSR, and exhibited “antisocial attitudes” in their avoidance of Soviet-sanctioned group activities. They had beliefs about the need for and possibility of revolutionary change that Snezhnevsky characterized as “exaggerated” and “delusional.” They also displayed a “diminished contact with reality” that undermined their ability to properly care for their own basic needs, as exhibited by their reluctance to conform to their nation’s available jobs and social standards. And finally, these activists displayed a “lack of insight” into how these behaviors made them a danger to themselves and their communities.

Meanwhile, the WPA’s “main charges” against Soviet psychiatrists included using expansive diagnostic criteria, incarcerating people who weren’t truly dangerous, not giving patients due process, and overusing psychotropic drugs for controlling patients. Basically, the WPA was proposing to reprimand Soviet psychiatrists for practices that most psychiatrists knew were common in the West, too.

As public pressure made the WPA shuffle toward a formal sanction, outraged Soviet psychiatrists themselves quit the WPA en masse first. The Soviets accused Western psychiatrists of ignoring medical science, caving to sensationalist news media, and becoming “too political.”

So, to summarize: In psychiatry, one person’s political grievances and visionary social revolution can easily be another person’s brain disease requiring forced treatment. And vice versa.

Something similar is on the rise in America today. Galen Meyers got ensnared in coercive treatment because of his deep concerns about capitalism and the fate of our planet.

* * *

Now thirty-four, Meyers told me that during his teens and early twenties, he became fascinated by the science of food systems and the environment, and increasingly concerned about “the way that the earth was being ravaged” and “how unsustainable” human industrial systems seemed. Meyers said his growing perspectives, arrived at through careful study, shattered the “delusions of grandeur” he’d had that his own future and that of Western civilization would be endlessly improving. He instead came to believe that human society was facing a “civilizational crisis.”

These realizations sent him into a “dark period,” with no idea of what solutions might look like. “I had a tremendously difficult time coping,” said Meyers. Still worse, he said, was the isolation he felt, as his close friends and family downplayed his concerns.

One day in 2010, his father, a doctor, said that he believed Meyers was manifesting clinical depression. “He looked at me with tremendous fear in his eyes. And he said, ‘Galen, if you were sick, how would you know that your thoughts about reality weren’t just coming from the biochemistry?’” His father said he’d arranged a place at a treatment center, and he would cut off his financial support for his son’s college studies if he didn’t check in immediately.

Meyers imagined he’d likely stay a few days and the experts at the treatment center would realize there was nothing wrong with him and explain that to his father. Instead, staff kept instructing Meyers to stay—for five months.

It was a high-end facility and Meyers said he wasn’t drugged, got fed well, the group therapy sessions were “very enjoyable,” and the staff and fellow patients were “generally nice and respectful.” Most of the clients and therapists alike had had substance use problems, and he learned much from hearing about the traumas that led them into addiction. Meyers repeatedly emphasized to me how much he benefited, learning to find deep connection with others and give “mutual support.”

Despite all this, there was one key aspect that Meyers said was “really intensely destructive”: the mental health professionals continued to pathologize his feelings. “When I told my story, it was constantly reinterpreted as, ‘There’s something else going on. He’s depressed, and that’s why he thinks the world is collapsing.’ It made me mistrust my own perception of reality. It made me mistrust my own intellectual process, which was really damaging. It was traumatizing trying to plead to be understood.” When Meyers was finally discharged from the facility, he felt more profoundly isolated than ever.

But Meyers started volunteering with environmental activist groups, eventually finding many like-minded people. He sometimes now takes on co-leadership roles, and has come to believe that his own inner pain about environmental-civilizational crisis is a manifestation of a collective pain—and the collective needs changing and healing as much as or more so than any individual. “Cultures are living systems, very much like a beehive,” said Meyers. “A society is a superorganism, and we human individuals are elements, or cells. There is pathology in the larger system—in the superorganism—and it’s expressing itself through individuals. It’s completely insufficient to try to create health by treating individuals’ brains, as though that is the source of the pathology. In fact, that approach can be really destructive. If we want to restore health to individuals, we must create more nurturing conditions in the relationships and communities, and even in the societies, where the suffering has developed.”

Meyers believes connecting and collaborating with others who are also experiencing these deep distresses point the direction toward both inner healing and transformative social change. And in hindsight, he said, the despair about humanity’s future that he went through in his youth became a vital catalyst for his learning and growth, both as a person and socially engaged activist. “It was absolutely necessary to open up and feel the pain of the larger system around me and not close myself off to it.”

* * *

Meyers’s perspectives raise important questions about the inherently political and repressive aspects of forced psychiatric treatment—especially at this juncture in our society. David Oaks similarly believes that vital revolutionary impulses will emerge from within people who are experiencing intense or extreme states and reaching out to connect with like-minded others—and that many forms of “madness” actually hold keys to the radical personal and social changes that humanity needs in this time of global crisis.

In the 1970s, Oaks experienced intense, unusual ideas and feelings and was detained, labeled mentally ill, and forcibly tranquilized. Yet Oaks told me that many aspects of his “extreme states” were challenging but also brought transformative insights about himself, society, nature, and spirituality. So, once freed, Oaks stopped taking psychiatric drugs and recovered, in part, through channeling his feelings into human rights activism. Oaks went on to direct MindFreedom for two decades. An accident in 2012 left him speech-impaired and using a wheelchair, and he currently offers consulting on disabilities, community organizing, and environmental sustainability, and decries the mental health system’s role in “climate change Normalgeddon.”

“The big-picture question [about climate change] is: Why are we so numb? Why aren’t we doing the really deep changes?” said Oaks. “The mental health industry is one of the institutions in society that has really controlled our thinking and feeling to keep us so-called ‘normal.’ It’s very dangerous.”

Instead, for people struggling inwardly in relation to climate change, Oaks proposed “going into your extreme deep feelings and thoughts, extreme overwhelming feelings and differences, and translating those into action.” He pointed to Greta Thunberg. Labeled with depression, anxiety, OCD, selective mutism, and Asperger’s, Thunberg herself described her traits as a “superpower” for her activism, and activism as a boon to her well-being.

“Her willingness to be different is why she went to [Swedish Parliament] every Friday, and that became a movement led by young people all over the world,” said Oaks. “That wasn’t called normal.”

Conversely, a high-profile Australian psychologist in 2019 declared that Thunberg was delusionally "caught up in a doomsday scenario" and she "should be getting treatment." That perspective is part of a growing movement of mental health professionals who frame people's distressed reactions to floods, droughts, and wildfires, and rising worry about climate change, as mental disorders. Even some climate activists are educating the public alongside trauma therapists and the Substance Abuse and Mental Health Services Administration, and help funnel people in distress into treatments. In 2017, the American Psychological Association teamed up with environmental policy group ecoAmerica to produce guidelines on responding to climate change threats with combined community resilience–building and mental health services. The American Psychiatric Association and a new Climate Psychiatry Alliance have helped ensure similar messaging got included in the Medical Society Consortium on Climate and Health and the United Nations' Sendai Framework for Disaster Risk Reduction.

But will treating climate-related distresses as mental disorders help or hinder change? The American Psychological Association report stated that "negative emotions" about climate change are "normal"—unless they're "extreme" and "interfere" with thinking or acting "rationally." The authors didn't specify what "acting rationally" should look like in reaction to, say, the possibility of "climate feedback loops" that some argue could suddenly erupt and destabilize civilization with blinding rapidity.

But psychiatrist Burns Woodward pronounced in *Psychiatric Times* that people who have "distressing or disabling" feelings or "catastrophic thinking" about climate disruption have serious mental disorders. "Such patients need treatment with psychotherapy and/or medication," he declared. Woodward added that climate activists are "especially vulnerable," and therefore it may be clinically advisable to use psychiatric or psychological interventions "to curb internet searches, calls to public officials, and hounding of family members about energy usage."

So, are intensely passionate or disruptive environmental activists mentally disordered or rationally revolutionary? Or both? After all, many of our current societal norms of feeling, thought, and behavior can seem "insane," as they fuel inequities, injustices, individual and mass violence, and ecological suicide-spirals of many different kinds. Such questions therefore become more potent by the day, as does the specter that psychiatric authorities could play a major role influencing our collective political future.

* * *

All of this is part of a wider political trend. In our polarized culture, many people increasingly, and seriously, believe those who disagree with them on any major medical, scientific, environmental, social, or political issues are delusional and out of touch with reality. Psychiatrists are picking up this flag, too.

For example, shortly after the storming of the US Capitol Building in 2021, *Scientific American* medical editor Tanya Lewis interviewed forensic psychiatrist Bandy X. Lee. Lee was former faculty of the Yale School of Medicine and currently president of the World Mental Health Coalition, a group of mental health professionals seeking to educate people “about fitness for government leadership and other current sociopolitical dangers.”

In the interview, Lee described former president Donald Trump and his supporters as delusional, pathological, paranoid, with a “propensity for violence,” and living in a “shared psychosis.”

And how did Lee propose making Trump’s supporters mentally healthy again? “Because I specialize in treating violent individuals, I always believe there is something that can be done to treat them,” said Lee. “But they seldom present for treatment unless forced.”

Lest never-Trumpers feel smugly buffered from the clinical gaze, the *New York Post* and other conservative media outlets have reported on how “science says liberals, not conservatives, are psychotic.”

PART FIVE

SCIENCE, LIES, AND OTHER POSSIBILITIES

CHAPTER 21

THE THANK-YOU THEORY

Some people would argue that we should still uphold involuntary psychiatric interventions for those people who are truly severely troubled and are later thankful that they were forcibly treated.

Exactly who are those people, though? And are they actually the majority—or even a substantial minority?

* * *

In the trade journal *Psychiatric Times* in 2020, emergency psychiatrist Scott Zeller and nurse Emily Kircher coached their colleagues: “Do not fear potential backlash. Therapists might be reluctant to engage emergency services or obtain an involuntary hold because they are concerned their patient will feel betrayed. Although an individual might initially be angry, in most cases, they will later be very thankful.”

I asked Zeller if he could point to any studies supporting his declaration that most people become thankful. Emailing through a California Vituity Healthcare media representative, Zeller said that his assertion was “based on [his] more than 30 years of experience.”

This notion has been promoted for so long by psychiatric professionals, pro-force organizations, and governments that, in the 1970s, Harvard psychiatrist Alan Stone dubbed it the “Thank-You Theory” of civil commitment.

Zeller declined to estimate what percentage of his former patients were *not* thankful. But most studies suggest it’s a very large percentage, even among people who recognize that they were genuinely struggling emotionally at the time of their hospitalization. Sara Kenigsberg's experiences illustrate why—civil commitment sent her spiraling into an abyss from which she feared she might never climb out.

* * *

After college, Kenigsberg moved to New York in 2012 and launched into a high-stress profession in the media. "I put everything into work, while not really investing much in my own self-care," she told me.

During one of her regular calls home to her parents, Kenigsberg talked about feeling overly stressed at work. Her parents expressed worries. Kenigsberg visited a psychiatrist, and was prescribed the sedative clonazepam.

Kenigsberg immediately felt so sluggish from the drug that the following day she had to leave work early. The next call with her family happened shortly after she'd also had a long, sleepless flight, and Kenigsberg recalled saying, "I don't feel well; I feel really drowsy. I feel like I'm going to lose my job. If I lose my job, I'll die."

Her suggestive words worried her parents. Not long after hanging up, Kenigsberg was sitting in her apartment, and there was a knock. She opened the door to see four police officers.

* * *

There haven't actually been many formal studies of the thank-you theory—and virtually none in the US or Canada—except various surveys that asked former involuntary patients not so much if they were grateful, but whether they subsequently agreed they should have been detained, or derived any benefits from their stay in the hospital, or what complaints they had, and so on. The theme of "perceived coercion" has consistently emerged.

For example, a 2010 UK survey of hundreds of former involuntary patients found that "perceptions of coercion were consistently associated with treatment satisfaction," with those "not having experienced coercive measures (such as restraint, forced medication, and seclusion) being more satisfied." Basically, any individual patient's experiences may or may not involve pressure, threats, or physical force, and researchers have consistently found that, as patients perceive rising levels of coercion occurring, the level of positive impacts they afterwards report experiencing plummets.

This is why, when psychiatrists like Zeller promote civil commitment with such broad, unqualified claims, many traumatized victims of forced treatment feel brushed aside like irrelevant collateral damage. These polarized perspectives were encountered frequently by Baltimore psychiatrist Dinah Miller during her research for *Committed: The Battle Over Involuntary Psychiatric Care*.

Miller has spent most of her career doing voluntary outpatient care, so she was perplexed, she told me, when the popular blog she ran with other psychiatrists was for years deluged with “comments from people who are angry at psychiatrists.”

In her own experience of psychiatric detentions, and in talking with other psychiatrists, Miller said, “We see people get better, and then they leave the hospital. And there’s not the continuity to know these people are so upset and angry and distressed by this.”

Miller said she thought “the system had to be doing something wrong,” and decided to collaborate with psychiatrist Annette Hanson to investigate. In *Committed*, they write that “gratitude certainly doesn’t seem to be the sentiment expressed by the majority of those who speak up.” And by the end of their research, both psychiatrists felt much more cautious about civil commitment. “We think that people should be treated better,” Miller told me. “And treated with the idea that they might be traumatized by the treatment.”

But that’s not a cautionary message that tends to get publicly promoted; so, like many people, Kenigsberg’s parents simply assumed that calling 911 could only be helpful.

* * *

Kenigsberg explained that she wasn’t suicidal, but the police said they had to take her to the hospital for evaluation.

“I had no understanding of what mental hospitals really were, or what happened at them,” Kenigsberg told me. Staff informed her that if she didn’t sign herself in, she’d be committed. Instantly, she felt “shocked and shamed” about being imprisoned as if she were a “dangerous mental patient.”

After she waited through the weekend, a psychiatrist met with her for just a few minutes, she said, before he diagnosed her with bipolar disorder, prescribed lithium, and suggested she’d need to take the drug for the rest of her life. She reluctantly took it.

Then she waited more in the hospital. “There’s literally nothing to do,” she described. “You’re sitting there just eating and watching TV. How is that helpful?”

When I asked for more details of her experiences being hospitalized, Kenigsberg became uncomfortable. She compared it to how sexual assault victims can feel when compelled to disclose details and thereby relive the pain, while simultaneously exposing themselves to others’ judgments. “It’s almost like I have to prove that I was not crazy enough to have that happen to me.”

Kenigsberg was released after a week. “When I got out, I felt such shame about being hospitalized and receiving this diagnosis.” And the lithium seemed to make her feel worse. “I was so scared that I’m going to have this mental illness for the rest of my life. I got really depressed, not understanding.”

To this day, she feels even more humiliation about the fact that she subsequently got re-hospitalized more than once over the next year. She would stay on the drugs for a time and feel worse, and then stop the drugs. Family members worried about her not taking the prescribed treatments, and called 911.

She listed the ways her lifelong sense of herself was steadily broken down through this cycle.

“If you’re brought in by police to a facility,” she said, “automatically you’re kind of guilty, because why else would police be bringing you in?”

While she’d previously been a respected, successful professional, getting labeled with bipolar disorder opened the door for hospital staff to commit her and ignore her opinions and wishes. “They acted like they knew better than I did about what I needed.”

When their treatments didn’t help her and she stopped them, she was given the still more stigmatizing label of “non-compliant mental patient” who was “lacking insight.” Staff began managing her like she needed constant monitoring.

Kenigsberg said the medical staff’s convictions were so strong that she herself started thinking she must indeed be “sick” and “not capable,” and that the bipolar disorder diagnosis was a “death sentence” for the person she’d once been.

She often felt like a “caged animal” in the hospital. The food was abysmal, she wasn’t allowed to exercise, the drugs contributed to her gaining weight, she was losing contact with friends, and she had to leave her job. “I just couldn’t function anymore. Then, I didn’t believe in myself anymore. So, that caused me to be very depressed, where I actually did become suicidal.”

After just one short year she appeared to have transformed into the very kind of chronically ill patient the psychiatrists had labeled her as. “I don’t know if you’ve seen the Netflix documentary *Making a Murderer*?” she asked. “It’s like ‘Making a Mental Patient.’”

* * *

A 2007 review of studies of people’s experiences of involuntary hospitalization by University of London psychiatrists identified many negative themes: views and voices ignored, feeling dominated under strict rules, physical violations, frustration, and powerlessness. People often felt the treatment they received was meaningless, not appropriate, and more like punishment. The hospital staff didn’t seem competent or supportive, and the hospitals were unpleasant with limited activities, unhealthy food, and no personal space. Many described psychiatric detention as a major disruption to their lives, which left them feeling angry and aggrieved.

“They are disappointed in the staff and mental health system in general and feel pessimistic about their future,” wrote the authors. “This leads to feelings of hopelessness, frustration, low self-esteem and loss of control over their lives. These powerful emotions make patients feel insecure about themselves and question their value.”

Meanwhile, public talk about the “stigma” of mental disorders puts a genteel face on what’s more accurately described as widespread, entrenched, sanist bigotry. Surveys repeatedly find that the majority of Americans don’t want to live near, be romantically involved with, or have someone close to them marry someone labeled with a mental disorder.

In *Unequal Rights: Discrimination Against People with Mental Disabilities and the Americans with Disabilities Act*, attorney Susan Stefan describes how simply getting a mental disorder/disability diagnosis on your medical record can have serious, lifelong legal consequences.

While wide variances in laws and levels of enforcement exist across states, writes Stefan, a mental disorder label or having been psychiatrically hospitalized can be a basis upon which you can be denied licenses in many professions, or required to allow licensing boards access to years of your medical records. You can lose parental rights, be disallowed a medical advance directive, disallowed access to your own medical records, denied insurance, denied organ transplants, have your treatment history brought into criminal court to attack your credibility as a witness, and denied a driver’s license or housing. Stefan points to state laws like in Kentucky: “Marriage is prohibited and void: With a person who has been adjudged mentally disabled." Some states allow denying the right to vote, such as New Mexico, where every person is qualified to vote except "by reason of mental incapacity." And the range of poisonous ways in which divorcing couples and parents fighting over child custody use psychiatric labels and wellness-check calls against each other would themselves fill a book.

These kinds of discrimination, born from the psychiatric diagnostic label alone, are "crushing" and "pervasive throughout American society," writes Stefan. They sap people's hope and strength, and fill them with anxiety. And if people buckle and break under all this discrimination, Stefan points out, their breakdowns often get blamed on their own mental "condition."

* * *

Kenigsberg finally challenged her forced treatment in court.

Sitting in the hospital's hearing area, with her appointed attorney from New York's Mental Hygiene Legal Services, became a life-transforming experience. Kenigsberg was thinking, "What crime did I commit? How am I sitting in court right now for a ruling on whether they're going to keep me locked up in a hospital or not?"

The hospital psychiatrist argued that people with bipolar disorder are more likely to endanger themselves or others.

Kenigsberg's attorney pressed the psychiatrist to put aside prejudicial generalities about the diagnostic label and address whether Kenigsberg, personally, presented any actual danger to herself or anyone.

The judge set Kenigsberg free.

* * *

A 2009 study in the *British Journal of Psychiatry* observed that, while psychiatrists routinely evaluate most involuntary patients as benefiting from treatment, patients' own views "vary widely." The authors interviewed former and re-admitted involuntary patients and found that symptoms, diagnoses, and specific treatments had no predictive value for how well these people would be doing a year later. But if the patients vehemently disliked the forced treatment from the outset, then the treatment usually would not have helped them.

The authors noted that this shouldn't be surprising. A robust body of research shows that "therapeutic alliance" is the most reliable predictor of outcomes for all types of psychiatric and psychological treatments. When there's a strong sense of mutual respect, understanding, and warmth between therapist and patient, then both sides are more likely to feel improvement is occurring. “Our study shows that it also applies to involuntary admissions,” the researchers wrote.

A US study of the thank-you theory was led by Duke University psychiatrist Marvin Swartz. After one year of forced treatment while residing outside of hospitals, in their homes in North Carolina communities, only 28 percent of patients felt they’d benefited. “[W]e find little basis to support Stone’s thank-you theory,” Swartz concluded. “[M]ost subjects view [outpatient commitment] at least ambivalently and with little gratitude.” Swartz also noted that even the patients who expressed gratitude may have “believed that their acquiescence to their psychiatrist’s view that they had needed treatment was socially desirable and might confer an advantage by hastening discharge.”

Indeed, psychiatrists may well be the *least reliable* observers on this issue. The fact that they regularly administer forced treatment naturally biases many psychiatric professionals toward feeling and hoping it’s helping—a kind of placebo effect on the medical staff themselves. In addition, since many people remain detained solely on the basis of their ongoing resistance to treatments, countless former patients told me they’d quickly learned that the fastest—and often only—way out was to start expressing appreciation for the treatments. Indeed, it’s extremely common for psychiatrists’ discharge records to include indications that the patient expressed gratitude and pledged to continue to take medications.

This perspective was also shared with me by Sandra Steingard, a Vermont psychiatrist who has practiced and written about forced treatment. “Sometimes people really are grateful,” she said. However, after interacting with former involuntary patients through public speaking and blogging on *Mad in America*, Steingard said, “What I realized is that there’s still a power differential and what someone tells me in my office can be different from what someone might tell me who doesn’t have that patient-doctor relationship with me.”

Swartz wrote that even genuine gratitude might reflect Stockholm syndrome, “a form of acquiescence on the part of disempowered individuals who have come to identify with the agents of their control.” This is especially relevant in light of how antipsychotic drugs are well known to diminish resistance and motivation.

Massachusetts Wildflower Alliance director and former psychiatric patient Sera Davidow expressed a similar idea to me. She described someone at a public meeting who talked about how forced treatment had helped him. “However, he also talked about how he hasn’t been able to work in twenty years,” said Davidow. And she observed shaking and slowed speech, common adverse effects of antipsychotics. “It becomes very hard to separate out who’s saying that because they’ve really had a good experience and went on to have a full life, and who’s saying that because they’ve been so beaten down, and they think this is really the best that ever could have been.”

The polarization of perspectives can become even more acute: many people who’ve experienced forced treatment compare it to being sexually assaulted—including people who’ve actually experienced sexual assault. These people feel horror and outrage at anyone promoting a belief like “most people will be thankful for getting sexually assaulted.” Conversely, many people who implement forced treatment cannot tolerate any suggestions that they’re akin to rapists.

* * *

Though freed by a judge, Kenigberg’s recovery was only beginning. “I had to rebuild my life,” she told me.

Kenigsberg stayed in bed for two months, depressed from her yearlong ordeal. One day, a friend gave her a gift certificate for a month of free daily coffee at a neighborhood coffee shop. “It was one small thing that got me out of bed,” said Kenigsberg.

She walked every day to get coffee. She decided to exercise to lose the weight she’d gained, and her posts about her health journey gathered ten thousand followers on Instagram—and, she emphasized, won her new acquaintances who didn’t know her as a “mental patient.”

Then she began to re-narrate her story, on her own terms. Her strong-minded, questioning, and outspoken nature had frequently gotten her into trouble with hospital staff, she said. “But once I got out, it really helped me.”

She researched diagnoses and psychotropics, and connected with others who’d experienced civil commitment and called themselves survivors of psychiatry. “I was like, wow, that’s a thing?!” said Kenigsberg. “This is exactly how I feel; I feel like I’m a psychiatric survivor.”

She began to tell herself, “I’m not broken. I am capable. I can be successful. I can listen to my intuition again.”

Kenigsberg eventually went to graduate school, and soon got media and advocacy work again, including with the influential MoveOn. She later became supervising video producer for the Democratic presidential nomination run of Bernie Sanders, and in 2020 helped lead President Joe Biden's election-campaign digital video strategy. She openly acknowledged her previous psychiatric incarceration and criticized mental health laws in a *Washington Post* op-ed.

Despite these successes and the years that have passed since her commitment, Kenigsberg can still feel "triggered," she said, by public discussions about creating more mental health services. "When you're saying 'more mental health care,' what are you talking about? Is it more involuntary treatment? There's this slogan, 'It's okay to not be okay.' It's not true. Our society punishes people for being not okay."

She's recently joined the board of the Bazelon Center for Mental Health Law. "I've become passionate about fighting for the rights of people who've experienced having their autonomy taken away based on a mental illness label."

One day, Kenigsberg reached out personally to the judge who'd released her from civil commitment. They've since become friends. "I said to him, 'You saved my life. If you hadn't let me out, I would have stayed stuck in the system, and literally it would have killed me. You gave me the option to get out and rebuild my life. Thank you.'"

CHAPTER 22

DOES FORCED TREATMENT IMPROVE MENTAL HEALTH?

Detention and forced treatment are core, routine aspects of mental health systems around the world. So, regardless of an issue as subjective as subsequent gratitude, one might assume that the objective scientific evidence supporting these practices is strong—overwhelming, even.

I went looking for evidence that forcibly treating people in psychiatric hospitals improves their mental health or has other positive outcomes for them, over the short or long term. I found a well-worn trail of people who'd gone before me, all coming up empty-handed.

* * *

The National Institute of Mental Health pointed me to two studies on forced treatment over twenty years, neither of which examined effectiveness or outcomes. They declined my interview requests.

The Substance Abuse and Mental Health Services Administration media relations office apologized for not responding previously and promised to respond this time, then never did.

The American Psychiatric Association did not respond to requests for an interview. Their official position statement on involuntary hospitalization and treatment declares the practice to be a "public responsibility" but, unlike some of their other position statements, provides no evidence or scientific citations. Their position on forcibly treating people living in the community acknowledges that there's "no broad consensus" on its effectiveness (see chapter twelve).

Since the end of the scandalous era of abusive large asylums, US- and Canadian-based researchers have virtually never tackled the question of whether or not contemporary methods of forcibly hospitalizing people helps them. A 2006 review of studies of outcomes of involuntary hospital admissions by British researchers found only eighteen studies internationally. The authors commented that these relatively weak studies left nothing but mysteries as to "the reasons why some patients show substantial improvement and/or positive attitudes, whereas others are displeased with the treatment they received or do not improve clinically." A 2014 international review by Italian researchers similarly found "only a few" studies of good quality examining outcomes after coercive psychiatric measures. In 2016, a study of coercion in mental health care published in the *British Journal of Psychiatry* found that "robust evidence is hard to come by." These authors said the evidence that does exist, though, suggests that forced treatment "is not associated with improved outcome." Even the references that psychiatrist and pro-force ideologue E. Fuller Torrey emailed me, when I delved into the studies instead of relying on his summaries, made statements like, "There is no scientific evidences [sic] from controlled studies" about the effectiveness of involuntary treatment. When I pointed this out, Torrey acknowledged, "I am not aware of other studies showing that involuntary hospitalization or treatment have positive outcomes."

So, what about specific aspects of coercive care?

An international review by Spanish researchers found that the use of seclusion, physical restraints, and chemical restraints were "very common in psychiatric hospitalization" despite a "remarkable lack" of evidence to support their use.

A review by the international Cochrane Collaboration similarly found that, "No controlled studies exist that evaluate the value of seclusion or restraint" in psychiatric care, despite many reports showing "serious adverse effects." A later Cochrane review examined other management approaches used in inpatient settings such as locked wards, constant monitoring, larger staff ratios, and so on. The authors concluded that these approaches "are not supported by evidence" and are "difficult to justify."

Psychiatrists routinely prescribe tranquilizing and sedating psychotropics in inpatient settings for nurses to give "as required" in "emergencies." Some studies found about 50 percent of patients in locked wards are given these extra dosages as frequently as ten times in less than a week. Is this helpful or effective? Is it better than giving the same drugs regularly, or not at all? Is it even safe? A Cochrane review "found no trials" examining these questions. "Although the practice of using medication 'as required' is common," the authors wrote, "there is currently no good evidence as to whether this is the best way of helping people."

A 2016 study in *PLOS One* summarized, "Despite the widespread use of coercive measures . . . there is a remarkable lack of empirical evidence as to their association with treatment outcomes." The European authors pointed to another recent review of the international literature that found only thirteen studies in modern history of effectiveness of civil commitment and forced treatment, all of "poor" quality, that reported "mixed" findings. "Psychiatric forced medication is a remarkably under-studied practice," they wrote. And like most other researchers, they found that "use of forced medication is associated with patient disapproval of treatment" and has "toxic" impacts on patient attitudes.

In a 2012 paper, "Involuntary Treatment in Europe: Different Countries, Different Practices," psychiatrist Torsten Jacobsen called for change. Jacobsen was the chair of the Danish Psychiatric Association, sat on the European Board of Psychiatry, and was president of the Psychiatry section of the European Union of Medical Specialists (UEMS). With members in thirty-seven countries, UEMS represents 1.6 million medical specialists aiming to enhance "the study, promotion and harmonisation" of "the highest level" of scientific practices.

In the paper, Jacobsen summarized that involuntary treatment appears to be "based on tradition rather than evidence." Jacobsen pointed to a review of uses of emergency psychiatric evaluations, detentions, seclusion, restraints, and forced drugging regimens in Western countries, and noted there were vast variations in hospital practices without "any obvious reason for the differences." The best explanation appeared to have nothing to do with patient characteristics, different health care systems, or effectiveness of methods, wrote Jacobsen, but simply local hospital staff's attitudes and habits.

Like everyone else, Jacobsen also found no reliable scientific evidence that forced treatment helps people. "When we subject patients to involuntary measures, the least we can do is to monitor their clinical outcome," he wrote. "Otherwise, we cannot tell whether treatment is effective."

Jacobsen then wrote that he hoped to spearhead change in this long "neglected and overlooked" core aspect of modern mental health systems. "The UEMS section of Psychiatry has taken up the challenge to provide guidelines for monitoring involuntary treatment." European psychiatrists would lead the charge in “benchmarking” the appropriate scientific monitoring of civil commitment practices, and then develop and disseminate “best practices,” with the goal “to safeguard patients’ autonomy and right to effective treatment.” The time of psychiatrists forcibly treating people based on their “gut feeling” was over, declared Jacobsen, and would soon be replaced by a new, “enlightened stage” in modern psychiatry. “If we succeed in proving effectiveness, we can also improve the image of psychiatry and acceptance of involuntary treatment,” he wrote.

But in 2019, researchers linked to the World Health Organization (WHO) conducted a comprehensive narrative review of the evidence and summarized yet again that there is “very little research” into the effectiveness of civil detention and involuntary treatment. The authors stated, “It is paradoxical that coercive interventions in mental healthcare continue to be used extensively although there is little evidence they confer any clinical benefits. Available research does not suggest they are clinically effective, improve patient safety or result in better clinical or social outcomes. In contrast, coercive practices are often associated with negative outcomes for patients with significantly adverse impacts on satisfaction and quality of life . . . Many of those subjected to involuntary admission do not feel it is justified or beneficial and tend to recall their experience as highly distressing and even traumatic.”

The WHO authors argued that internationally rising rates of forced treatment represent a “system failure” that’s linked to “entrenched problems” rooted in psychiatry’s historical tendencies to override people’s basic human rights. Consequently, the authors concluded, turning back the tide “will require more than legislative tinkering and will necessitate a fundamental change in the culture of psychiatry.”

The UEMS Psychiatry division apparently concluded something similar. In early 2022, I asked UEMS Psychiatry what follow-up work they’d done in the wake of Jacobsen’s public pledge to establish standards for best practice in coercive treatment. UEMS told me that they were in fact close to issuing a report—one that would instead establish standards for “best practice in using alternatives to coercive approaches.”

* * *

Notably—though it’s obviously less likely to cause harm—there’s so far little evidence that hospitalization is effective at helping *voluntary* patients, either. A review in *Archives of Psychiatric Nursing* concluded, “There is a dearth of literature related to client outcomes after inpatient psychiatric treatment.” Some of the best evidence we have—though the researchers themselves usually struggle to downplay or dismiss their own findings—are studies that show suicide rates skyrocket after psychiatric hospitalization even among previously non-suicidal people (see chapter ten).

More generally, even though there are endless pleas for ever more funding, there’s little monitoring of real-world outcomes from our mental health service systems as a whole. Are patients who are treated voluntarily or involuntarily feeling better overall, functioning better, getting jobs, finding homes? One of the only such monitoring programs I found in North America was King County, Washington’s “Mental Health Report Card.” Over nearly a decade, the same findings were reported each year: Some patients receiving mental health services got jobs, some lost jobs, the majority experienced no change. Some got homes, some became homeless, the majority experienced no change. And so on. In 2016, the county stopped issuing the reports.

This dearth of real-world evidence that the hundreds of billions of dollars spent annually in America are truly producing helpful outcomes for people and society as a whole was flagged in a 2016 National Academy of Medicine discussion paper. A diverse team of psychiatric researchers from major universities and the National Institute of Mental Health called for the “[d]evelopment and implementation of clearly measurable standards” for outcomes in mental health care services.

* * *

All of this inevitably raises the question as to whether governments and psychiatrists tend to *avoid* doing serious studies of real-world outcomes of involuntary treatment. Do they already suspect the findings would provoke embarrassing, even damning public questions?

CHAPTER 23

“SAFE” AND “EFFECTIVE”?

Psychiatric medications have been scientifically demonstrated in clinical trials to be effective for *voluntary* patients. So, even in the absence of evidence from large-scale, real-world outcomes, can’t we by extension reasonably presume these treatments are effective for involuntary patients, too?

Though, perhaps we should first clarify what “effective” means: How effective, at doing what?

* * *

The National Alliance on Mental Illness (NAMI) website tells us that psychotropic drugs are not only “safe and effective” but “protect brain cells from damage caused by brain illnesses.” And psychologist Xavier Amador writes in a book distributed by NAMI that psychotropics are “like insulin for diabetes.” The American Psychiatric Association similarly declares that mental illness “is a medical problem, just like heart disease or diabetes.”

WebMD tells us that antidepressants treat depression “by balancing chemicals in your brain called neurotransmitters.” Healthline, another popular medical website, states that antipsychotics treat bipolar disorder “by blocking brain chemicals dopamine D2 and serotonin 5-HT2A receptor activity.”

Free speech laws give a lot of leeway to health websites, mental health organizations, medical doctors, psychiatrists, and news media—which is a major reason pharmaceutical companies lavish money on them. All of the above statements are flatly fraudulent and illegal if directly uttered by psychiatric drug manufacturers themselves.

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Profits in pharmaceuticals are now rivaled only by the energy, technology, and financial sectors. And financial conflicts of interest in clinical trials, academic research institutions, health websites, health organizations, and news media organizations are rampant. Marcia Angell, the former longtime *New England Journal of Medicine* editor, wrote in 2009, “It is simply no longer possible to believe much of the clinical research that is published, or to rely on the judgment of trusted physicians or authoritative medical guidelines.”

In a 2011 exchange with psychiatrists in the *New York Review*, Angell added, “I have spent most of my professional life evaluating the quality of clinical research, and I believe it is especially poor in psychiatry. The industry-sponsored studies usually cited to support psychoactive drugs—and they are the ones that are selectively published—tend to be short-term, designed to favor the drug, and show benefits so small that they are unlikely to outweigh the long-term harms.”

Since Angell wrote her 2004 book, *The Truth About Drug Companies: How They Deceive Us and What to Do About It*, conflicts of interest and resulting medical misinformation emerging from manipulated clinical trials have only deepened and broadened, as described in subsequent books such as Ben Goldacre’s *Bad Pharma: How Drug Companies Mislead Doctors and Harm Patients*, David Healy’s *Pharmageddon*, Peter Gøtzsche’s *Deadly Medicines and Organised Crime: How Big Pharma Has Corrupted Healthcare*, and Joel Lexchin’s *Doctors in Denial: Why Big Pharma and the Canadian Medical Profession Are Too Close for Comfort*.

From 2016 to 2017, I had a unique opportunity to collaborate as lead writer and editor on several research projects with ex-patients, psychiatrists, psychologists, pharmacologists, and others through Inner Compass Initiative, a new US nonprofit seeking to educate people about psychiatric drugs and tapering. In one project, we wanted to summarize the basic safety and effectiveness of the main classes of psychotropics—but how to do that with so much unreliable research to wade through? We hit upon a more manageable approach: we decided to open a window into how the Food and Drug Administration (FDA) decided to approve common psychotropics. After all, gaining access to the market as a “safe and effective medication” is where the rubber hits the road.

The FDA itself, though, has been widely criticized for its growing dependence on pharmaceutical industry funding and its porous conflict-of-interest firewalls as high-level staff move back and forth between working at the FDA and in the industry. And indeed, delving into the FDA's internal records changed my whole understanding of what the words *safe* and *effective* have come to mean in psychiatry.

* * *

In drug-approval trials, the effectiveness of psychotropics is never determined by looking at their effects on brain chemistry. Indeed, the FDA-approved manufacturers' drug labels for all psychotropics make it clear that the drugs' mechanisms of action are "unknown." So, for example, when Otsuka advertised that its antipsychotic Abilify "modulates both synaptic dopamine and serotonin," the FDA notified the company it was violating the law. The FDA told Janssen its claims that its antipsychotic worked by acting on a "specific receptor" in the brain were "false or misleading because the mechanism of action of Risperdal is unknown." The FDA reprimanded Pfizer for making a model brain showing how its anti-anxiety drug worked: "This suggestion of proof of the mechanism of action is false."

Essentially, while psychotropic drugs are known to impair, mimic, or alter the operations of many of the dozens of different neurotransmitter communication systems in the brain, central nervous system, organs, and the endocrine, cardiovascular, digestive, metabolic, and reproductive systems, no one has so far been able to untangle how any particular drug effects may or may not relate to any common mental disorders—that is "unknown."

Consequently, in scientific studies submitted by drug companies to the FDA, the efficacy of psychotropics is actually measured simply using symptom-checklist tools that are much like the mental health screening questionnaires described in chapter two. And it takes very little apparent subjective change, over very little time, to get a psychiatric drug approved as "effective."

The antidepressant Paxil's effectiveness in treating generalized anxiety disorder was evaluated in two clinical trials that lasted only eight weeks. Participants' apparent "anxious mood," "fears," and "tension"—along with how often they sighed, felt giddy, or had to pee—were rated on point scales of zero to four. On average, out of fifty-six possible points, those taking Paxil scored only two to three points lower than people taking placebo pills. Paxil was on this basis approved by the FDA as effective for treating anxiety. Meanwhile, eight times as many people taking Paxil complained of decreased libidos.

Over two six-week trials, the people taking the benzodiazepine sedative Klonopin were rated as about 20 percent less anxious. And they had about one-and-a-half panic attacks weekly while people on placebo had about two. On that basis, Klonopin got approved as effective in treating panic disorder. Meanwhile, the people taking Klonopin reported feeling more exhausted and, when they later tried to get off the addictive drug, they experienced more anxiety and panic attacks than they'd ever had before.

In many cases, the drugs actually failed to show any efficacy, but manipulations got them approved, anyway.

Across four clinical trials, the antidepressant Zoloft was declared ineffective in treating post-traumatic stress disorder (PTSD); however, the FDA still approved Zoloft for PTSD, because the drug appeared somewhat effective for a subgroup of the participants in two of the trials.

Five clinical trials found the mood stabilizer Lamictal ineffective for short-term treatment of bipolar disorder; nevertheless, the drug company GSK then proposed testing Lamictal for *long-term* treatment of bipolar disorder. The FDA called this proposal "novel." During two eighteen-month trials, Lamictal again failed to beat placebo. However, GSK and the FDA repeatedly redefined what a "relapse" or "mood episode" might be until, after the trials were done, they found a way of describing "mood episode" that made the drug look slightly more effective at preventing mood episodes than placebo, and Lamictal got approved.

The evidence in literally every trial we reviewed was similarly insubstantial. And larger, more formal reviews of drug trials submitted to the FDA have reached comparable findings.

Irving Kirsch, currently associate director of the Program in Placebo Studies and a lecturer in medicine at Harvard Medical School, famously revealed that most SSRI antidepressants beat placebo by only about two points out of fifty on the Hamilton Rating Scale for Depression. How much is two points? If you've stopped "wringing" your hands and "pulling" your hair, and now are "fidgeting" with your hands and "playing" with your hair, that's two points of improvement. If you no longer "appear" apprehensive, but only "feel" that way, that's two points better. If your "suicidal ideas" get replaced by a feeling that "life is not worth living," that's two points of improvement.

In 2020, FDA researchers themselves reviewed data for drugs approved to treat schizophrenia between 1991 and 2015. Generally, people who took antipsychotics scored about four points lower than people taking placebo, out of 210 possible points on the commonly used Positive and Negative Syndrome

Scale (PANSS). How much is four points on the PANSS? If your conversational "rapport" with your psychiatrist changes from "extremely" bad to "moderately severely" bad, and your mannerisms and posture shift from "abnormal" to "slight awkwardness," that's four points improvement.

Meanwhile, the placebo effect in nearly all of these trials was usually so massive, one could only surmise that most research psychiatrists chronically lie or delusionally inflate their ratings. Or that most patients desperately want to believe drugs can help them. Or that scientists merely showing attentive interest in others' inner experiences can be remarkably curative of everything from mild depression to severe schizophrenia. Or *all of these* may be going on?

In any case, in light of how comparatively little the drugs themselves seem to help, should we be *forcing* millions of people who don't feel benefits to suffer their adverse effects? And how safe are these drugs, anyway?

* * *

"Safe is a relative concept," Marc Stone told me. "It's basically, 'We do think there are situations in which the benefits outweigh the risks.' And that's basically all we can say." Stone, a physician and the Deputy Director for Safety in the FDA's Office of New Drugs, continued: "There are situations in which things just look so bad from a risk-benefit standpoint that we say, 'No, we can't in good conscience put this drug on the market.' But most of the time, if we can establish a drug is effective, then the question of whether the risk-benefit is worth it is going to depend a lot on the decision for the individual patient. Which is something that is the practice of medicine and not something that we try to determine at FDA."

Essentially, a drug aimed at treating the last stages of terminal cancer is understandably permitted by the FDA to have a much riskier, harmful side-effect profile than a chemical for removing common warts. And Stone explained that the FDA's harm-vs.-benefit calculations for psychotropics often occur amid assumptions that some unknown percentage of people diagnosed with any mental disorder have something more like terminal cancer than common warts, and might kill themselves or otherwise die due to their struggles. With this in mind, only very rarely has the FDA considered a psychiatric drug to be *too* dangerous.

Indeed, Stone expressed frustration that many physicians and people taking psychiatric medications assume FDA approval means "extremely safe," and fail to critically evaluate the risks themselves. “You have to ask, ‘Is it worth it?’ And that’s often a question that depends on the patient, the patient’s particular circumstances, the degree of disability,” said Stone.

Lithium is so toxic it was once banned altogether. It damages the thyroid and renal function, and causes goiters and cognitive and memory impairment. A study of long-term users found kidney disease in nearly half of patients. Other mood stabilizers like Lamictal can cause life-threatening rashes and organ failures. Depakote can cause blood disorders, acute liver damage, life-threatening pancreatitis, and elevated levels of ammonia in the blood and brain that can lead to severe neurological disorders and death. Anti-anxiety benzodiazepines can cause intense addiction within weeks, blurred vision, severe muscle spasms, and seizures. Antidepressants can cause blood disorders, lung disease, seizures, and life-threatening serotonin syndrome. Stimulants retard children’s growth and cause heart attacks.

Antipsychotics are the most harmful. They cause dramatic weight gain and—ironically in light of claims they’re like insulin for diabetics—cause high rates of diabetes. They can cause cognitive impairment. Loss of sexual function. Heart disease. Their impacts on metabolism and immunity cause dramatically increased death rates during heat waves, and from Covid-19. After five years on antipsychotics, 30 percent of patients have already developed tardive dyskinesia—permanent neurological damage that causes motor dysfunctions such as drooling, tongue-wagging, tremors, and shaking. And akathisia affects as many as 45 percent of users.

Tim Lee’s tragic story is an example of what can happen. In 2021, Lee was sixty-five and working in computer repair. As an Asian American child in a white Massachusetts suburb, he was often bullied. He developed paranoid feelings and, in adulthood, got forcibly hospitalized several times. Only gently pressured, Lee eventually agreed to take antipsychotics and, he told me, he felt grateful to avoid more hospitalizations. But the drugs gave him sexual dysfunction and lactating breasts. A different antipsychotic put him “in a stupor,” he said, and he gained enormous weight and developed diabetes. After many years, a doctor helped Lee taper to a lower dose so he could go back to work, and also prescribed a drug to help with the diabetes. The diabetes drug is now the target of class-action lawsuits for allegedly causing pancreatic cancer. Several months after our interviews, Lee died from pancreatic cancer.

* * *

Stone said occasionally the FDA declines to approve a drug because it's no more effective than a drug already on the market yet is significantly less safe. "We've had drugs, for example, for ADHD, that are stimulants that seem to produce a higher rate of psychosis than other stimulants. So we don't think they're necessarily a good choice."

That highlighted another issue. The FDA-approved manufacturers' drug labels identify that most psychotropics can sometimes cause hypersensitivity, mood swings, suicidal ideation, psychosis, agitation, rage, hallucinations, delirium, and more. Worse, many psychotropics get metabolized in ways that, when combined with common substances such as coffee, alcohol, cigarettes, marijuana, opioids, or certain foods and herbs, can induce highly volatile reactions that cause the blood serum levels of psychotropics to perilously rise or drop twofold, fourfold, or more. The drug labels warn physicians about such interactions, but it's rare to find patients, families, or even average doctors who are fully aware. Furthermore, some psychotropics are addictive (causing cravings), but over time virtually all cause physical dependence to form, leading to difficult withdrawal effects like "rebound psychosis" that can last weeks, months, or even years as the brain readjusts. Meanwhile, most clinical trials are highly controlled and last only weeks or a few months, yet many people take psychotropics for years in combination with other substances, vastly increasing the odds of both serious adverse effects and severe withdrawal reactions. How hazardous are these drugs under real-world conditions?

Stone acknowledged that long-term adverse effects after twelve weeks are a major gap in the FDA's safety evaluations. "We get post-marketing reports, but if something is subtle and slow to develop, then it's hard to distinguish that from some condition that may be completely unrelated to the drug," he said. A disturbing example: evidence suggests that long-term use of antipsychotics causes irreversible brain damage, but some scientists propose that mental disorders are somehow causing the brain damage—the dearth of reliable large-scale, long-term, placebo-controlled studies allows psychiatrists to affirm whichever belief they prefer.

So, millions of people are being forced to take medications that could make them psychotic or throw them into violent rages at a statistically measurable rate, seriously harm their bodies, or literally kill them—and yet these medications are demonstrably barely effective at reducing symptoms of mental disorders. This raises the question: Is there some other reason these drugs are so commonly used—something that they're actually *very effective* at doing?

* * *

Psychiatrist Sandra Steingard told me that her own readings of scientific studies changed her thinking about what psychotropics do effectively, and about involuntary treatment.

Retired from daily practice in 2019, Steingard still edits the journal of the American Association for Community Psychiatry. Early in her career, while working in the University of Pittsburgh's inpatient schizophrenia unit, she adopted the "biomedical model," she said, and came to believe psychotropic drugs acted directly on brain-based, biochemical causes of mental disorders.

However, in the wake of the blockbuster success of the antidepressant Prozac in the 1990s, a wave of new psychotropics was hitting the market, and she was soon dismayed to witness how psychiatry as a field got wrapped up in the "grotesque marketing" of the rapidly expanding psychopharmaceutical industry.

Steingard was deluged with pharma offerings at home and at the office, including balls and balloons for her kids, hand-delivered bagel baskets, weekly invitations to free lunches or luxurious dinners with drug company representatives, and all-expenses-paid conferences in exotic locales.

Steingard saw news media and the general public getting swept up in the same fervor of believing mental disorders were chemical imbalances for which psychotropics were targeted cures. She frequently spoke at NAMI gatherings. "They looked at me and took everything I said as gospel."

The weight of her voice in commitment hearings also grew, as attorneys and judges became similarly convinced psychotropics were like insulin for diabetics. "It was shocking how much power I had. When I would go in there, a well-educated doctor, the weight of my word was much, much heavier than the weight of the words of my patient." And she'd watch public defenders whiz through fifteen-minute hearings for twenty clients in a day. "You could not say with a straight face that people had good representation."

For a time, though, she made peace with the process. "I had this paternalistic idea, like I'm doing the thing that's best for this person, and this is for the greater good."

But it started becoming too obvious, she said, that psychiatrists would skew scientific evidence to support whichever pharmaceutical company was paying them. And when leading, reputable psychiatrists started suppressing the evidence that all antipsychotics cause massive, rapid weight gain—a fact Steingard had been witnessing in patients for years—that's when she became "livid" with what was happening. “I looked up to these people. It was awful.”

In 2011, Steingard read science journalist Robert Whitaker’s *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America*. Whitaker reviewed all of the long-term studies of psychiatric drugs—of which there is a scandalously small number—and found that over years the drugs became increasingly associated with worsening impacts on psychiatric symptoms, cognitive capacity, mood regulation, general health, functionality, and quality of life. Similar people who avoided or tapered off psychotropics tended to do better. “He raises the question whether these drugs in the long term do more harm than good,” said Steingard. “That led to a huge crisis. Because I’d spent my career trying to convince people to stay on these drugs.”

Her scientific curiosity stirred, Steingard delved into the original research Whitaker drew on. She was also influenced by UK psychiatrist Joanna Moncrieff.

In books like *The Bitterest Pills: The Troubling Story of Antipsychotic Drugs*, Moncrieff describes two contrasting beliefs about how psychiatric drugs work. She calls them the “disease-centered model” and the “drug-centered model.”

In the disease-centered model, psychiatric medications correct chemical imbalances in the brain. Other impacts of the medications, even very common ones like sedation, mental numbing, energetic stimulation, or tranquilization, get called “side” effects. But science has not identified any brain chemical imbalances that common psychiatric medications correct; there’s still no proof for the disease-centered model.

In the drug-centered model, though, psychotropics work like a mind-altering drug or painkiller. Some people find alcohol helpful to alleviate stress, but no one suggests these people’s brains have “alcohol deficiency.” Similarly, then, the most common psychotropic effects like sedation, numbing, energizing stimulation, or tranquilization can be understood as these drugs’ primary effects rather than as side effects. And there’s abundant evidence supporting this drug-centered model; namely, millions of people’s descriptions of how the drugs actually affect their minds.

These are not novel notions. Prior to the 1980s and ’90s, notes Moncrieff, antipsychotics, for example, were regularly described in the psychiatric literature and medical advertising as “tranquilizers” and “chemical restraints.” However, with widening use, the idea that we were putting people in chemical straitjackets became less palatable than the belief that the drugs had brain chemical imbalance–correcting “anti-psychosis” properties.

Chemical imbalance theories have “helped to present psychiatric activities as fundamentally therapeutic rather than coercive,” writes Moncrieff. “It was only with the disease-centered model that forcible drugging could be presented as a treatment for the patient’s underlying disease.” Medical models of mental illness can alleviate guilt about imposing forced treatment.

Today, our hospital regulators speak twin-tongued. The Centers for Medicare & Medicaid Services, for example, calls sedating and tranquilizing psychotropics “chemical restraints” when they’re given to restrain, but not if the purported intent is “treatment”—even though the dosages and effects in both situations are often the same.

Views like those of Whitaker and Moncrieff are becoming ever more widely acknowledged. In his 2022 review of decades of studies, psychiatrist and clinical-guide author Nassir Ghaemi of Tufts and Harvard universities became the latest prominent researcher to state that psychiatric diagnoses are “non-scientific,” that psychotropics have “no known or proven effect” on any “underlying disease,” and that most psychiatric medications are like “50 variations of aspirin” and “do not show long-term benefits.”

Eventually, Steingard came to a new perspective on her own years of clinical observations. Rather than seeing antipsychotics as “curing” psychosis, Steingard said she gradually concluded that the drugs tend to create dullness, indifference, and reduced motivation, but these effects “may have benefits for some people. That dulling may help them calm down.”

Basically, many psychotropics, and especially antipsychotics, are extremely effective at numbing, tranquilizing, or chemically restraining people’s minds. And that’s why they’re so useful in forced treatment. However, Steingard added, “If you dull down motivation and cognition over years and decades, you may also see long-term consequences such as poorer functional outcomes.”

By this time, Steingard was working at a community clinic in Vermont, with clients who were mostly poor and sometimes getting into trouble with their families or housing providers in ways that could potentially get them kicked out of their homes. Steingard no longer tried to convince these clients that psychotropic drugs cured illnesses. Instead, she’d explain that the drugs could help “contain” some of the behaviors that were getting them into trouble with others.

Nevertheless, she still didn’t see this approach as a true solution; the “power differential” between her and the patients remained too vast. “The problem is, doctors tend to be conservative, because we do worry about risk.”

Steingard stops short of suggesting forced treatment should never happen, but believes the system needs an overhaul that would include more robust protections for patients who often have legitimate reasons to decline drugs.

“What I’ve come to is: It’s harmful. Forcing treatment does harm. It’s brutal,” said Steingard. “If it was me, if some random psychiatrist had that power over me . . . That thought frightens me.”

And notably, drugs are not actually the most dangerous psychiatric treatments that can be administered against our will.

CHAPTER 24

ELECTROSHOCK AND PSYCHOSURGERY

"I have dense, pervasive memory loss for the first thirty-six years of my life," Sarah Price Hancock told me. "I have maybe 2 to 5 percent of my long-term memory left." Now forty-six, Hancock is bright, smart, and energetic, and frequently playful, sardonic, and funny—at least, that's how she appeared at the beginning of our video conversation. She cautioned me that, due to the severity of the brain damage, she could currently only function and speak at this level for an hour or two per day. She also said her formation of new memories was especially poor for things she wasn't exposed to or reminded of daily—so she might completely forget our interview later.

With involuntary psychiatric interventions hitting all-time highs, it's concerning that electroshock continues to be widely used and surgical brain interventions are making a comeback—their adverse impacts are often irreversible.

Electroconvulsive therapy (ECT) involves directing electrical shocks into the brain at about four to six times the intensity required to induce grand mal seizures while under general anesthesia. ECT has long been controversial. Like my father, Hancock suffered memory losses, apparently caused by brain damage—but hers were frighteningly worse. Hancock explained to me that she'd reconstructed much of her past through her family's help, and by reading her medical records and journals.

Hancock had an ordinary childhood growing up near San Diego, and studied at Brigham Young University (BYU). After developing pneumonia in her twenties, she was prescribed antibiotics and a steroid inhaler, and she suddenly started hearing voices and having other symptoms of psychosis. She was immediately given psychiatric drugs against her will.

“If they would have listened,” said Hancock, “they could have heard me say, ‘I didn’t have psychosis until you prescribed this medication.’ But they just saw this person as floridly psychotic.”

Seventeen years later, Hancock would be diagnosed with a long-standing, chronic hepatic encephalopathy precipitated by a liver fungal infection. An infected liver can sometimes toxify the brain and cause symptoms that look like serious mental disorders. Steroids, antibiotics, and psychotropics are known to worsen the condition.

But in 1998, Hancock wasn’t tested for hepatic encephalopathy, and over the next decade she was given dozens of psychotropics and labeled with depression, bipolar disorder, catatonia, schizoaffective disorder, and more. Psychiatrists started giving her ECT against her will as well—ultimately, she received 116 shocks, nearly six times as many as my father received.

Eventually, Hancock could no longer picture the faces of her own parents. She couldn’t navigate the city she’d grown up in. She began to lose the ability to do basic tasks. Formerly an editor of BYU faculty papers, Hancock now struggled to read and couldn’t type. “I could no longer do basic math. I had to relearn everything. I had lost much of my vocabulary.” She suffered persistent loneliness due to the loss of memories previously shared with family and friends. Her spatial orientation and physical functioning were also affected. “I could not walk through a doorway without slamming into my shoulder. I’d be in the middle of talking to someone and I’d just fall backwards.”

At the beginning of our conversation, Hancock had a mild twisting action in her mouth and a slight slur. An hour later, she’d degenerated into struggling to press out each individual word, like someone with a severe speech impairment. She pushed through, trying to explain what she’d learned about what I was now witnessing, the impacts of repeated electrical brain trauma on electrolyte levels, calcium-sodium regulation, channelopathy, brain microbleeding . . .

We agreed to continue another day. I disconnected the video, and wept.

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Over four hundred US hospitals perform ECT, as do many in Canada. Tracking is poor, but it appears that at least tens of thousands of North Americans every year receive it—an unknown number against their will—generating hundreds of millions of dollars or more in revenues for hospitals.

The University of Texas hospital website offers a description typical of what patients are told: “ECT is a safe and painless procedure . . . A finely controlled electric current is administered for less than one minute, creating a brief seizure in the brain.” While it’s not clear how ECT “works,” the website suggests rosily, “Theories suggest that this process may improve the way brain cells communicate with each other, help new brain cells to form, or help increase the amount of the brain’s ‘good chemicals’ that naturally reduce depression.”

Conversely, biomedical engineer Kenneth Castleman testified in an ECT lawsuit that a single, typical ECT shock is “about 200 times what is considered dangerous for ground fault leakage, approximately 100 times what Tasers, cattle prods, and electric fences use, about the same as what is used for stunning pigs, and roughly one-fifth as much as the electric chair.” Therefore, brain damage and memory loss, critics say, are ECT’s “cure” for depression.

The vast “reality gap” between these two characterizations has become emblematic of ECT discussions—within medical journals as much as in news media.

“The scientific and clinical evidence base for the efficacy and safety of ECT is large,” wrote prominent pro-ECT psychiatrist Charles Kellner, for example, in a 2011 article in *Psychiatric Times*. “In fact, there is a remarkably wide gap between what anti-ECT activists claim and the very substantial body of clinical and scientific evidence.”

In fact, there’s a remarkably wide gap between what Kellner claims and what the FDA’s independent scientific advisory committee on ECT found.

ECT devices were “grandfathered” in by the FDA from the 1930s and have never undergone formal testing for efficacy and safety. In 2009, the FDA struck an independent scientific advisory committee to examine the issue, and provided the committee with its own staff review of the existing scientific research.

The FDA found that ECT’s slightly positive impacts on depression lasted at most one month, and just achieving that required shocks every two days for three weeks. For other mental disorders, there was even less evidence for effectiveness.

The stronger the shocks were, the stronger the efficacy was, obtained “at the expense of increased memory and cognitive impairment,” stated the FDA. Anywhere from 29 to 79 percent of patients experienced enduring memory losses. And ECT’s long-term impacts on memory and cognitive and executive functions had never been adequately studied.

Meanwhile, ECT device manufacturers warned of the possibility of brain damage, and the American Psychiatric Association’s ECT guidelines acknowledged that some patients report “devastating cognitive consequences,” including “dense amnesia extending far back into the past,” and cognitive function “so impaired that the patients are no longer able to engage in former occupations.”

In 2011, the FDA’s independent scientific advisory committee recommended that the effectiveness and safety of ECT devices should finally be formally evaluated like other common, modern medical devices. But psychiatrists such as Kellner railed against this recommendation as unnecessary and potentially constraining of ECT’s uses, and the FDA hesitated to make a decision.

* * *

With the aid of friends, Hancock managed to flee psychiatric care. By 2015, she’d gotten the ECT stopped, tapered off the psychotropics, begun to manage her liver infection, and recovered enough functionality to become a rehabilitation counselor and adjunct professor at San Diego State University. But since 2017, she said, her physical condition has been degenerating. She must use a powered wheelchair. She has full speech functionality only intermittently. She experiences tetany seizures, vomiting, and loss of motor coordination that can at times stop her breathing.

But like many ECT recipients, Hancock has been unable to find any psychiatrists with expertise in, or willingness to assist with, managing adverse impacts from ECT. And other medical specialists are so reluctant to get ensnared in ECT controversies, many refused to formally evaluate her, let alone assist her. “I’ve had so many people tell me to my face that, ‘Yes, ECT caused this.’ And then they’re not willing to go on record,” said Hancock. “Doctors say, ‘I don’t go out of my lane.’”

Even a renowned American multi-university, multi-disciplinary rehabilitation institute for electrical trauma, with several psychiatrists on staff, declined to assess her, Hancock told me. I repeatedly contacted the institute myself asking about ECT injuries, and was ignored. Eventually I got the director on the phone, who talked with her team and then invited Hancock to get in contact. When Hancock told me she never heard back, I investigated and got no response from the institute.

For several decades, there’s been a vocal group of psychiatrists like Kellner, often connected to ECT device manufacturers, who launch vitriolic public attacks against anyone who prominently criticizes ECT.

For example, Kellner has bemoaned public fears about electroshock and blamed the “cry of ‘brain damage’ from the anti-ECT contingent.” Kellner has claimed critics are linked to “organizations that are antipsychiatry” like the “Church of Scientology.”

University of East London psychologist John Read, Harvard’s Irving Kirsch, and renowned psychologist Richard Bentall have in recent years coauthored reviews in medical journals that, like the FDA’s review, found most studies of ECT’s efficacy to be of generally poor scientific quality. Read later collected responses to his journal articles that came from pro-ECT psychiatrists, such as: “misinformation,” “sophistry,” “so extreme that to respond to them might give them a legitimacy that they do not deserve,” “polemic dressed in the clothes of a scientific review,” “misunderstanding of the tenets of evidence-based medicine,” “adds very little to anything approaching reasoned scientific debate,” and so on.

In the trade journal *Psychiatric Times* in 2021, Read, Hancock, and a medical doctor who had to retire after receiving ECT coauthored a scientific essay. Kellner and a coauthor didn’t address any specifics of the essay, but wrote in response that criticisms of ECT were too often just “misinformation and distortions” based on “ignorance” and “ideologically driven” attitudes “with questionable motives.”

* * *

Finally, a behavioral optometrist examined Hancock and found twenty-six eye-brain connectivity problems common to brain injuries. An ear, nose, and throat specialist diagnosed her vestibular and balance problems as rooted in brain injury. And Hancock found a workplace electrical injury specialist who confirmed that much of what she’s experiencing is common among survivors of extremely intense electrical shocks.

But even getting this far toward understanding what’s happening and learning ways to potentially slow the damages has been a long battle, said Hancock.

I asked her how she managed to navigate it all emotionally. At times she had to “treat it like a game” that she was learning, she said; otherwise she could “get really caught up in how bad things are.”

The FDA nearly always follows the recommendations of its independent scientific advisory committees. But in 2018, the FDA avoided media coverage by announcing in the wee hours after Christmas Day that ECT devices, when used to treat depression, would never be required to undergo testing for safety or effectiveness.

The FDA did mandate that ECT device manufacturers openly disclose that “[t]he long-term safety and effectiveness of ECT treatment has not been demonstrated.”

For many, this carte blanche given to electroshock raises the specter of psychiatry’s grim history of other harmful, invasive “treatments” from bloodletting to the lobotomies that put many people into near cognitive-emotional catatonia. Concerns are not misplaced; while many such treatments fell out of favor among psychiatrists, they were never legally banned. And some are coming back.

A 2019 *Journal of Legal Medicine* study reviewed regulations on psychosurgery in all US states. “Psychosurgery” can encompass anything from the inserting of microchip brain implants to a lobotomy’s catastrophic severing of connections to the frontal lobes.

Seventeen states have no regulations limiting any forms of psychosurgery. Most have some regulations, but these rarely amount to bans. Some simply specify that psychosurgery performed against someone’s will must be authorized during the civil commitment hearing process. Others require a second medical opinion or consent of a substitute decision maker. Some ban psychosurgery in state hospitals or on criminal prisoners. Most don’t even ban psychosurgery on children; for example, Idaho law states that no psychosurgery shall be performed on a child “except by order of a court upon a finding that the treatment is necessary.” California is one of only a few states that seem to fully illegalize all forms of psychosurgery on involuntary patients.

Over the past fifteen years, occasional reports have surfaced of psychiatrists performing psychosurgeries at US and Canadian hospitals—often promoted with the same breathless hype as lobotomies once were when the technique won the 1949 Nobel Prize in Medicine, the last time any psychiatric treatment garnered a Nobel. A 2015 *Wired* article hailed, “Psychosurgeons Use Lasers to Burn Away Mental Illness.” Techniques such as gamma knife radiosurgery, capsulotomy, and cingulotomy typically involve using focused radiation to destroy brain tissue. Other contemporary psychosurgery techniques involve implanting devices to deliver electrical impulses into the brain.

According to a 2019 article by US and Canadian researchers in the journal *Stereotactic and Functional Neurosurgery*, psychosurgery is undergoing a "renaissance." In one small survey, 87 percent of psychiatrists agreed that "ablative psychosurgeries"—where parts of a person's brain are destroyed or removed—are "a valid treatment" for mental disorders.

In a 2014 consensus statement, the American Society for Stereotactic and Functional Neurosurgery (ASSFN) also reported a "resurgence" in psychosurgeries. The ASSFN conceded that all the scientific evidence concerning if or how the techniques might work and how harmful they might be remains weak and "investigational," and therefore argued, "Informed consent must be obtained from competent patients." However, the ASSFN added that it was "acceptable" to perform psychosurgery on involuntary patients.

CHAPTER 25

TORTURE

If common involuntary psychiatric interventions such as psychotropic drugs and electroconvulsive therapy aren’t curative treatments for medically detectable conditions, then what are they?

Psychiatric holds and forced treatments, according to Tina Minkowitz, constitute discrimination, arbitrary detention, chemical restraint, and torture. They are tools of abuse and social control.

After years of scientific and public consultations, the United Nations and World Health Organization (WHO) now agree with Minkowitz. But will even this slow the rising tide of involuntary interventions?

* * *

Subjected to forced treatment in the 1970s, Tina Minkowitz soon joined others in speaking out against civil commitment.

Minkowitz eventually got a law degree and, over time, she said that some activists, including her, became “dissatisfied with the limited outcomes” they were achieving through reforms in laws or hospital practices. “It became apparent that legal reforms that stopped short of an outright ban were not protecting us against forced treatment,” Minkowitz told me. She and others became more focused on trying to abolish forced psychiatry altogether.

In 2001, Minkowitz heard about the United Nations’ (UN’s) efforts to develop what would eventually become the Convention on the Rights of Persons with Disabilities (CRPD). Conveniently situated in New York City not far from UN headquarters, Minkowitz began collaborating with the World Network of

Users and Survivors of Psychiatry (WNUSP), making submissions to the UN and attending meetings. She saw this as “a chance to get heard at the worldwide level in a way that could be influential.”

WNUSP was already a member of the International Disability Alliance (IDA), an organization uniting hundreds of different disability organizations that promote “leadership of persons with disabilities” within their organizations. What the IDA and CRPD consultation process already had in place, explained Minkowitz, was robust respect for the voices of people with disabilities—respect for what IDA’s guiding principles describe as the “sovereignty” and “expertise” of each group on issues affecting their own “constituency.” That is, if you want to understand what blind people need, you shouldn’t first ask doctors and sighted people; you should ask blind people themselves. People in wheelchairs, too, must speak for themselves. Those with intellectual disabilities should also be listened to and respected. So, why shouldn’t people labeled with mental disorders or disabilities also be asked about their needs? “There was a strong understanding of this principle, ‘nothing about us without us,’ and that you have to talk to disabled people about their own lives,” said Minkowitz. “Disabled people are the experts.”

And one of the main issues Minkowitz conveyed on behalf of WNUSP was that psychiatric incarceration and forced treatment of people labeled with mental disorders should be framed not as “health” issues involving “treating” people, but as contraventions of people’s rights so severe that they constitute discrimination and torture.

“I don’t care if you’re a psychiatrist, or Joe Schmoe, or my father. If you’re putting mind-altering drugs in my mouth against my will, you’re a torturer,” said Minkowitz. “If you are detaining me for reasons supposedly based on a disability, it’s arbitrary detention, no matter who you are, whether you think it’s in my best interest or not. Even if it’s only for ten minutes, that’s a trauma and an abuse. Even if the medical professionals involved have good intentions about it, the experience of powerlessness to stop aggression against your own body is one of the core features of torture.”

Minkowitz wasn’t alone in these beliefs. Many legal scholars have pointed, for example, to the blatant discrimination in how our laws don’t allow forcibly detaining and tranquilizing anyone else for simply appearing to present some vaguely hypothetical future risk to themselves or others—only people labeled with mental disorders.

And in some ways, mainstream psychiatry itself sowed the seeds for

Minkowitz's views. By characterizing mental-emotional distresses as probably caused by as-yet-unknown brain dysfunctions, psychiatrists essentially defined mental disorders as disabilities not unlike genetic blindness, learning impairments, or paralysis. And people who are blind, intellectually struggling, or paralyzed have rights. Doctors are not supposed to subject them to invasive medical procedures against their will; ideally, systems are set up to support them in functioning and making their own decisions.

Minkowitz also brought, however, expanded dimensions to the understanding of "mental disability." Some people identify as having a mental disorder/disability. Others—like Minkowitz herself—do not identify as having a mental disability; however, she's been labeled by others as having one. Meanwhile, some don't believe they have brain diseases or "mental illnesses," but do recognize that their functioning can be somewhat impaired by, say, depressed feelings, anxiety, and a lack of accommodations in their workplace. All of these people, Minkowitz pointed out, are at risk of getting subjected to mental health laws—and therefore, she argued, they should qualify under the CRPD as disabled persons. In effect, then, to protect anyone from the potentially dire legal and human rights consequences of getting labeled with arbitrary psychiatric diagnoses requires protecting everyone.

"The conceptual framing of forced psychiatric interventions as violations of people's human rights based on their *real* or *alleged* disabilities—this was key to our success in the CRPD," said Minkowitz.

Other leaders from organizations of psychiatric survivors and consumers from around the world also spoke to the UN in condemnation of forced treatment. And, in 2006, Article 12 of the finalized CRPD declared that "persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life." Article 14 declared that "the existence of a disability shall in no case justify a deprivation of liberty." In the mental health context, these proclamations were revolutionary—and other changes soon ensued.

In 2013, the UN Special Rapporteur on Torture concluded that, under the CRPD, the administration of psychiatric interventions such as antipsychotic medications and electroconvulsive therapy against any person's will constituted "torture" and should be subject to "an absolute ban." And, in 2016, the UN Working Group on Arbitrary Detention stated that involuntary psychiatric hospitalization and forced treatment were "prohibited" under the CRPD.

The US has signed on to the CRPD but the Senate hasn't ratified it. Canada registered a "reservation" against Article 12, retaining authority to allow other people to control and make decisions against the will of people labeled with disabilities.

There've yet been no substantive changes to civil commitment laws in either country. But Minkowitz believes one important impact so far has been that the CRPD has helped rights advocates from the broader disability and anti-incarceration communities gain more understanding of civil commitment as a human rights issue. She pointed, for example, to the Black Lives Matter movement and the "Breathe Act" draft bill from congressional representatives Ayanna Pressley and Rashida Tlaib that calls for America to "reduce jail, prison, other incarcerated populations, and populations in civil commitment facilities . . . and ultimately empty these facilities entirely."

"I think the CRPD gives focus and dignity to the demand for abolition of involuntary commitment that we didn't have before," said Minkowitz.

* * *

Psychiatrists have started taking notice—and resisting.

In a 2019 editorial in the journal of the World Psychiatric Association (WPA), psychiatrist Paul Applebaum, a member of the American Psychiatric Association's Council on Psychiatry and the Law, claimed that the CRPD process was "captured by some of the most radical elements of the patients' rights movement" (in another article he specifically cited Minkowitz). Applebaum argued that psychiatrists and governments must "ignore the CRPD, reinterpret it, or amend it." The Canadian Psychiatric Association supported the WPA's attack.

These reactions were predictable—it's become common in recent decades for psychopharmaceutical industry leaders to actively work to undermine scientifically credentialed or other high-profile voices criticizing the harms of forced psychiatric treatments.

Conversely, in the 1960s and early '70s, critics of forced psychiatric treatment were famous and widely respected. Some of their names—like Michel Foucault, R. D. Laing, Erich Fromm, Kate Millett, Thomas Szasz, Judi Chamberlin, Dorothy E. Smith, Erving Goffman, and Ivan Illich—are still well known today. They changed practitioner and public attitudes and inspired the shuttering of large asylums.

But since the late 1970s and '80s, coincidental with the pharmaceutical industry's growing influences on psychiatry, mental health organizations, news media, and governments, the stronger the critic's credentials, the more intense the political resistance and blowback. Efforts to restrict public debate began occurring at the national level down to individual communities and institutions.

One of the first high-profile critics of that new era to fall was psychiatrist Loren Mosher. Throughout the 1970s, Mosher was chief of the Center for Studies of Schizophrenia at the US federal government's National Institute of Mental Health (NIMH). Mosher also edited a top research journal, *Schizophrenia Bulletin*. But Mosher also openly expressed his concerns about psychiatry's increasingly cozy relationship with the pharmaceutical industry and intensifying fixation on biological treatments.

In his memoir, *Soteria: Through Madness to Deliverance*, Mosher described how the NIMH poured millions of dollars into giving kidney dialysis to schizophrenia patients with perfectly fine kidneys. A 1979 *Washington Post* article hailed their "remarkable improvement" and suggested that the "chemical imbalance" that caused schizophrenia had finally been discovered. "The dialysis cure was absurd," wrote Mosher, "but it was symptomatic of a darker reality." Mosher started suspecting psychiatry *needed* to believe mental disorders had biological causes to "justify its existence" as a medical profession, and to justify its core practice of forcibly treating people.

Mosher launched his own pilot with NIMH funding, Soteria House, a home in California where people were diverted from the psychiatric hospital to live in a collaborative, non-coercive, supportive environment. Soteria quickly seemed successful—and equally quickly, Mosher received blowback. Mosher wrote that the political pressures coming from "the conventional medical establishment" to shut Soteria down became "intense." Relationships between representatives of the drug industry and NIMH staff had become "clubby," said Mosher, and these voices demanded his ouster. The NIMH conducted five site-evaluation visits and eight formal reviews of Soteria—levels of monitoring that "set records for scrutiny," commented Mosher. Everyone knew, he wrote, that if Soteria worked even passably well, it would be disastrous for the drug industry, biological psychiatry, and proponents of forced treatment. "To demedicalize madness would call the entire profession's existence into question."

Mosher also testified as an expert witness in *Rennie v. Klein*, the seminal forced-treatment case in America that finally established some rights for a competent person to refuse psychotropics. After that, while Mosher was away on a business trip, he was fired. Soteria lost its NIMH funding and closed.

In 1998, Mosher expressed decades of professional-political frustration in a public letter renouncing his membership in the American Psychiatric Association. Mosher accused the APA of entering an “unholy alliance” with drug companies, the National Alliance on Mental Illness, and NAMI’s “psychiatric God” E. Fuller Torrey, to help parents more easily enact “legally enforced” tranquilization on children.

Mosher later said he was forever after “marginalized” from mainstream psychiatry.

* * *

Next came the Harvard-trained Peter Breggin. Through the 1980s and ’90s, Breggin became one of the first popular psychiatrist-authors to criticize in detail the growing relationship between psychiatry and the drug industry, alongside disturbing examinations of the harms of common treatments. In *Toxic Psychiatry*, Breggin mined medical journals to show that, before drug industry public relations experts got involved, psychiatrists routinely described antipsychotics and electroshock as intended to disable people’s brain functioning. Terms like *chemical restraints*, *head injury*, *cognitive impairment*, and *emotional blunting* were commonly used to describe how treatments “work.” Breggin had successive national bestselling books and appeared on *The Today Show*, *Nightline*, *60 Minutes*, *20/20*, and *Larry King Live*.

This also made him a prime target. Wherever Breggin went to talk, mainstream psychiatric agencies, associations, and organizations would often contact the organizers to try to get him banned. Breggin appeared on *The Oprah Winfrey Show* in 1987 and NAMI tried to get his license revoked. A medical board panel grilled Breggin for an hour before clearing him. “The entire process was one of bizarre intimidation,” Breggin told the *New York Times*.

A 1994 *Time* article marked the turning of the tide. *Time* editor Christine Gorman acknowledged that drug manufacturer Eli Lilly had launched a full-scale war against Breggin, including “to deluge journalists with material intended to discredit the maverick psychiatrist.” Yet Gorman herself then uncritically reiterated industry talking points, writing that “mountains of evidence” showed mental disorders “are triggered by chemical imbalances in the brain that can be rectified with medication,” and Breggin was “dangerous” because his views “stop people from getting treatment. They could cost a life.”

With advertising law changes, over the next decade pharma money flowing into US news media outlets skyrocketed from $12 million to over $4 billion annually. Breggin kept writing on hot-button psychiatric issues, but disappeared from the mainstream spotlight.

* * *

The most recent high-profile target was Peter Gøtzsche. An internal medicine specialist, Gøtzsche has published research in many top medical journals including the *BMJ*, *Lancet*, *JAMA*, and *New England Journal of Medicine*. He also cofounded the Cochrane Collaboration, an international effort to evaluate medical research with less dependence on drug company influences, and led the university-affiliated Nordic Cochrane Center in his native Denmark. His 2013 book, *Deadly Medicines and Organised Crime: How Big Pharma Has Corrupted Health Care*, won a British Medical Association award.

But then he began more vigorously investigating psychiatry. “I thought it was much more evidence-based than it is,” Gøtzsche told me in 2021. “It took me many years to get to the bottom of this mess, and to realize psychiatry is the biggest catastrophe we have in health care. It’s absolutely second to none. But psychiatrists are so good at concealing this.”

Never shy about speaking bluntly—and comfortable wading into volatile scientific debates about mammography and vaccines as well—Gøtzsche published writings arguing that biochemical imbalance claims are pure myth, psychotropics overall do more harm than good and prematurely kill five hundred thousand people worldwide every year, and not only should forced treatment be banned but psychotropics should be restricted because doctors cannot be trusted to prescribe them with appropriate judiciousness.

The counterattacks came fast and hard.

Cochrane’s UK headquarters, its growing research empire increasingly reliant on government funding and allowing drug company conflicts, publicly distanced itself from Gøtzsche. Denmark’s national drug agency criticized him. The Danish Minister of Health, recounted Gøtzsche, essentially suggested he was a lunatic who should be fired.

Written complaints came in to Cochrane UK, prompting a formal review. Those complaints came from E. Fuller Torrey.

Torrey wrote that Gøtzsche’s opinions about antipsychotics and his link to an organization critical of overdrugging meant Gøtzsche—and by extension Cochrane—couldn’t be trusted to “be objective” in evaluating the effectiveness of antipsychotics. Yet, in these emails, Torrey identified himself to Cochrane simply as “Associate Director for Research, Stanley Medical Research Institute”—and didn’t disclose that he also happened to be founder, board member, and spokesperson for Treatment Advocacy Center, America’s most prominent promotors of forced treatment using antipsychotics.

War ensued. Cochrane’s board voted six to five to expel Gøtzsche; four board members immediately resigned in protest. One said, “Industry will be elated. Oh finally, we are offering Peter’s head on a platter.” *Science*, *Nature*, *BMJ*, *Lancet* and other prominent science media reported on the scandal. Directors of thirty-one Cochrane centers called for an independent investigation. Petitions signed by thousands circulated demanding Gøtzsche’s reinstatement. One of America’s own most well-known and widely cited medical researchers, Stanford University’s John Ioannidis, defended Gøtzsche as “undoubtedly a giant, one of the greatest scientists of our times.”

Nevertheless, Gøtzsche was fired from the Nordic Cochrane Center, and lost his associated university professorship. Other issues came into play, Gøtzsche told me, but “psychiatry actually played the biggest role in my expulsion from Cochrane.”

* * *

For every publicized, dramatic case like these, there are countless forms of pressure occurring in the shadows of institutions and communities around the continent.

After the very first article I ever published that presented the polarized perspectives of psychiatrists and former involuntary patients, the regional government health department’s senior leadership didn’t suggest any quotes or facts were wrong—but they banned me from getting any future interviews. They also requested a meeting with the newsweekly’s editor, writing threateningly to him that they “hoped” such an interview ban “does not become extended” to all of the paper’s other journalists. They ultimately backed down, but the experience made me start to wonder what other pressures were going on out there behind closed doors.

In 2011, I was invited to speak at the nondenominational Unitarian Church of Vancouver. Over the ensuing years, I watched as Reverend Steven Epperson and his wife Diana’s efforts to host public education events about the risks of psychiatric drugs and forced treatment led to frequent blowback in their professional and private lives.

For Epperson, one of the worst experiences came in 2017, during a celebration of the United Nations Universal Declaration of Human Rights. The church hosted an intimate open mic night for people who'd been forcibly treated to share their personal stories. Epperson said several people told "heart-wrenching" stories—but then the event went off the rails. A pro-force mental health organization had publicized the event to its members. "What was meant to be testimonies of people who've felt harmed by forced treatment became a parade of parents professing the virtues of the mental health laws and forcing psychiatric treatments on their children," said Epperson. One by one the people who'd felt harmed by forced treatment departed. "It was the sanctuary at my church, and they were getting re-traumatized. I felt like I'd betrayed the very people I was trying to set up this safe space for."

Around this time, a married psychiatrist and therapist in Epperson's congregation lost their adult son to suicide as he was trying to get off psychotropics. The couple launched formal complaints all the way up to Unitarian headquarters in Boston, accusing Epperson of being responsible for the young man's death. Epperson was repeatedly cleared of wrongdoing. However, while Epperson was on a brief sabbatical, a psychiatrist got himself on the church board, and convinced the board to assume greater control over Epperson's activities.

Recently, a psychiatrist told me he was fired from his university position on the grounds that he allegedly had a "rigid" attachment to psychotherapy and was not sufficiently "open" to biological treatments. He'd been watching his field become more focused on psychotropics and involuntary treatment for years, he said. "But when you actually confront it, there's kind of a pit in your stomach."

Another time, he advised a new, chronically depressed client that the antidepressants she'd been taking for years weren't proven to be much more helpful than sugar pills. The client filed a complaint. The medical licensing body didn't say he was scientifically incorrect, yet nevertheless reprimanded him for his "disparaging" attitude about antidepressants, which was "not in keeping with modern psychiatric practice." With this strike on his license, he said, "I'm a little anxious. It's compromising how I am with patients." The psychiatrist, who is Jewish, compared being truly honest with people about the problems with psychiatric science, psychotropics, and forced treatment to holding spiritual services underground in Soviet Russia. He acknowledged that sounded dramatic, but continued, "I think it's closer to the truth than I wish it were."

Shutting down the World Health Organization's voice may prove more difficult. In 2021, the WHO struck back at psychiatrist-critics, observing that few countries were complying with the CRPD and “human rights abuses and coercive practices remain all too common” in psychiatric hospitals. The WHO published guides for health care providers to help “put an end to human rights violations in mental health care” such as “involuntary admission and treatment, seclusion and physical, mechanical and chemical restraints.” The WHO described alternative approaches that were “respectful of human rights and focused on recovery” and shown to be “successful and cost-effective.”

Many of these alternatives have been around for decades, though. So, why haven’t they been implemented?

CHAPTER 26

ALTERNATIVES, AND THEIR SUPPRESSION

If we look for a single "monolithic" alternative to prisons, writes Liat Ben-Moshe in *Decarcerating Disability*, we'll likely end up right back at creating prisons holding millions of people. This applies to civil commitment as well. Even when used with caring intentions, psychiatric detention and forced treatment powers are enacted in so many different circumstances, with so many different kinds of people, for so many different reasons and goals, that it's counterproductive to try to come up with one alternative that will address every situation. But that's not a despairing observation—it's a cause for hope and creativity, and an impetus to consider the myriad ways that we, individually and collectively, could be better responding to people who are experiencing inner distress or struggling to function within society's current parameters of normalcy.

Obviously, we could more meaningfully tackle the many underlying social inequities and injustices that contribute to many mental-emotional crises. But in specific instances of individual, immediate crisis, many people I spoke with said that simply making efforts to truly connect with people and help problem-solve with them can prevent many hospitalizations.

"Sometimes folks having extreme psychosis do have delusions, and it's really difficult," said Debbie Plotnick of Mental Health America. "That doesn't mean that you can't connect with them, and you can't listen to them, and you can't ask them what they want, and help them. And then you've started the connection. Does it take time? Does it take effort? Yes. Is it always successful?

Not always. But it often is.”

If problem-solving fails, said peer-specialist Kimberly Comer, a valuable personal connection has still been made. For those who might find benefit in voluntary treatment, that connection can be respectfully leveraged. “There are ways to empower somebody to get treatment without having to traumatize them. I can reason with them. I can get them to help. Will it take time? Absolutely.”

A parallel path could involve financially supporting family or other home caregivers—those chosen by patients themselves—thereby also helping reduce family conflicts and crises. Budgeting for such salaries seems feasible, considering that the current approach of detaining one person for a common three-week stay in a psychiatric hospital can cost $30,000.

Some experts in grassroots social engagement, like John McKnight of DePaul University’s Asset-Based Community Development Institute, argue that professionalized social service industries have fostered dependence and rendered us all increasingly inept at such creative problem-solving. McKnight advocates re-schooling ourselves in embracing difference and diversity, and encouraging, supporting, and collaborating in “mutual aid” with our neighbors.

Community-based problem-solving might at times demand that we become more adaptively responsive in ways that could challenge us personally or professionally. For example, attorney Susan Stefan said that in her decades of experience in civil commitment cases, the situations that seemed most insoluble weren’t people who were occasionally violent or frequently hallucinating, but who simply seemed persistently “unmanageable.” Stefan described a man who wrote formal complaints weekly, sometimes daily, accusing virtually everyone around him of rape. “His community providers felt that they had to investigate every single complaint because the rules required it, and they got sick of doing that,” she said. They stopped providing him any assistance at all, and the man ended up institutionalized for almost two years. Eventually, a working solution was achieved. Stefan said, “Now he has his own apartment, happy as a clam, writes complaints every day, and sends them to his attorney, who does not have the same obligation to investigate them as the staff.”

Many structured, formalized alternatives to psychiatric detentions and forced treatments have been piloted, and have frequently proven reasonably successful with even the most troubled people. Yet none have ever been implemented at large scales in North America. Simultaneously, at the microscale of individual facilities, under mental health laws, governments have given psychiatrists final decision-making authority over the treatment of patients, and that means psychiatrists also have authority over other mental health staff. This has led to another immensely influential, politicized use of mental health laws: The marginalizing of non-medical approaches.

* * *

Growing up in Michigan, Colleen Donaldson was a sensitive child, afraid of certain teachers, and had challenges reading and speaking that got her put into special education classes. She started having panic attacks, skipping school, and attempting suicide. “I think I just felt really lonely. And I felt like I couldn’t talk to anyone about how I felt,” said Donaldson.

Her parents taught her to be more aware of her breathing, went for relaxing walks with her before school, and found her a talk therapist with an artistic bent who would become a lifelong friend. Donaldson eventually realized she felt better when doing gymnastics and other physical activities, and got a master’s in Dance Movement Therapy (DMT). She went on to work as a dance movement therapist in six psychiatric hospitals in Oregon.

Now in her thirties, Donaldson told me that many DMT techniques were developed for “cultivating the wellness” within people experiencing extreme states or not relating verbally. She described a patient in his twenties with matted hair covering his face who was frequently hostile on the ward, yelling, swearing, and getting into arguments. One day he was watching Donaldson lead a group of patients in movements using a giant rubber band. The group tried to form a five-pointed star and needed one more person. The man stepped in, and interacted silently with the others through various dance-like formations. “It was after that point that he started being communicative with people, and he was less paranoid,” said Donaldson.

Did medical staff then start calling on her to intervene with other hostile patients? Donaldson said, “Whenever I would tell a story like that to a doctor or nurse, almost always the reaction was, ‘Wow, the medication’s finally kicking in!’”

Donaldson described a young woman who just sat in a catatonic state in the dimness of her hospital room, heavily drugged. “She had crusts on the front of her scrubs that were from the drool.”

Donaldson introduced herself and narrated aloud what she was doing while searching for any nonverbal cues. She turned on quiet background music and brought out several soft balls of different textures with tails and little glowing lights, and began moving them about. “I noticed that she was tracking it with her eyes.”

Donaldson visited the woman every other day for half an hour, each time seeking to expand the connection. The woman began picking the varying objects up and reacting with more obvious like or dislike to body-awareness activities. After several weeks, Donaldson went on a brief vacation, and the woman was discharged. Donaldson later bumped into her and the woman cried, “Hey, beautiful, how are you!?” She remembered everything, and told Donaldson she’d felt appreciated and cared for.

Akathisia caused by psychotropics, though, was a constant for which Donaldson had little to offer. “As a dance movement therapist, we think about someone’s health in terms of their movement,” said Donaldson. The greater the comfort, range, and dynamics of one’s capacity to move, the greater the resilience and health. “So that’s what we would try and draw out in dance therapy.” She said it was frustrating to see people’s bodies and psyches trapped in drug-induced agitation and stressful movements such as incessant rocking, pacing, and body tensing. “I would see people just in these horrible states.” Only medication reductions could help, but medical staff often took the position that, despite their agitation, the patients had improved because they were no longer saying delusional or upsetting things. “It was this very one-dimensional view of health,” commented Donaldson.

While it’s not unusual for American psychiatric hospitals to offer creative arts therapies, in Donaldson’s experience, many medical staff don’t take non-drug approaches seriously. “I felt like we were the great face to put on the advertising flyer,” she said. Psychiatrists would sometimes refer to her job as “babysitting” patients. “There was an attitude that we needed to stay in our lane, and that the psychiatrists were really doing the heavy lifting. If you were to suggest that a patient shouldn’t take meds, then you were flagging yourself as someone who’s ignorant, and that shouldn’t really be listened to, or respected.” In her seven years at six hospitals working with thousands of patients, Donaldson could recall only one time a psychiatrist said that a patient didn’t need drugs and could just do other therapies.

In 2020, Donaldson moved to Wisconsin, hoping to develop a private practice. “I realized that I couldn’t work in the hospital system anymore,” she said. Because of the dominance of involuntary drugging, any impacts she could have in hospitals were only “very temporary,” and she could not help patients “get the type of life that they would want or that I would want for them.”

Most best-practice guidelines recommend having peers who've been psychiatric patients meaningfully involved in hospitals. And one of the most valuable contributions a peer can make, said Kimberly Comer, is to bring a "trauma-informed" perspective—sensitivity to the fact that past and present traumas likely contributed to a person's crisis, and that psychiatric hospitals and forced treatment themselves can be re-traumatizing. "There is no setting in which a peer specialist should not be involved. They can make a system that's absolutely overwhelming and terrifying, less so. It lets them know they're not alone." Going deeper, New Hampshire–based Intentional Peer Support gives workshops in building peer-to-peer relationships as an interactive process of shared learning about the social causes of distress and community-based solutions. Robust implementation of any form of peer involvement at institutional policy and decision-making levels, however, is extremely rare across North America.

In 2021, the *New York Times* reported on a new psychiatric hospital where patients "wake up in private rooms with views of the wooded Santa Cruz Mountains, have breakfast in airy communal spaces and can hang out in landscaped courtyards throughout the day." That's wonderfully ambitious, but for many former patients, if there'd merely been better food than typical hospital slop, opportunities for exercise, learning, and outdoor activities, and staff who were passably warm and friendly, that would've revolutionized their experience. Indeed, retrospective studies have suggested that the simple, humanitarian, rural retreats offered by Quakers in the nineteenth century apparently produced better quality of life and recovery rates for people labeled with schizophrenia or other mental disorders than modern approaches.

Providing stronger, more independent, and transparent oversight, and making regulators more arm's-length from facility operators' and governments' inherent conflicts of interest, would obviously help. Merely giving psychiatric patients as many rights as criminals get would precipitate enormous change. And many studies have suggested that "procedural justice" can be therapeutic: if people feel they've at least gotten good representation from a lawyer, an impartial judge, and a fair hearing, they feel better. However, only a handful of states and provinces have so much as funded specialized law offices with expertise in civil commitment.

Health care advance directives allow us to maintain a measure of control if we become somehow physically incapacitated or lapse into a coma. Supported decision-making alongside psychiatric advance directives (PADs) could allow people to outline the interventions they'd want in a crisis—allowing those who are thankful for previous forced interventions to authorize them again, while giving others the ability to at least guide the process a little. But many states and provinces have passed laws against or don't practically support using advance directives to avoid future forced psychiatric treatment. A 2021 article by Duke University researchers stated that, even where PADs are encouraged by governments, there remain "persistent barriers" such as "health systems' reticence to implement them." Many psychiatrists remain resistant to how PADs can weaken their own decision-making authority.

Some have argued for allowing emergency detentions to occur while eliminating forced treatment—or allowing forced treatment but only once in a person's lifetime for a very brief testing period to allow them to make a decision based on direct experience. In either scenario, though, one person playing both jailer and purported healer seems inherently problematic. Why not establish an interdisciplinary team that focuses on supportively helping people problem-solve their circumstances, and let psychiatrists simply be an offered service? Psychiatrists, though, regularly counter that, without forced drugging, some patients would "languish" in hospitals—as if the fact that psychiatric hospitals tend to be sorrowful, decrepit places where little healing occurs is a reasonable rationale for overriding patients' wishes still further.

But many people agree with the United Nations and World Health Organization that psychiatric civil commitment and involuntary treatment constitute arbitrary detention and torture, and need to be completely abolished.

In 2021, the WHO released a collection of guides and evidence-based examples for reshaping mental health systems to be more respectful of human rights. Hospitalization alternatives included a residential treatment center in Norway that eschews the dull, prison-like atmosphere of most hospitals and instead provides "a highly structured environment that is organized like a full-time workday for the people using the service," along with diverse therapeutic options and approaches, physical activities, and weekends off at home. A house in Switzerland, modeled after Mosher's Soteria, hosts people in crisis and staff living together and sharing cooking, cleaning, and planning for therapeutic work they want to do. Afiya House, run by Wildflower Alliance in Massachusetts, is a peer-run emergency respite home that gives people an alternative to hospitalization and offers friendship, safety, and support. An adapted form of emergency intervention from Finland, called Open Dialogue, involves an interdisciplinary team hosting meetings with a person in crisis and their family and social network. Rather than viewing a crisis as something entirely inside one person's head, crises are seen as occurring within social circumstances, and everyone contributes to developing shared solutions.

Most of these models have been known for decades, though, and have gone largely unfunded by governments, despite their success rates and obviously reduced risks compared to drugs, electroshock, and psychosurgery.

But ultimately, there's no better example of the psychiatric system's resistance to non-medical alternatives than, on the one hand, the enormous popularity of counseling, talk therapy, and intensive mind-body psychotherapies in our culture and the fact that these are minimally available or nonexistent in our psychiatric hospitals.

Of course, non-drug therapies can still feel invasive if forced on you, and the science in support of their effectiveness even for voluntary patients is often little better than for medicalized interventions. Nevertheless, crusading attorney James Gottstein won a precedent case at the Alaska Supreme Court in 2006, where the court declared that the systemic suppression of these alternatives was unconstitutional. Following US Supreme Court guidelines, the Alaska court wrote that, before forcibly drugging patients, psychiatrists had to establish that there was "no less intrusive alternative treatment" that the patient might willingly participate in. There was hope this could spur change across the country.

But the decision was largely ignored by hospitals in practice, and fought against by government and hospitals in the courts. After the makeup of the Alaska Supreme Court changed, Gottstein told me, "make options available" soon got whittled down to "if options are available."

"So this is saying, they could force-drug someone because they chose not to fund a feasible alternative," said Gottstein.

* * *

Many experts believe that, as a society, we don't just need to rethink how we respond to mental disorders—we need to understand differently what serious mental disorders or "madness" even are. Kale Woods has become one of those people.

Woods, a transgender nonbinary person in their late twenties, was working toward a master's degree in clinical psychology at Columbia University. On a school break in 2018, Woods was visiting family near San Francisco. They were getting up early to help at their father's company, coming back to a bustling family home, trying to develop ideas for their graduate thesis—and not getting much sleep. Their brother offered some pot cookies as sleep aids, but over the next few days Woods kept consuming more cookies, stopped sleeping altogether, and slipped into an altered state. "I'm not sure if they were dreams or hallucinations or incorporating real-life material into both," said Woods.

In the altered state, Woods tried to make sense of their childhood, having experienced sexual abuse while growing up in a Moonie cult that damned the LGBTQ community. Woods suddenly saw all of human society as a collection of interacting subcultures conducting well-intentioned but often-misguided efforts to improve the world through experiments in social indoctrination and behavior control. Woods riffed to others about what we should learn from Moonies, multi-level marketers, sexism, capitalism, racism, and all forms of "groupthink propaganda." And as they riffed faster than insights were coming to a friend who was studying to become a social worker, the friend said, "I think you should go to the hospital."

By this point, Woods felt like an immersive social researcher with a chance to explore the cult of psychiatry, and so they reacted gamely, "Let's see what happens!" Woods ended up forcibly committed.

The hospital appeared to be a set for a reality television show slash social-science project: cameras everywhere; admission form waivers; staff/cast/crew running tests on people and monitoring. "I was having trouble with understanding what was real and what wasn't," said Woods. The mind-altering antipsychotics were also contributing to their "reality-testing problems." The alternately unnatural, unfriendly, and sinister communications and power relationships going on between staff and patients added to Woods's mounting upset and disorientation.

After catching up on sleep, though, Woods was discharged thirteen days later. Three years later, they were still processing what happened.

On one hand, suggested Woods, they were a psychotic person with an abusive childhood who got locked up and re-traumatized. On the other hand, they were indeed an immersive researcher of madness making important observations about our carceral society "from the inside." The latter belief felt better and, Woods suggested, had "protective" and "healing" effects.

I suggested this was not unlike an artist who tries to make sense of their own suffering and go beyond it through reframing the suffering in their art.

"There's this theory from comparative religions," said Woods. "They could be explaining a natural phenomenon with theology. The theological explanation could be real, but it doesn't really matter. Whether it's real or not, it's meaningful to those who are experiencing it. And therefore it has meaning; it has adaptive function. What is the adaptive function of hallucinations and delusions? I think it's people making sense of the trauma that they're experiencing. I finally have a real understanding that mental illness is not an illness; it's a logical reaction, an adaptation of the body and brain to stress."

Psychologist and former involuntary patient Ron Bassman of MindFreedom articulated a similar idea. "Some people will go into a kind of altered state where their reality will change, because the reality that's consensual is so disturbing, and it's destroying who they are, so they seek out something else," said Bassman. Some people shift into "extreme confidence" about their own interpretations, which often gets called mania or psychosis, he said. Others "give up" on their dreams and plunge into depression. Either way, said Bassman, such experiences are often "part of a search for becoming who they believe they are." Tranquilizers may keep such people quieter, but "stuck."

Outside biomedical psychiatry, countless non-medical mental health professionals, spiritual leaders, artists, and others have similarly theorized about the importance, and healing and transformative potentialities, of such altered states. One of the most influential contemporary thinkers is psychiatrist and psychedelic researcher Stanislav Grof.

In *Beyond the Brain: Birth, Death and Transcendence in Psychotherapy*, Grof points out that, in many cultures throughout history, people have deliberately induced voices, visions, and altered states through psychedelics, intense breathing, sleep deprivation, mystical practices, trance-dancing, fasting, rituals of pain, and so on. Grof outlines an "expanded cartography of the psyche," where much of what American psychiatry's diagnostic manual calls mental illness has in other cultures traditionally held a revered place as a potential catalyst for transcending "normal" reality and experiencing breakthroughs and transformation.

Probably most of us have experienced, for example, intense sadness or anxiety that leads to making important, ultimately positive changes in our lives. Evolutionary theory supports this notion of deviation from norms having potentially invaluable adaptive functions. Someone who likes sitting all day in a cave scrawling on walls could look like a deranged danger to themselves in a hunter-gatherer culture, but in computer-based culture excels. Conversely, today, psychiatry pathologizes boys who want to be constantly moving—young men whose insatiable energy likely would have been prized in hunter-gatherer cultures. In this light, it may prove to be our own culture's self-destructive blunder, at this critical historical juncture, to have transferred supreme powers of judgment and control over deep changes in human psyches to medical students with little experience exploring different cultural viewpoints or the vaster reaches of the brain's inner world.

Characterizing bouts of "madness" as in any way potentially valuable, natural, healing, or transformative is anathema to biological psychiatry. Psychiatric nurse Jonathan Gadsby, for example, told me he learned some of the Hearing Voices Network's techniques for listening to voices to gain an understanding and ability to live with them. Gadsby found the approach helped some of his most seriously troubled clients. Nevertheless, said Gadsby, "I had to be very careful whom I spoke to about it, because some would see it as colluding with delusions, and really wrong, and really bad."

For Woods, the journey through civil commitment was in one way traumatizing, but also transformative—they ultimately wrote about civil commitment for their master's thesis. Now what to do with their degree? "I have this accreditation in a field that I think is inhumane," said Woods.

Woods later found a job with a nonprofit that assists people facing civil commitment. "I feel very positive about it. I get to advocate for the person—what they want for themselves."

* * *

I'm often myself asked to advocate, and for the best advice I've culled over the years for navigating commitment and regaining or maintaining freedom. My perspectives tend to reflect the two main underlying topics of this chapter: cultivate inner exploration, and navigate social circumstances carefully.

Firstly, there are strategies for strengthening one's grounding in broader, non-medicalized, non-pathologized ways of thinking and living.

It seems vital to cultivate friendships that provide the mutually respectful ability to talk frankly about any kinds of feelings or thoughts without fear, pathologization, or calling 911. Additionally, learning to be alone without fear or judgment of one's own inner experiences, to question oneself, and to journey with any thoughts and feelings as they come up can go a long way toward increasing self-understanding and preventing unwanted interventions by others.

In a connected vein, it seems rare for people to go into prolonged inner crisis and get psychiatrically detained if they're able to remain in touch with their holistic physical health. Conversely, pushing against the body's limits tends to intensify whatever's happening in the mind—for better or worse. Nature and fresh air, sleep, careful limits on uses of any psychoactive drugs, moderate activity and exercise, and healthy nutrition all contribute to prevention, resilience, and recovery. Unlike efforts to forcefully define and control "mental health," there's a mysterious, grander wisdom and harmony that emerges organically from within.

Secondly, if detained, there are strategies for gathering social support to counteract those very powers of the medical staff to define and control what "mental health" supposedly is.

Most pointedly, because the true breadth and reach of mental health law powers are a kind of open cultural secret, many people are understandably shocked the first time they get ensnared, and react outwardly with confusion, anger, outrage, and fear, which then get labeled as symptoms of dangerous illness. It's usually better to recognize that you've encountered a bear while navigating a steep, rugged cliff, and calmly, carefully determine the steps back to safety—and those steps are usually more *social* than mental.

Social supports can be extremely helpful. Visitors signal to the hospital staff that "ordinary" people know you as an "ordinary" person with a social, family, or work life, and that outsiders are monitoring staff behaviors. (However, if visitors say anything negative about you, no matter how innocuous and ordinary, it can serve as cryptic confirmation for a psychiatrist's worst assessment: e.g., "Spouse reports lately feeling concern for patient's emotional state.") Even when overridden by mental health laws, most reasonable staff and judges will still at least consider the voices linked to a financial power of attorney, health care representation agreement, advance directive, and similar support documents. And medical staff make notes constantly that weigh heavily at hearings, so keeping simple, straightforward written records of events, conversations, complaints, agreements, and so on can help defend against bias. Professionals also tend to be more law-abiding when responding in writing.

In parallel, while medical staff routinely say that forced treatment is for improving the mental health of the patient, they cannot in fact read people's minds. What they do is evaluate outward behaviors against selected social standards. So, patients get their freedom back not necessarily when they feel better, but when psychiatric staff, judges, or tribunal members themselves feel better. Basically, regardless of how inwardly “crazy” they may or may not be, the people who get released the quickest are usually those who behave acceptably—they perform reasonably functionally, communicate politely, are judicious about what they reveal, and figure out how to answer in emotionally reassuring detail the common fear-based, judgmental question, “If we release you, what will you do?”

CHAPTER 27

THE RISING PSYCHIATRIC SURVEILLANCE STATE

Carlene Byron was participating on Facebook in a group for separated and divorced women. A communications professional and former board member for a NAMI chapter in North Carolina, Byron was going through a separation and staying with a friend who was running a covert shelter for women escaping abuse.

Byron wrote about having suicidal feelings, though she said she was very clear about having no current intent. “I was venting,” she told me. “I wanted somebody to just say, ‘Of course, you feel like crap, everything awful is happening.’”

At midnight, police showed up. Byron said the shelter’s owner was as startled as she was that police had learned about Byron and tracked her there. The two of them never found out how.

“I was very angry,” said Byron. “I think the biggest feeling was just this huge loss. This was the only support group I had. And it was not a safe place.” Never knowing how or why it happened, Byron said, just made the experience more unnerving.

Byron could have been a victim of either of the next two big waves of psychiatric encroachment: electronic psychiatric surveillance and community-based mental health training. Both could massively expand the number of people getting pushed toward mental health authorities.

In 2015, the National Institute of Mental Health's director, Thomas Insel, left to work at Google. Just eighteen months later, Insel cofounded the tech/mental health start-up Mindstrong. *Wired* asked, what led the "star neuroscientist" to "bail on Google-sized money and data?" The essence of the answer: rapid developments and enormous profits in the expanding world of "digital psy." The movement is drawing investment from governments, universities, and the biggest players in the high-tech and health care industries.

Insel cofounded Mindstrong with a former pharma executive, and they quickly brokered a deal to get Mindstrong's app implemented in mental health systems in more than a dozen counties in California. But theirs is just one of thousands of mental health monitoring tools and engagement apps being hatched in public–private–academic partnerships, some with hundreds of millions of dollars in venture-capital backing. Many focus on mining everything we do with our electronic devices, and using artificial intelligence and algorithms to help us—or others watching us—detect early signs of possible mental-emotional problems in how, when, and where we swipe, tap, type, and talk, do web searches, play games, complete surveys, and move around during our days and nights.

And that's just one front in the digital psy invasion.

Facebook has implemented algorithmic tools to find users at risk of suicide, and the American Foundation for Suicide Prevention and other groups are experimenting with monitoring other social media. Others have been exploring using outdoor surveillance cameras and algorithmic tools to identify people "at risk."

The FDA has approved the first digital pill—an antipsychotic with an edible sensor that broadcasts to a wearable patch, which then relays information through your smartphone to a cloud-based server, confirming when you're "treatment compliant."

As elementary and secondary schools have increasingly incorporated computer-based education, more than 1,400 US school districts have contracted Gaggle to algorithmically monitor the documents, emails, and chats of 4.5 million children and youth for signs of mental health problems, possible bullying, violence, suicidal feelings, or self-harm. A tool from Securly is monitoring 10 million more students across 10,000 schools.

Some schools and other institutions have also been installing surveillance microphones and algorithmic software to "identify stress and anger before violence erupts."

The University of Toronto’s Citizen Lab has described a burgeoning “Hub Model of Community Safety” in which “situation tables” bring together data and representatives from police, education, addictions, social work, mental health, and other agencies and institutions to “generate individual and community risk profiles” and “formulate a plan of intervention” for people perceived to be at risk. Some states are building mental health–monitoring databases that combine and analyze records from law enforcement and social service agencies with information scraped from people’s personal social media accounts.

People have been turned back at the US-Canada border for “mental health reasons.” This led to revelations that Canadian police put records of their wellness checks into databases, which are then shared with the FBI and Homeland Security.

Vehicles of people under court-ordered mental health treatment are getting flagged and tracked in many police Automatic License Plate Recognition systems.

The list goes on—and interventions without consent are common features of these surveillance systems. Under-discussed and surprisingly unresisted is how profoundly these surveillance tools and the associated aggressive interventions are constraining allowable speech and feelings.

In its first year in 2017, Facebook’s algorithm triggered thousands of police wellness checks on unwitting users.

The American Hospital Association likened Mindstrong to “a fire alarm” to alert authorities “when an emotional crisis seems imminent,” and an American Psychiatric Association evaluation found that many smartphone mental-wellness apps include procedures for covertly initiating police wellness checks without user consent.

Operators of locked assisted living and group homes told me that, using mental health apps and “telepsychiatry” communications, a single psychiatrist can now oversee the coercive drugging of hundreds of people across vast territories.

One 2,300-student Michigan school district acknowledged getting mental health alerts from the Gaggle monitoring tool literally every day. Nationally, in 2020, Gaggle alerts led to more than 273,000 interventions by school officials—a number that had nearly tripled since 2018. According to a *Guardian* report, examples included school officials intervening “within minutes” after a South Carolina middle school student started writing about suicide for an English assignment, and a Cincinnati student getting psychiatrically hospitalized after writing about self-harm.

* * *

It’s not only digital spaces that are being colonized. There are also major efforts underway to integrate mental health monitoring and intervention still more deeply into communities.

After reading an article where I’d expressed concerns about community-based mental health initiatives leading to more people getting forcibly hospitalized, the former executive deputy commissioner of health and mental hygiene for the City of New York contacted me to discuss “ThriveNYC,” the most comprehensive effort yet to incorporate mental health approaches throughout the fabric of a city. Psychiatrist Gary Belkin was calling to blow the whistle on ThriveNYC—his own initiative.

Belkin is currently a visiting scientist at Harvard, and describes himself as a “policy activist” on the social and emotional impacts of climate change. Belkin took me back to the beginning of ThriveNYC. “I created the whole thing. I pitched this idea that we need a new approach.”

That new approach, explained Belkin, would be to “empower” as many ordinary people as possible at hundreds of New York City government agencies, health institutions, and nonprofit organizations to do mental health interventions.

Somewhat to Belkin’s own surprise, then-mayor of New York Bill de Blasio and first lady Chirlane McCray embraced his vision. “It was stunning, the amount of money and the range of resources and agencies of the city government they were committing to that, and how ambitious the initiatives were, how seriously it was really put to work,” said Belkin.

From 2015 to 2019, Belkin worked to implement a $250 million-per-year budget driving fifty-four distinct but overlapping programs, all guided by a cross-agency, cross-sector governance model.

One primary goal of ThriveNYC, Belkin explained, was to get mental health professionals to train community members who had regular contact with the public to identify people in mental distress wherever they encountered them, be able to assist them, and, if advisable, know exactly where to direct them for more intensive professional mental health help. “It’s a way to open up the net of who’s able to help people,” said Belkin.

Staff at shelters were trained to administer symptom checklists. Hundreds of “Mental Health Service Corps” clinicians were stationed at high-traffic locations such as primary care clinics. A crisis line call center was staffed with professionals specially trained in giving tele-counseling, making assessments, and routing people to services. At NYPD, a beat police officer could get patched directly to a mental health clinician who could help respond to an incident over the phone or get immediately dispatched to the scene. Teachers were trained to teach social-emotional learning from kindergarten through grade twelve. Day-care staff received training, and thousands of members of the clergy received "toolkits" for bringing mental health awareness and skills to their congregations. "All of these things were supposed to connect, and I can give you one hundred other examples," said Belkin.

I told Belkin that, to me, all of this sounded like a nightmare—extending exponentially the eyes and ears of the mental health system, and opening countless new doorways for people to get spotted, labeled, and funneled into hospitalization and forced treatment.

But Belkin vehemently denied this was ever his intent. A key goal of ThriveNYC was to "upskill" citizens to help one another. Recognizing the role of community and social factors in individual mental well-being, Belkin said he hoped to "demedicalize" distress, "deprofessionalize" responses, and expand "mutual support" in neighborhoods. "I said one outcome measure that we should have for ThriveNYC's effectiveness was zero referrals to the police department," said Belkin. "We were teaching 'helping' skills, not 'screen and refer' skills."

However, ThriveNYC came under increasing fire from major New York news media. At times it was for management trip-ups, or inabilities to demonstrate measurable outcomes. But criticisms exploded after every visible incident of a person labeled with mental illness assaulting someone. "Chinatown murders prove ThriveNYC is a sickening failure" declared a *New York Post* editorial, arguing that the program had done nothing to address "the real mental health crisis in our city—people living on the street" who were schizophrenic, violent, and in need of forced treatment.

What Belkin said he found "disappointing" was that major mental health treatment providers and professionals didn't stand up to counter this bigoted chorus. Suggesting that the most important role of the mental health system is a "military assault" against "violent schizophrenics," said Belkin, not only factually misrepresents 99.9 percent of patients, but strips the "humanity" from the other 0.1 percent as well. "There are people with schizophrenia who are more functional than women with maternal depression," commented Belkin. But treatment providers “stayed silent. There wasn’t that countervailing voice.”

In retrospect, Belkin said the silence of mainstream treatment providers was “sadly predictable,” because of the “shortsighted business model” that dominates the mental health system. The current dominant model is a crisis intervention approach, and if ThriveNYC became successful in preventing people from ever going into crisis, then that would threaten the survival—or at least the current business models—of many institutions that depend on detaining and treating people in crisis. “I underestimated just how much learned helplessness there was in the conventional mental health system to imagine doing things better,” said Belkin.

In any case, in response to the criticisms, the mayor and first lady started cutting core features of ThriveNYC and redirecting funds. This turned ThriveNYC into “something that I don’t recognize anymore,” said Belkin. A former deputy commissioner of police became the new operational lead. “The momentum shifted back to the ‘moment of crisis’ and became all about policing and controlling and disciplining.”

I told Belkin I’d seen this pattern repeatedly. I described the many mental health education curricula that begin by encouraging kids to learn coping skills and support one another, yet by about page twelve start adding statements like, “But if you’re upset for more than two weeks you could have a serious brain disease that requires medication like insulin for diabetes.” Coercion and forced interventions are never far behind.

“I agree with you there’s a real slippery slope there,” said Belkin. “I guess the story of ThriveNYC is that we got to page twelve. And it just proved too powerful.”

* * *

Smaller variations of ThriveNYC are being launched in many communities, even as mental health surveillance systems simultaneously expand into digital spaces. Meanwhile, an ever-expanding array of feelings are said to be “mental health problems” that require professional interventions: infant upset; toddler anxieties; school struggles; juvenile deliquency; employment fears; performance nervousness; economic stresses; environmental despair; pandemic-lockdown grief; confrontations with aging, and so on. It’s becoming difficult to find any inner experiences that aren’t indicators of either “good mental health” or a “mental health problem”; the mental health system is essentially colonizing everything it means to be human.

When we talk about “economic health,” though, no one proposes that doctors should be running all banks, businesses, and the Federal Reserve. Yet it seems we’re increasingly forgetting that “mental health” is also just a metaphor. Is it really going to help if we respond to our society’s fast-rising tide of personal, environmental, economic, spiritual, and social crises by giving more people psychiatric treatments, by force if necessary? Where will that lead?

We are at a crossroads.

CHAPTER 28

WHAT CAN BE DONE

Hundreds of billions of dollars every year flow through a massive web of mental health corporations, public and private institutions large and small, and nonprofit organizations with tentacles reaching into nearly every aspect of our lives. It's no longer clear where the mental health system ends and maternal centers, day cares, schools, social media, criminal justice systems, social services, workplaces, and nursing homes begin. Never in history have there been so many psychiatric inpatient beds, and never has such a large percentage of the North American population been psychiatrically labeled or had so many points of contact with mental health services and treatments. Our culture is more "psychiatrized" than ever.

In parallel, psychiatric coercion, detention, and forced treatment—judicial and extrajudicial—are on the rise. If we combine the millions of people labeled with mental disorders who are getting civilly committed, put under a guardianship, incarcerated in the criminal-forensic psychiatric system for relatively trivial wrongdoing, chemically restrained in a nursing home, drugged as minors, or coerced in the community through court orders, housing policies, and social security financial levers, the number of Americans caught in this "psychiatric carceral system" dwarfs that of America's notoriously large prison system, which itself is a partial psychiatric institution. The numbers in both the US and Canada are *orders of magnitude larger* than the total number of people incarcerated at the historical peak of our mass asylums. The psychiatric control system today becomes more comparable to the immense reach of the entire prison, probation, and parole systems combined—and possibly bigger.

Author and ex-psychologist Tana Dineen has provocatively argued that, as certain societies have historically organized themselves around particular racial, economic, religious, or political beliefs, North America is moving ever deeper into becoming a "psychocracy"—a society managed and governed by psychological–psychiatric beliefs, values, and goals.

Certainly, as ever more people suffer mentally and emotionally from mounting economic, environmental, social, and political stresses, virtually all of our "social support" services are morphing into unregulated, unaccountable "social-psychiatric policing" systems. Yet it's difficult to find any knowledgeable person who'll say that the mental health system has been successful at solving virtually any of the large-scale problems it's meant to address. Instead, it's become routine for insiders and outsiders, proponents and critics alike to describe the system as "broken" and "in crisis."

The predominant message from mainstream mental health professionals is that the central problem is too many people not getting treatment, and this can only be solved with more mental health funding, more services, more education and outreach. Many also call for more inpatient beds, more early intervention on children, more persistent, long-term forced treatment of people living in the community, and more expansive laws allowing more forced treatment of wider ranges of people.

But will any of that actually help? The mental health establishment looks more like a vast, failing empire, desperately clinging to power through rising uses of force against growing numbers of disgruntled, traumatized, and resistant people. It's entrenched with leaders who apparently still believe in many of the prejudices and harsh psychiatric practices of bygone eras.

Worse, forced psychiatric treatment is getting resuscitated and strengthened as an arm of a broader movement in our society away from the ethics of honest debate and democratic processes, and toward heightening authoritarianism. Many of us rationalize suppressing perspectives or controlling the lives of others based on science, faith, or values—but underneath is our own fear, intolerance, and strength of conviction that we ourselves couldn't possibly be wrong, we couldn't possibly be the ones who are deluded. And the logic of psychiatric force feeds this, turning the lens constantly toward how delusional or lacking insight "the other" appears to be. But are some people simply well adapted and empowered in an insane society, while others thrash and struggle in its nets?

Collectively, we’ll only be able to work together toward truly constructive change if we have, at the very least, some basic, shared understanding. And for that shared understanding to emerge, we’ll need more transparency and honesty about what’s actually going on when we civilly commit people.

“There is a definite moral, ethical, public administration need, or duty, for these institutions to tell us what they’re doing,” said UCLA’s David Cohen. “They should start with a number.” Practically everyone has an opinion about the need to lock some people up, yet Cohen was one of the first academic researchers in decades to even attempt to quantify how many in America are already being detained under mental health laws, let alone study who they are and what’s happening to them. “The motives we invoke to justify involuntary care are not examined very carefully,” said Cohen.

To better understand what kinds of outcomes involuntary psychiatric interventions are actually having, Cohen argued that we need formal studies by diverse teams of researchers from different backgrounds and perspectives. “They should listen to the complaints people have about how they were treated. And they should set up commissions where they solicit input from a wide range of different people.”

We’re far from that. Yet another telling example: it took me months of back and forth with the Centers for Medicare & Medicaid Services simply to get their media relations office to finally clearly admit, on the record, “CMS does not currently have the data you are requesting. Individual facilities and state agencies may have this data.” Basically, CMS doesn’t bother to collect the numbers of involuntary psychiatric detentions that hospitals around the country register. Why don’t they, and why was admitting the truth so politically sensitive? CMS wouldn’t say. But CMS is overseen by the federal Department of Health and Human Services, at the time under political appointee Xavier Becerra—who has spent much of his political career pushing expanded mental health insurance coverage while getting supported by organizations that promote or profit from forced treatment. I repeatedly asked Becerra’s media relations team if he’d consider instructing CMS to start collecting psychiatric detention data—they did not respond.

It’s often said that openly discussing the rising rates and harms of civil commitment could ultimately harm people by frightening them from seeking help. But what impacts is this vast shroud of secrecy having?

“It could be terrible, the more it’s actually hidden,” suggested Cohen. “Our intentions to keep things quiet, not to unsettle too many people, may actually turn out to be bad for society, and for the people we’re trying to help.” Certainly, the depth of shock, betrayal, and disempowerment many people experience the first time they’re detained, and the scale of enduring fear that the mental health system has created for countless former patients, are already immeasurably vast.

* * *

There may be some need or value in using physical force at times to temporarily restrain even a nonviolent adult from taking an action. But the practices of civil commitment have become far too hidden behind bigoted caricatures and paternalistic platitudes. Even if some percentage of people have derived some benefits from civil commitment, as a society, we need to be more honest about the arbitrary diagnostic labels; the draconian mental health laws; the extreme police aggression against law-abiding citizens that the laws authorize; the often meagerly helpful and very harmful treatments; the call tracing and other forms of surveillance; the financial conflicts of interest; the institutional corruption; the shocking and widespread misuses, overuses, and abuses of psychiatric powers; and the deep and lasting damages inflicted on ever-growing numbers of people. Have we collectively learned nothing from the many other historical cases of institutional nightmares born from conferring inordinate legal powers with inadequate oversight? Behind veils of secrecy and discredited voices of victims, all manner of corruption and abuse fester and spread.

The psychiatric civil commitment system has become so vast, and the uses of psychiatric power have penetrated so far-reachingly into every nook and cranny of our society, that organized political responses are desperately needed. Harmed victims along with dissenting voices and their proposals for change need to be listened to, financially supported, and encouraged much more frequently and persistently.

Indeed, the fact that all mental health practitioners and institutions involved in psychiatric detentions and forced treatment are not themselves rising up in unison to actively and vigorously promote increased transparency may be the single worst indictment against them. They undermine their own claims that they help more than they harm, and fail to prove themselves worthy trustees of the extraordinary legal powers they’ve been given. Consequently, mental health laws have developed into a power that’s out of control—a weapon too dangerous for anyone to safely wield.

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NOTES

CHAPTER 1

STOLEN VOICES

Percentage taking psychotropics: Moore, Thomas. “Adult Utilization of Psychiatric Drugs and Differences by Sex, Age, and Race.” *JAMA Internal Medicine* 177, no. 2 (February 1, 2017). https://doi.org/10.1001/jamainternmed.2016.7507

“National Prescription Drug Utilization Information System.” Canadian Institute for Health Information. https://www.cihi.ca/en/national-prescription-drug-utilization-information-system

Terlizzi, EP. “Mental Health Treatment Among Adults: United States, 2019.” NCHS Data Brief, no 380 (2020). https://www.cdc.gov/nchs/products/databriefs/db380.htm

political pushes by psychiatric guilds: For a history of the American Psychiatric Association’s political, financial, and promotional efforts to position mental and emotional problems as medical issues, see Whitaker, Robert. *Psychiatry Under the Influence: Institutional Corruption, Social Injury, and Prescriptions for Reform*. (Palgrave Macmillan: New York, 2015).

news media coverage For example: McGinty, Emma. “Trends In News Media Coverage Of Mental Illness In The United States: 1995–2014.” *Health Affairs*. 35, no. 6 (June 2016). https://doi.org/10.1377%2Fhlthaff.2016.0011

Whitley, Rob. “Good News? A Longitudinal Analysis of Newspaper Portrayals of Mental Illness in Canada 2005 to 2015.” *Canadian Journal of Psychiatry* 62, no. 4 (April 2017). https://doi.org/10.1177/0706743716675856

Roth Edney, D. “Mass Media and mental illness: A literature review.” Canadian Mental Health Association, Ontario Division (January 2004). https://ontario.cmha.ca/wp-content/files/2012/07/mass_media.pdf

Corrigan, P.W.. “Newspaper stories as measures of structural stigma.” *Psychiatric Services*, 56 (May 1, 2005). https://pubmed.ncbi.nlm.nih.gov/15872163/

E. Fuller Torrey quotes: Messick, Graham, producer. *60 Minutes*. “Imminent Danger.” Aired September 29, 2013, on CBS. https://www.cbsnews.com/news/untreated-mental-illness-an-imminent-danger/

Detentions in Canada and the US: Statistics come from government online sources, studies, court cases, and freedom of information requests. For example:

JH v. Alberta Health Services, ABQB 540 (2019). https://canlii.ca/t/j1hjk

Freedom of Information Response: “Alberta Involuntary Admissions January 2013 to September 2018.” Alberta Health Services.

“Operating in Darkness: BC’s Mental Health Act Detention System.” Community Legal Assistance Society (November 2017). https://d3n8a8pro7vhmx.cloudfront.net/clastest/pages/1794/attachments/original/1527278723/CLAS_Op

Brooks, Megan. “Involuntary Psychiatric Admissions Quadruple.” *Medscape* (February 27, 2018). https://www.medscape.com/viewarticle/893189

Freedom of Information Response: “Number of Physician Visits for Involuntary Admissions.” Ontario Ministry of Health and Long-term Care.

Lebenbaum, Michael. “Prevalence and Predictors of Involuntary Psychiatric Hospital Admissions in Ontario, Canada: A Population-Based Linked Administrative Database Study.” *BJPsych Open* 4, no. 2 (March 2018). https://doi.org/10.1192/bjo.2017.4

“Hospital Mental Health Database (HMHDB) Quick Stats: Mental Health and Addictions Hospitalizations in Canada,Supplementary Tables, 2017–2018 (XLSX).” Canadian Institute for Health Information.

“California Involuntary Detentions Report” (Various fiscal years). Government of California Department of Health Care Services, Mental Health Analytics Section. https://www.dhcs.ca.gov/services/MH/Pages/InvoluntaryDetention-MH.aspx

Freedom of Information Response: “Involuntary Detentions.” California Department of Health Care Services.

“The Baker Act: FY17/18 Annual Report.” The Baker Act Reporting Center, College of Behavioral and Community Sciences, University of South Florida. https://www.usf.edu/cbcs/baker-act/baker-documents/reports.aspx

“A Profile of the State of Colorado’s Care and Treatment of People with Mental Illness: Title 27, Article 65.” (Reports for Fiscal Years from 2011 to 2016). Office of Behavioral Health, Colorado Department of Human Services. https://spl.cde.state.co.us/artemis/huserials/hu10519internet/

About 34 percent civilly committed: Lutterman, Ted. “Trends in Psychiatric Inpatient Capacity, United States and Each State, 1970 to 2014.” National Association of State Mental Health Program Directors (August 2017). https://www.nri-inc.org/media/1319/tac-paper-10-psychiatric-inpatient-capacity-final-09-05-2017.pdf

their own five-year quest: Lee, Gi and David Cohen. “Incidences of Involuntary Psychiatric Detentions in 25 U.S. States.” *Psychiatric Services* 72, no. 1 (January 1, 2021). https://doi.org/10.1176/appi.ps.201900477

European rates of commitment: Sheridan Rains, Luke. “Variations in Patterns of Involuntary Hospitalisation and in Legal Frameworks: An International Comparative Study.” *Lancet Psychiatry* 6, no. 5 (May 2019). https://doi.org/10.1016%2FS2215-0366(19)30090-2

No assurance detentions help people: Goldman, Matthew. “Patients’ Civil Liberties: Improving Policies While Keeping the Patient at the Center.” *Psychiatric Services* 72, no. 1 (January 1, 2021). https://doi.org/10.1176/appi.ps.72103

CHAPTER 2

THE EXPANDING DIAGNOSTIC NET

THE EXPANDING DIAGNOSTIC NET

irresponsible Williamson: *Anderson Cooper 360*. "Cooper Presses Williamson on Her Mental Health Views." Aired August 1, 2019 on CNN. https://www.youtube.com/watch?v=9m7WgSP-RqE The unedited live version has become difficult to find online, but for some media responses to the live version see: Spencer, Miranda. "The Media Scolds Marianne Williamson (and Gets It Wrong)." *Mad In America*. (August 19, 2019). https://www.madinamerica.com/2019/08/media-scolds-marianne-williamson/

chemical imbalance outmoded: Spiegel, Alix. "When It Comes to Depression, Serotonin Isn't the Whole Story." NPR (January 23, 2012). https://www.npr.org/sections/health-shots/2012/01/23/145525853/when-it-comes-to-depression-serotoninisnt-the-whole-story

pseudoscientific myth: Pies, Ronald. "Debunking the Two Chemical Imbalance Myths, Again." *Psychiatric Times*, Vol. 36, Issue 8 (August 1, 2019). https://www.psychiatrictimes.com/view/debunking-two-chemical-imbalance-myths-again

schizophrenia is caused by a chemical imbalance: "Schizophrenia." Johns Hopkins Medicine. Accessed February 9, 2022. https://www.hopkinsmedicine.org/health/conditions-and-diseases/schizophrenia

mood disorders likely caused by an imbalance: "Mood Disorders." Johns Hopkins Medicine. Accessed February 9, 2022. https://www.hopkinsmedicine.org/health/conditions-and-diseases/mood-disorders

figure of speech: "What Causes Depression?" Harvard Health. (June 24, 2019). https://www.health.harvard.edu/mind-and-mood/what-causes-depression

Imperial medicalization of normality: Frances, Allen. "Don't People in Chronic Pain Have Enough to Deal With?" *HuffPost*. (May 1, 2013). https://www.huffpost.com/entry/dsm-5-chronic-pain_b_2916904

caught in DSM-5 net: Frances, Allen. "A Warning Sign on the Road to DSM-V: Beware of Its Unintended Consequences." *Psychiatric Times*. Vol 26 No 8 (June 26, 2009). https://www.psychiatrictimes.com/view/warning-sign-road-dsm-v-beware-its-unintended-consequences

shrink the pool of normality: Bosely, Sarah. "Psychologists Fear US Manual Will Widen Mental Illness Diagnosis." *The Guardian* (February 9, 2012). https://www.theguardian.com/society/2012/feb/09/us-mental-health-manual

disappointingly distant: "Statement by David Kupfer, MD—Chair of DSM-5 Task Force Discusses Future of Mental Health Research." American Psychiatric Association Press Release No 13-33 (May 3, 2013). https://robwipond.com/wp-content/uploads/2021/10/statement-from-apa-dsm-chair-david-kupfer.pdf

experts don't agree very reliably: Kraemer, Helena. "DSM-5: How Reliable Is Reliable Enough?" *American Journal of Psychiatry* 169, no. 1 (January 1, 2012). https://doi.org/10.1176/appi.ajp.2011.11010050

Regier, D. "DSM-5 Field Trials in the United States and Canada, Part II: Test-Retest Reliability of Selected Categorical Diagnoses." *American Journal of Psychiatry* (2013). https://doi.org/10.1176/appi.ajp.2012.12070999

clinical criteria arbitrary: "About RDoC." National Institute of Mental Health. Accessed October 11, 2021. https://www.nimh.nih.gov/research/research-funded-by-nimh/rdoc/about-rdoc

lack of treatment specificity: Kupfer DJ. *A Research Agenda for DSM V*. (Washington, D.C.: American Psychiatric Association, 2002).

medical conditions that cause mental symptoms: First, Michael. "Medical Assessment of the Patient with Mental Symptoms—Psychiatric Disorders." *Merck Manuals Professional Edition* (February 2020).

https://www.merckmanuals.com/professional/psychiatric-disorders/approach-to-the-patient-with-mental-symptoms/medical-assessment-of-the-patient-with-mentalsymptoms

misdiagnoses common: Anderson, Eric. “American Association for Emergency Psychiatry Task Force on Medical Clearance of Adults Part I: Introduction, Review and Evidence-Based Guidelines.” *Western Journal of Emergency Medicine* 18, no. 2 (February 2017). https://doi.org/10.5811/westjem.2016.10.32258

Wilson, Michael. “American Association for Emergency Psychiatry Task Force on Medical Clearance of Adult Psychiatric Patients. Part II: Controversies over Medical Assessment, and Consensus Recommendations.” *Western Journal of Emergency Medicine* 18, no. 4 (June 2017). https://doi.org/10.5811/westjem.2017.3.32259

surveillance video: Johnson. Erica. “Video Captures Patient Crawling out of Hospital after Staff Dismiss Pleas for Help.” *CBC News* (January 18, 2021). https://www.cbc.ca/news/gopublic/hospital-patient-crawls-out-mental-illness-1.5871307

McGill University–led meta-analysis: Levis, Brooke. “Accuracy of Patient Health Questionnaire-9 (PHQ-9) for Screening to Detect Major Depression.” *BMJ* 365 (April 9, 2019). https://doi.org/10.1136/bmj.l1476

GAD-7 overdiagnoses: Plummer, Faye. “Screening for Anxiety Disorders with the GAD-7 and GAD-2.” *General Hospital Psychiatry* 39 (April 2016). https://doi.org/10.1016/j.genhosppsych.2015.11.005

performs worse: Staples, Lauren. “Psychometric Properties and Clinical Utility of Brief Measures of Depression, Anxiety, and General Distress: The PHQ-2, GAD-2, and K-6.” *General Hospital Psychiatry* 56 (January 1, 2019). https://doi.org/10.1016/j.genhosppsych.2018.11.003

diagnose seventeen disorders in fifteen minutes: “MINI.” (September 7, 2016) Harm Research Institute. https://harmresearch.org/index.php/mini-international-neuropsychiatric-interview-mini/

more than half of Americans: Kessler, Ronald C. “Lifetime Prevalence and Age-of-Onset Distributions of DSMIV Disorders in the National Comorbidity Survey Replication.” *Archives of General Psychiatry* 62, no. 6 (June 2005). https://doi.org/10.1001/archpsyc.62.6.593

more than half before age eighteen: “Mental Illness.” National Institute of Mental Health. Accessed October 11, 2021. https://www.nimh.nih.gov/health/statistics/mental-illness

Merikangas, Kathleen. “Lifetime Prevalence of Mental Disorders in US Adolescents: Results from the National Comorbidity Study-Adolescent Supplement (NCS-A).” *Journal of the American Academy of Child and Adolescent Psychiatry* 49, no. 10 (October 2010). https://doi.org/10.1016/j.jaac.2010.05.017

psychiatric diagnosis is an inexact science: *Addington v. Texas*. 441 U.S. 418 (1979). https://supreme.justia.com/cases/federal/us/441/418/

CHAPTER 3

“WISE AND BENEVOLENT PATERNALISM” WITH A GAVEL AND NEEDLE

massive curtailment of liberty: *Humphrey v. Cady*. 405 U.S. 504 (1972). https://supreme.justia.com/cases/federal/us/405/504/

governmental interference: *Rennie v. Klein*. 462 F. Supp. 1131 (D.N.J. 1978). https://law.justia.com/cases/federal/district-courts/FSupp/462/1131/2142341/

give birth or abort: *Rogers v. Okin*. 478 F. Supp. 1342 (D. Mass. 1979). https://law.justia.com/cases/federal/districtcourts/FSupp/478/1342/1899607/

good reason to refuse: *Rennie v. Klein*. 462 F. Supp. 1131 (D.N.J. 1978). https://law.justia.com/cases/federal/districtcourts/FSupp/462/1131/2142341/

86 percent of 170,000 wellness checks: Williams, David. "New York City Will Send Mental Health Teams Instead of Police to Respond to Some 911 Calls." CNN (November 11, 2020). https://www.cnn.com/2020/11/11/us/new-york-city-mentalhealth-911-trnd/index.html

"B-Heard: Transforming NYC's Response to Mental Health Crises—First Three Months of Operations." City of New York (2021). https://mentalhealth.cityofnewyork.us/wp-content/uploads/2021/10/FIRST-QUARTER-OF-OPERATIONS-FINAL.pdf

Eric Zink: "I was Swatted During Mental Health Live Stream! My Experience!" YouTube video posted by Eric B Zink (March 12, 2019). https://www.youtube.com/watch?v=Wkxm9yyajeU

criteria for civil commitment: Mental health legislation describing the criteria for involuntary detention and treatment for each state and province is available from the respective governments and usually online. For example:

California Welfare and Institutions Code. Chapter 2: Involuntary Treatment. https://leginfo.legislature.ca.gov/faces/codes_displayexpandedbranch.xhtml?tocCode=WIC&division=5.&title=&part=1.&chapter=2.&article=

British Columbia Mental Health Act. http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96288_01

For an overview of US state legal regimes, see also: Daily, Lisa. "Grading the States: An Analysis of Involuntary Psychiatric Treatment Laws." Treatment Advocacy Center (September 2018). Note that Treatment Advocacy Center strongly promotes forced treatment, so its analyses should be understood in that context. https://www.treatmentadvocacycenter.org/grading-the-states

wise and benevolent paternalism: Perlin cites e.g., Chodoff, P. "The Case for Involuntary Hospitalization of the Mentally Ill." *American Journal of Psychiatry* 133, no. 5 (May 1976). https://doi.org/10.1176/ajp.133.5.496

exaggerated the dangerousness: Torrey, E. Fuller. *Out of the Shadows: Confronting America's Mental Illness Crisis* (New York: John Wiley and Sons, 1997), p.152.

reluctant to comply: Ibid, p.151.

aggregate power: Perlin, Michael. *The Hidden Prejudice: Mental Disability on Trial*. (Washington, DC: American Psychological Association, 2000.) p.90.

no clear association with clinical need: Sheridan Rains, Luke. "Variations in Patterns of Involuntary Hospitalisation and in Legal Frameworks." *Lancet Psychiatry* 6, no. 5 (May 2019). https://doi.org/10.1016/S2215-0366(19)30090-2

70 percent ER doctors boarding: ACEP Emergency Medicine Practice Committee. "Practical Solutions to Boarding of Psychiatric Patients in the Emergency Department." American College of Emergency Physicians (October 2015). https://www.macep.org/Files/Behavioral%20Health%20Boarding/Practical%20Solutions%20to%20Boar

CHAPTER 4

THE CATCH-22 OF “INSIGHT”

Reasons for Judgment: *Mullins v. Levy*. 2005 BCSC 1217. Supreme Court of British Columbia (2005). https://www.bccourts.ca/jdb-txt/sc/05/12/2005bcsc1217err1.htm

‘lack of insight’ promotion: “Anosognosia.” Treatment Advocacy Center. Accessed October 11, 2021. https://www.treatmentadvocacycenter.org/key-issues/anosognosia

For example, see also: “Anosognosia.” National Alliance on Mental Illness. https://www.nami.org/About-Mental-Illness/Commonwith-Mental-Illness/Anosognosia

Brody, Barbara. “Anosognosia: Why Some People Stop Taking Their Meds.” WebMD. https://www.webmd.com/schizophrenia/what-is-anosognosia

“Coordinated Specialty Care for First Episode Psychosis Manual I: Outreach and Recruitment.” National Institute of Mental Health. https://www.nimh.nih.gov/health/topics/schizophrenia/raise/coordinated-specialty-care-for-first-episode-psychosismanual-i-outreach-and-recruitment

“Psychosis.” British Columbia Schizophrenia Society. https://www.bcss.org/education/about-mental-illness/psychosis/

adverse effects too severe: Velligan, Dawn. “Why Do Psychiatric Patients Stop Antipsychotic Medication? A Systematic Review of Reasons for Nonadherence to Medication in Patients with Serious Mental Illness.” *Patient Preference and Adherence* 11 (March 3, 2017). https://doi.org/10.2147/PPA.S124658

insight-assessment tools: Beck, Aaron. “A New Instrument for Measuring Insight: The Beck Cognitive Insight Scale.” *Schizophrenia Research* 68, no. 2 (June 1, 2004). https://doi.org/10.1016/s0920-9964(03)00189-0

reporting on the trend: Smith, Mark. “Voluntarily Checking Into Psychiatric Hospital, Easy. Checking Out? Not So Much.” WFAA-TV (November 7, 2017). https://www.wfaa.com/article/news/local/investigates/voluntarily-checking-intopsychiatric-hospital-easy-checking-out-not-so-much/287-489740526

in 2021 nothing had changed: Huffman, Charlotte. “Some Texas Psych Hospitals Continue to Hold Patients Against Their Will, Complaints Show.” WFAA-TV (March 10, 2021). https://www.wfaa.com/article/news/local/investigates/texas-psychhospitals-hold-voluntary-patients-mental-health-against-their-will-complaints-show/287-956cb7b7-d75c-4f06-a2c7-2f49f35cdfe5

CHAPTER 5

“MINIMALLY ADEQUATE” CARE

dirty, stark, austere and smelly: *Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass. 1979). https://law.justia.com/cases/federal/district-courts/FSupp/478/1342/1899607/

elude routine government inspections: Center for Clinical Standards and Quality/Survey & Certification Group. “Policy and Requirements for an Application for Approval of an Accreditation Program.” Centers for Medicare & Medicaid Services (May, 2018). https://www.cms.gov/Medicare/Provider-

Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/applicationrequirements.pdf

more than 350 incidents: Gilbert, Daniel. “Public Crisis, Private Toll.” *Seattle Times* (September 8, 2019). https://projects.seattletimes.com/2019/public-crisis-private-toll-part2/

Portland, Oregon’s psychiatric system: For example: Budnick, Nick. “Multnomah County Mental Health Whistleblower Sues.” *Portland Tribune* (April 2, 2019). https://pamplinmedia.com/pt/9-news/424201-329989-county-mental-healthwhistleblower-sues

Budnick, Nick. “State Finds Patients Endangered at Legacy’s Unity Center.” *Portland Tribune* (August 3, 2018). https://portlandtribune.com/pt/9-news/402588-299350-state-finds-deficiencies-at-unity-center

California model overwhelmed for years: Harbarger, Molly. “Sales Pitch for Portland’s Mental Health ER Omitted Numerous Red Flags.” *The Oregonian/OregonLive* (February 6, 2020). https://www.oregonlive.com/health/2020/02/portlandspsychiatric-er-troubles-echo-those-of-california-hospital-sold-as-a-best-practice.html

Alaska: DeMarban, Alex. “Troubled Alaska Psychiatric Institute Receives Accreditation.” *Anchorage Daily News* (April 12, 2019). https://www.adn.com/alaska-news/anchorage/2019/04/12/troubled-alaska-psychiatric-institute-receives-accreditation/

Bellevue: “Use of Restraints on Psychiatric Patients at Bellevue Hospital Center.” Disability Rights New York (2016). https://www.dropbox.com/sh/2av38b8nlcmmqkf/AAApHx3khFT_DnZkojgCeHS0a?dl=0&preview=a.+bellevue-restraint-report.pdf

Alameda: “Disability Rights California Files Lawsuit Against Alameda County for Its Failed Mental Health System.” Disability Rights California Press Release (July 30, 2020). https://www.disabilityrightsca.org/press-release/disability-rightscalifornia-files-lawsuit-against-alameda-county-for-its-failed

locked in seclusion for a year: Michels, Holly. “State Hospital Patients Sue, Claiming Psychological, Emotional Harm.” *Montana Standard* (September 16, 2017). https://mtstandard.com/news/local/state-hospital-patients-sue-claimingpsychological-emotional-harm/article_e569a6a7-f683-52bd-b1ff-f480ff3d428e.html

St. Elizabeths: “Abuse Unabated: Restraint and Seclusion at St. Elizabeths Hospital.” Disabilty Rights DC (September 2020). https://www.uls-dc.org/media/1209/abuseunabatedfinal.pdf

security guards not investigated: “Annual Report 2018.” Disability Rights Florida. https://disabilityrightsflorida.org/documents/Disability_Rights_FL_2018_Annual_Report.pdf

lawyers blocked from hospital: Innes, Stephanie. “Advocacy Group Settles Lawsuit Against Arizona State Hospital.” *Arizona Republic* (November 20, 2019). https://www.azcentral.com/story/news/local/arizona-health/2019/11/20/arizona-centerdisability-law-settles-lawsuit-psychiatric-hospital-access/4254671002/

shaking and crying: For links, see “Jane Doe et al v. Fairfax Behavioral Health.” Disability Rights Washington (April 30, 2019). https://www.disabilityrightswa.org/cases/jane-doe-john-doe-h-s-by-and-through-his-guardian-v-fairfax-behavioral-health/

sexual abuse of children for a decade: Hargrove, Adrianna. “$127 Million Lawsuit Claims Years of Abuse at Children’s Hospital in New Kent County.” NBC12 (October 20, 2020). https://www.nbc12.com/2020/10/20/million-lawsuitclaims-years-abuse-childrens-hospital-new-kent-county/

Newsroom. “Psychotherapist at Virginia Children’s Hospital Indicted on Sex Crimes.” NBC12 (February 6, 2020). https://www.nbc12.com/2020/02/06/psychotherapist-virginia-childrens-hospital-indicted-sex-crimes/

routinely discounted the credibility: "Turning a Blind Eye: How Breakdowns in State Hospital Oversight Leave Patients Vulnerable to Physician Abuse and Professional Misconduct." Disability Rights Texas (February 2013). https://media.disabilityrightstx.org/wp-content/uploads/2018/08/16012056/Turning-a-Blind-Eye-State-Hospital-Investigative-Report-FINALfeb-18-2012.pdf

patient dumping: Hubert, Cynthia. "'Greyhound Therapy': Nevada Psychiatric Patients Bused to Different States Win Lawsuit." *Governing* (November 2, 2018). https://www.governing.com/archive/tns-nevada-hospital-psychiatric-patients-lawsuit.html

Hubert, Cynthia. "Jury Finds in Favor of Mentally Ill Patients Who Were Bused out of Nevada Psychiatric Hospital." *Sacramento Bee* (November 1, 2018). https://www.sacbee.com/news/local/article220994870.html

absence of systemic oversight: "Operating in Darkness: BC's Mental Health Act Detention System." Community Legal Assistance Society (November 2017). https://d3n8a8pro7vhmx.cloudfront.net/clastest/pages/1794/attachments/original/1527278723/CLAS_Op

deeply entrenched: Poitras, Jacques. "'Mistreatment and Inadequate Care' at Psychiatric Hospital, Says N.B. Ombud." CBC News (February 7, 2019). https://www.cbc.ca/news/canada/new-brunswick/charles-murray-restigouche-hospital-1.5009426

McPhail, Colin. "Class-Action Lawsuit Launched over Alleged Negligence at Restigouche Hospital Centre." CBC News (May 28, 2019). https://www.cbc.ca/news/canada/new-brunswick/restigouche-hospital-centre-patients-class-action-lawsuit-1.5153473

infestation of maggots: *United States v. Com. of Pennsylvania*, 902 F. Supp. 565 (W.D. Pa. 1995). https://law.justia.com/cases/federal/district-courts/FSupp/902/565/2597226/

wide variation on most measures: Shields, Morgan. "Quality of Inpatient Psychiatric Care at VA, Other Government, Nonprofit, and For-Profit Hospitals: A Comparison." *Psychiatric Services* 68, no. 3 (March 1, 2017). https://doi.org/10.1176/appi.ps.201600074

seemingly unrelated to the types of patients: Staggs, Vincent. "Variability in Psychiatric Facility Seclusion and Restraint Rates as Reported on Hospital Compare Site." *Psychiatric Services* 71, no. 9 (September 1, 2020). https://doi.org/10.1176/appi.ps.202000011

despite glaring need: Shields, Morgan C. "Patient Safety In Inpatient Psychiatry: A Remaining Frontier For Health Policy." *Health Affairs* 37, no. 11 (November 2018). https://doi.org/10.1377/hlthaff.2018.0718

patient safety is under-researched: Thibaut, Bethan. "Patient Safety in Inpatient Mental Health Settings: A Systematic Review." *BMJ Open* 9, no. 12 (December 1, 2019). https://doi.org/10.1136/bmjopen-2019-030230

barred systemic investigations: "Text - H.R.3717 - 113th Congress (2013-2014): Helping Families in Mental Health Crisis Act of 2013." 113th Congress (2013-2014). https://www.congress.gov/bill/113th-congress/house-bill/3717/text

80 percent health and safety citations: Manat Health. "The High Cost of Compliance: Assessing the Regulatory Burden on Inpatient Psychiatric Facilities." National Association for Behavioral Healthcare (March 19, 2019). https://www.nabh.org/the-high-cost-of-compliance/

dangerously lax: Wolfe, Sidney. "Ranking of the Rate of State Medical Boards' Serious Disciplinary Actions, 2017-2019." Public Citizen (March 31, 2021). https://default.salsalabs.org/Tb1b94f48-1c39-45e2-9a43-216f329942cf/dd3230b1-fac04448-8b48-6fa9452c75a3

not understood acting in the public interest: BC Ombudsman. "Acting in the Public Interest? Self-Governance in the Health Professions: The Ombudsman's Perspective." Special Report No. 24 to the

Legislative Assembly of British Columbia (May 2003). https://bcombudsperson.ca/assets/media/Special-Report-No-24-Self-Governance-in-the-Health-Professions-TheOmbudsmans-Perspective.pdf

problems have persisted: Steering Committee on Modernization of Health Professional Regulation. "Recommendations to Modernize the Provincial Health Profession Regulatory Framework." Government of British Columbia (August 2020). https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/professional-regulation/recommendations-tomodernize-regulatory-framework.pdf

ocean of information hidden: Mendleson, Rachel. "Canada's Medical Watchdogs Know More About Bad Doctors Than They Are Telling You." *Toronto Star* (May 2, 2018). https://projects.thestar.com/doctor-discipline/part-2/

right of conscientious objection: Gadsby, Jonathan. "Mental Health Nursing and Conscientious Objection to Forced Pharmaceutical Intervention." *Nursing Philosophy* Vol 22 Iss 4 (October 2021). https://doi.org/10.1111/nup.12369

CHAPTER 6

"YOU ONLY FIGHT BACK ONCE": PSYCHIATRIC POWER AND PREJUDICE

improve its future population: Hurst, C. C. "Germany's Sterilization Law: What It Might Accomplish." *New York Times* (August 5, 1934). https://www.nytimes.com/1934/08/05/archives/germanys-sterilization-law-what-it-might-accomplish-abritish.html

central and critical: Strous, Rael. "Psychiatry During the Nazi Era: Ethical Lessons for the Modern Professional." *Annals of General Psychiatry* 6, no. 1 (February 27, 2007). https://doi.org/10.1186/1744-859X-6-8

role in perpetrating structural racism: "APA's Apology to Black, Indigenous and People of Color for Its Support of Structural Racism in Psychiatry." American Psychiatric Association (January 18, 2021). Accessed October 20, 2021. https://www.psychiatry.org/newsroom/apa-apology-for-its-support-of-structural-racism-in-psychiatry

more Black than white patients with schizophrenia: "Historical Addendum to APA's Apology to Black, Indigenous and People of Color for Its Support of Structural Racism in Psychiatry." American Psychiatric Association. Accessed October 20, 2021. https://www.psychiatry.org/newsroom/historical-addendum-to-apa-apology

conducted four surveys: "APA's Structural Racism Task Force and Resources—Task Force Survey Results." American Psychiatric Association. https://www.psychiatry.org/psychiatrists/structural-racism-task-force

overrepresentation of Indigenous children: For example: "Disproportionality Rates for Children of Color in Foster Care." National Indian Child Welfare Association (2019). https://www.nicwa.org/wp-content/uploads/2019/08/Disproportionality-Table-2019.pdf

Clark and Cram: Still, Larry. "Lawyers Saddened After Colleague Sent for Psychiatric Tests." *Vancouver Sun* (April 28, 1994).

Gatehouse, Jonathon. "Bruce: No Truce: Lawyer has Long Tilted at Windmills." *National Post*

(December 11, 1999).

CHAPTER 7

“HOUSING FOURTH” AND THE MYTH OF DWINDLING HOSPITAL BEDS

pattern of violence: Torrey, E. Fuller. “Why Deinstitutionalization Turned Deadly.” *Wall Street Journal* (August 4, 1998). https://www.wsj.com/articles/SB902183542448858500

now generally accepted: Carey, Benedict. “Bring Back Asylums?” *New York Times* (March 5, 2018). https://www.nytimes.com/2018/03/05/health/mental-illness-asylums.html

more and more in prison: Raphelson, Samantha. “How the Loss of U.S. Psychiatric Hospitals Led to a Mental Health Crisis.” NPR (November 30, 2017). https://www.npr.org/2017/11/30/567477160/how-the-loss-of-u-s-psychiatric-hospitals-led-toa-mental-health-crisis

The New Asylums: *FRONTLINE*, “The New Asylums.” PBS. Originally aired May 10, 2005. https://www.pbs.org/wgbh/pages/frontline/shows/asylums/special/excerpt.html

Homelessmentallyilldeinstitutionalized: Mac, Gabriel. “Schizophrenic. Killer. My Cousin.” *Mother Jones* (May–June 2013). https://www.motherjones.com/politics/2013/04/mental-health-crisis-mac-mcclelland-cousin-murder/

impotent in the face: Snook, John & Torrey, E. Fuller. “America Badly Needs More Psychiatric-Treatment Beds.” *National Review* (February 23, 2018). https://www.nationalreview.com/2018/02/america-badly-needs-more-psychiatric-treatmentbeds/

streets and prisons filled: Starr, Penny. “Donald Trump Is Right About Mental Illness and Mass Shootings.” *Breitbart* (September 2, 2019). https://www.breitbart.com/politics/2019/09/02/penny-starr-donald-trump-is-right-about-mental-illness-andmass-shootings/

jails house ten times more: Gold, Jenny. “Report: Jails House 10 Times More Mentally Ill Than State Hospitals.” Kaiser Heath News (April 8, 2014). https://khn.org/news/report-jails-house-10-times-more-mentally-ill-than-state-hospitals/

has been a tragedy: Wente, Margaret. “The Mentally Ill Have the Right to Be Well.” *Globe and Mail* (February 12, 2013). https://www.theglobeandmail.com/opinion/the-mentally-ill-have-the-right-to-be-well/article8466731/

shortage of inpatient beds: Moran, Mark. “APA Rings Alarm in Nation’s Capitol About Crisis in Mental Health Care.” *Psychiatric News* (January 1, 2020). https://doi.org/10.1176/appi.pn.2020.1a14

criteria make it nearly impossible: McCance-Katz, Elinore. “Changing Focus: The Right to Treatment of Serious Mental Illness.” Substance Abuse and Mental Health Services Administration (April 16, 2018). https://www.samhsa.gov/sites/default/files/the_right_to_treatment.pdf

co-authored, shadow authored by, or otherwise involved: Ben-Moshe, Liat. *Decarcerating Disability: Deinstitutionalization and Prison Abolition* (Minnesota: University of Minnesota Press, 2020) p.157.

hundreds of millions of dollars from Theodore Stanley: Stanley Medical Research Institute website. Accessed February 10, 2022. https://www.stanleyresearch.org/about/

begging and idleness: Foucault, Michel. *History of Madness* ed. Jean Khalifa, trans. Jonathan Murphy and Jean Khalifa. (Routledge: London and New York, 2006), p.62

11 state hospital beds per 100,000 people: Fuller, Doris. “Going, Going, Gone. Trends and Consequences of Eliminating State Psychiatric Beds.” Treatment Advocacy Center (2016). https://www.treatmentadvocacycenter.org/storage/documents/going-going-gone.pdf

near bottom of OECD: Hewlett, E. “Making Mental Health Count: The Social and Economic Costs of Neglecting Mental Health Care.” OECD Health Policy Studies (2014). https://doi.org/10.1787/9789264208445-en

most analyses fail to include: Lutterman, Ted. “Trends in Psychiatric Inpatient Capacity, United States and Each State, 1970 to 2014.” National Association of State Mental Health Program Directors (August 2017). https://www.nri-inc.org/media/1319/tac-paper-10-psychiatric-inpatient-capacity-final-09-05-2017.pdf

neither apt nor meaningful: “Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice.” Substance Abuse and Mental Health Services Administration (2019). https://www.samhsa.gov/resource/ebp/civil-commitment-mental-health-care-continuum-historical-trends-principles-law

918,700 people in residential-care communities: Caffrey, Christine. “Residential Care Community Resident Characteristics: United States, 2018.” NCHS data brief, no. 404 (September 1, 2021). https://stacks.cdc.gov/view/cdc/103826

40 percent with serious mental illness: Khatutsky G. “Residential Care Communities and Their Residents in 2010: A National Portrait.” DHHS Publication No. 2016-1041. National Center for Health Statistics (2016). https://www.cdc.gov/nchs/data/nsrcf/nsrcf_chartbook.pdf

one spent some time homeless: Petersen, Karen. “Redevelopment of Tertiary Psychiatric Services in British Columbia: A Prospective Study of Clinical, Social, and Residential Outcomes of Former Long-Stay Inpatients.” *Schizophrenia Research* 149, no. 1 (September 1, 2013). https://doi.org/10.1016/j.schres.2013.05.022

chronic sleep deprivation: Waters, Flavie. “Severe Sleep Deprivation Causes Hallucinations and a Gradual Progression Toward Psychosis with Increasing Time Awake.” *Frontiers in Psychiatry* 9 (July 10, 2018). https://doi.org/10.3389%2Ffpsyt.2018.00303

37% of prisoners and 44% of jail inmates: Bronson, J. “Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011–12.” Bureau of Justice Statistics (June 2017). https://bjs.ojp.gov/content/pub/pdf/imhprpji1112.pdf

violence, mental disorders, substance use: For example: Fazel, Seena. “Schizophrenia and Violence: Systematic Review and Meta-Analysis.” *PLOS Medicine* 6, no. 8 (August 11, 2009). https://doi.org/10.1371/journal.pmed.1000120

alcohol and violence: For example: National Institute on Alcohol Abuse and Alcoholism. “Alcohol, Violence, and Aggression - Alcohol Alert No. 38-1997.” Accessed October 22, 2021. https://pubs.niaaa.nih.gov/publications/aa38.htm “Based on published studies, Roizen (3) summarized the percentages of violent offenders who were drinking at the time of the offense as follows: up to 86 percent of homicide offenders, 37 percent of assault offenders, 60 percent of sexual offenders, up to 57 percent of men and 27 percent of women involved in marital violence.”

a 2021 review of such studies: Whiting, Daniel. “Violence and Mental Disorders: A Structured Review of Associations by Individual Diagnoses, Risk Factors, and Risk Assessment.” *Lancet Psychiatry* 8, no. 2 (February 2021). https://doi.org/10.1016/S2215-0366(20)30262-5

dozens of states in the 5 to 10 percent range: Shannon, Sarah. “The Growth, Scope, and Spatial Distribution of People with Felony Records in the United States, 1948–2010.” *Demography* 54, no. 5 (October 2017). https://doi.org/10.1007/s13524-017-0611-1

US Secret Service: National Threat Assessment Center. “Mass Attacks in Public Spaces - 2019.” U.S. Secret Service, Department of Homeland Security (August 2020). https://www.secretservice.gov/sites/default/files/reports/2020-09/MAPS2019.pdf

bulk of offenses drug possession, traffic violations, disorderly conduct and so on: For example: Modestin, Jiri. “Criminality in Men with Major Mental Disorder With and Without Comorbid Substance Abuse.” *Psychiatry and Clinical Neurosciences* 59, no. 1 (2005). https://doi.org/10.1111/j.1440-1819.2005.01327.x

Stueve, A. “Gender Differences in the Relationship Between Mental Illness and Violence: Evidence From a Community-Based Epidemiological Study in Israel.” *Social Psychiatry and Psychiatric Epidemiology* 33, no. 1 (November 1, 1998). https://doi.org/10.1007/s001270050211

Tiihonen, J. “Specific Major Mental Disorders and Criminality: A 26-Year Prospective Study of the 1966 Northern Finland Birth Cohort.” *American Journal of Psychiatry* 154, no. 6 (June 1, 1997). https://doi.org/10.1176/ajp.154.6.840

worse than random guessing: For example: Garrett, Brandon L. “Judging Risk.” California Law Review, Vol. 108, No. 2 (April 2020). https://www.californialawreview.org/print/judging-risk/

Barefoot v. Estelle, 463 U.S. 880 (1983). https://supreme.justia.com/cases/federal/us/463/880/ The American Psychiatric Association itself testified to the US Supreme Court that psychiatrists could not predict possible future violence. Ironically, the court, expressly concerned about protecting the daily use of such predictions throughout the justice and civil commitment systems, dismissed the APA’s admission: “We are not persuaded that such testimony is almost entirely unreliable.”

Housing Fourth: Wamsley, Laurel. “White House Names Controversial Pick To Head Homelessness Office.” NPR (December 5, 2019). https://www.npr.org/2019/12/05/785129572/white-house-names-controversial-pick-to-head-homelessnessoffice

first significant gun reform: Brownlee, Chip. “What You Need to Know About the Senate Gun Reform Bill.” *The Trace* (June 24, 2022). https://www.thetrace.org/2022/06/senate-gun-bill-safer-communities-act/

Texas youth without procedural fairness or transparency: *Jenny Lisette Flores, et al. v. Jefferson B. Sessions, Attorney General et al*. “Memorandum in Support of Motion to Enforce Settlement.” CV 85-4544-DMG (AGRX). https://www.clearinghouse.net/chDocs/public/IM-CA-0002-0054.pdf

Pettersson, Edvard. “Immigrant Kids Are Forcibly Medicated in Custody, Lawyers Say.” *Santa Fe New Mexican* (June 25, 2018). https://www.santafenewmexican.com/news/immigrant-kids-are-forcibly-medicated-in-custody-lawyers-say/article_e39047c9-6fea5bd5-9d31-a65973b05f66.html

arrests appear to be driven by their circumstances: “The ‘Unwanteds’: Looking for Help, Landing in Jail.” Disability Rights Oregon (Spring 2019). https://www.droregon.org/s/Report-The-Unwanteds-Looking-for-Help-Landing-in-Jail2019-June18.pdf

hospitals making hundreds of calls annually to police: “From Hospitals to Handcuffs: Criminalizing Patients in Crisis.” Disability Rights Washington (May 2020). https://www.disabilityrightswa.org/wp-content/uploads/2020/05/Hospitals-to-Handcuffs-FINAL.pdf

did not suffer from any psychiatric condition: *JH v. Alberta Health Services*, ABQB 540 (2019). https://canlii.ca/t/j1hjk

unnecessary institutionalization: For lawsuits and settlements with states, see Department of Justice

“Health Care Fraud and Abuse Control Program Annual Reports.” https://www.justice.gov/criminal-fraud/health-care-fraud-and-abuse-control-program

unnecessarily hospitalized for months: Mitchell, Beth. “Warehoused: Inappropriate Institutionalization of Texas Foster Youth.” Disability Rights Texas (March 8, 2019). https://media.disabilityrightstx.org/wp-content/uploads/2019/03/07200850/Warehoused-Inappropriate-Institutionalization-of-Texas-Foster-Youth-03.08.19-FINAL.pdf

Louisiana: Enfinger, Emily. “SPLC Files Class Action Lawsuit Against Louisiana Department of Health.” *Shreveport Times* (November 8, 2019). https://www.shreveporttimes.com/story/news/2019/11/08/splc-files-class-action-lawsuit-against-louisianadepartment-health/2530405001/

Illinois: Eldeib, Duaa. “Hundreds of Illinois Children Languish in Psychiatric Hospitals After They’re Cleared for Release.” *ProPublica* (June 5, 2018). https://features.propublica.org/stuck-kids/illinois-dcfs-children-psychiatric-hospitals-beyondmedical-necessity/

CHAPTER 8

HOW MUCH IS AN INVOLUNTARY PATIENT WORTH?

stress on that broken system: Patel, Norm. “The Coming Mental-Health Crisis.” *The Atlantic* (May 14, 2020). https://www.theatlantic.com/ideas/archive/2020/05/coming-mental-health-crisis/611635/

handle this coming surge: Wan, William. “The Coronavirus Pandemic Is Pushing America into a Mental Health Crisis.” *Washington Post* (May 4, 2020). https://www.washingtonpost.com/health/2020/05/04/mental-health-coronavirus/

most comprehensive estimate: “Behavioral Health Spending & Use Accounts, 2006-2015.” Substance Abuse and Mental Health Services Administration (February 2019). https://store.samhsa.gov/product/Behavioral-Health-Spending-and-UseAccounts-2006-2015/SMA19-5095

estimated $16 billion: “Health System Resources for Mental Health and Addictions Care in Canada.” Canadian Institute for Health Information (July 2019). https://www.cihi.ca/sites/default/files/document/mental-health-chartbook-report2019-en-web.pdf

$182 billion annually to manage justice system: Wagner, Peter. “Following the Money of Mass Incarceration.” Prison Policy Initiative (January 25, 2017). https://www.prisonpolicy.org/reports/money.html

depression costs $210.5 billion annually: Greenberg, Paul. “The Economic Burden of Adults with Major Depressive Disorder in the United States.” *Journal of Clinical Psychiatry* 76, no. 2 (February 2015). https://doi.org/10.4088/JCP.14m09298

schizophrenia costs $281.6 billion annually: “Societal Costs of Schizophrenia & Related Disorders.” Schizophrenia & Psychosis Action Alliance (July 2021). https://sczaction.org/insight-initiative/societal-costs/

confidential trade secrets: Stensland, Michael. “An Examination of Costs, Charges, and Payments for Inpatient Psychiatric Treatment in Community Hospitals.” *Psychiatric Services* 63, no. 7 (July 2012).

https://doi.org/10.1176/appi.ps.201100402

Mental Health America website quotes For example: “The Science Behind Mental Illness and Recovery.” Mental Health America. Accessed October 17, 2021. https://mhanational.org/science

NAMI funding: Harris, Gardiner. “Drug Makers Are Advocacy Group’s Biggest Donors.” *New York Times* (October 21, 2009). http://www.nytimes.com/2009/10/22/health/22nami.html

CHAPTER 9

SCHOOLING CHILDREN TO BECOME MENTAL PATIENTS

Percentage of infants and children taking psychotropics: Pennap, Dinci. “Patterns of Early Mental Health Diagnosis and Medication Treatment in a Medicaid-Insured Birth Cohort.” *JAMA Pediatrics* 172, no. 6 (June 2018). https://doi.org/10.1001/jamapediatrics.2018.0240

about 9 percent of children: Zablotsky B. “Mental health treatment among children aged 5–17 years: United States, 2019.” NCHS Data Brief, no 381. National Center for Health Statistics (2020). https://www.cdc.gov/nchs/products/databriefs/db381.htm

Canadian Institute for Health Information. “Care for Children and Youth With Mental Disorders — Data Tables.” (2022).

cannot be overstated: Walker, Tim. “Are Schools Ready to Tackle the Mental Health Crisis?” National Education Association (September 13, 2018). https://www.nea.org/advocating-for-change/new-from-nea/are-schools-ready-tackle-mentalhealth-crisis

alarming numbers not getting treatment: Mostafavi, Beata. “Half of U.S. Children with Mental Health Disorders Are Not Treated.” University of Michigan Health Lab (February 18, 2019). https://labblog.uofmhealth.org/rounds/half-of-uschildren-mental-health-disorders-are-not-treated

numbers seeking treatment rising at alarming rate: “Mental Health Diagnoses Among US Children, Youth Continue to Rise at Alarming Rate.” Children’s National Hospital (November 2, 2018). http://childrensnational.org/news-andevents/childrens-newsroom/2018/child-and-youth-mental-health-diagnoses-rising

brain chemistry can cause emotional upset: New York State Education Department. “Mental Health Education Literacy in Schools: Linking to a Continuum of Well-being—Comprehensive Guide.” NYSED.gov (July 2018). http://www.nysed.gov/common/nysed/files/programs/curriculum-instruction/educationliteracyinschoolsfinal.11.2018.pdf

Columbia university study: Sultan, Ryan S. “Antipsychotic Treatment Among Youths with Attention-Deficit/ Hyperactivity Disorder.” *JAMA Network Open* 2, no. 7 (July 26, 2019). https://doi.org/10.1001/jamanetworkopen.2019.7850

most highly recommended educational program: National Center for School Mental Health. “School Mental Health Quality Guide: Mental Health Promotion Services & Supports (Tier 1).” NCSMH, University of Maryland School of Medicine (2020). https://www.schoolmentalhealth.org/media/SOM/Microsites/NCSMH/Documents/Quality-Guides/Tier-1Quality-Guide-1.29.20.pdf

distorted the study results: “GlaxoSmithKline to Plead Guilty and Pay $3 Billion to Resolve Fraud Allegations and Failure to Report Safety Data.” Department of Justice Press Release (July 2, 2012). https://www.justice.gov/opa/pr/glaxosmithkline-plead-guilty-and-pay-3-billion-resolve-fraud-allegations-and-failure-report

“Documents and Resources from the July 2, 2012 GlaxoSmithKline (GSK) Press Conference.” Department of Justice Press Release (September 15, 2014). https://www.justice.gov/archives/opa/documents-and-resources-july-2-2012-glaxosmithkline-gsk-press-conference

quotes from educational materials co-authored by Stan Kutcher: “Mental Health & High School Curriculum Guide—Understanding Mental Health and Mental Illness Version 3.” (2017). http://mhlcurriculum.org/wp-content/uploads/2020/11/fixed-guide-dec-2017-online-cover-and-interior-1.pdf

“Mental Health and High School Curriculum Guide—Teacher Knowledge Update.” (undated). https://mhlcurriculum.org/wp-content/uploads/2018/11/final-teacher-knowledge-update.pdf

“A Comprehensive Mental Health Literacy Learner Resource for Pre-service and Practicing Teachers.” (undated). Accessed June 6, 2022 via https://my.selkirk.ca/media/myselkirkca/myselkirkforstaff/tools/in-housetraining/MHL-Online-Module-Training.pdf

students ordered out of school: Book, Matthias. “Stanford University Systematically Violates the Rights of Students with Mental Health Disabilities.” Disability Rights Advocates (May 17, 2018). https://dralegal.org/wp-content/uploads/2018/05/AmendedComplaint_Final.pdf

condition students’ continued enrollment on mandatory treatment: Miller, Melissa. “Before It’s Too Late: The Need for a Legally Compliant and Pragmatic Alternative to Mandatory Withdrawal Policies at Postsecondary Institutions.” *Review of Law and Social Justice* 25:1 (Summer 2016). https://gould.usc.edu/students/journals/rlsj/issues/assets/docs/volume25/Summer2016/2.Miller.pdf

years of problems at Sempervirens: For example: Burns, Ryan. “County Mental Health Branch in Crisis After Mass Resignations of Doctors, Nurses.” *Lost Coast Outpost* (February 27, 2015). https://lostcoastoutpost.com/2015/feb/27/county-mentalhealth-branch-crisis-after-mass-resi/

Stansberry, Thadeus. “Breaking the Cycle.” *North Coast Journal* (January 21, 2016). https://www.northcoastjournal.com/humboldt/breaking-the-cycle/Content?oid=3524301

“Sempervirens Report No. 28277.” HospitalInspections.Org. Association of Health Care Journalists (August 4, 2017). http://www.hospitalinspections.org/report/28277

brain chemicals have been balanced: “Mighty Minds Backgrounder.” Girl Guides of Canada, Kids Help Phone, Psychology Foundation of Canada. https://www.girlguides.ca/WEB/Documents/GGC/programs/MightyMinds_Background-2016_Final.pdf

often leave campus handcuffed: Reeves, Megan. “Florida’s Flawed Baker Act Rips Thousands of Kids from School.” *Tampa Bay Times* (December 10, 2019). https://www.tampabay.com/news/education/2019/12/10/floridas-flawed-baker-act-ripsthousands-of-kids-from-school/

LaPeter Anton, Leonora. “The Baker Act Set Out to Improve Care. Now It’s Ensnaring More Children.” *Tampa Bay Times* (December 10, 2019). https://www.tampabay.com/news/education/2019/12/10/the-baker-act-set-out-to-improve-care-now-itsensnaring-more-children/.

a 162 percent increase: Charlesworth, Jennifer. “Detained: Rights of Children and Youth Under the Mental Health Act.” BC Office of the Representative for Children and Youth (January 2021). https://rcybc.ca/reports-and-publications/detained/

ran away from foster care: Kiggins, Steve. "US Marshals-Led Operation Locates 27 Missing Children in Virginia." *USA Today* (November 2, 2020). https://www.usatoday.com/story/news/nation/2020/11/01/us-marshals-operation-virginia-27missing-children/6117291002/

hell itself on Earth: Reinstein, Julia. "Paris Hilton Testified That She Was 'Abused on a Daily Basis' at a Treatment Facility for Teens." *BuzzFeed News* (February 9, 2021). https://www.buzzfeednews.com/article/juliareinstein/paris-hilton-abusetestimony-utah

staff in thirty-three states: "Residential Treatment Programs: Concerns Regarding Abuse and Death in Certain Programs for Troubled Youth." Government Accountability Office (October 10, 2007). https://www.gao.gov/products/gao-08-146t

exploiting troubled kids is big business: Miller, Jessica. "Provo Canyon School's History of Abuse Accusations Spans Decades, Far Beyond Paris Hilton." *Salt Lake Tribune* (September 20, 2020). https://www.sltrib.com/news/2020/09/20/provo-canyon-schools/

report on Sequel Youth and Family Services: "Let Us Come Home." Disability Rights Washington (October 2018). https://www.disabilityrightswa.org/wp-content/uploads/2018/10/Let-us-Come-Home.docx

Sequel facilities had closed down: For example: Rood, Lee. "Firm Accused of Abusing Troubled Teens in Iowa, Elsewhere under Fire Again." *Des Moines Register* (July 18, 2019). https://www.desmoinesregister.com/story/news/2019/07/18/firm-accused-abusing-troubled-teens-iowa-elsewhere-under-fire-again/1749599001/

vermin-infested buildings: "Desperation Without Dignity: Conditions of Children Placed in For Profit Residential Facilities." National Disability Rights Network (October 2021). https://www.ndrn.org/wp-content/uploads/2021/10/NDRN_Desperation_without_Dignity_October_2021.pdf

OIG reports: Levinson, Daniel R. Inspector General. "Treatment Planning and Medication Monitoring Were Lacking for Children in Foster Care Receiving Psychotropic Medication." Department of Health and Human Services (September 2018). https://oig.hhs.gov/oei/reports/oei-07-15-00380.asp

Levinson, Daniel R. Inspector General. "Second-Generation Antipsychotic Drug Use Among Medicaid-Enrolled Children: Quality-Of-Care Concerns." Department of Health and Human Services (March 2015). https://oig.hhs.gov/oei/reports/oei-07-12-00320.pdf

grown dependent on pharmaceuticals: De Sa, Karen. "Drugging Our Kids Part 1." *Mercury News* (August 24, 2014). https://extras.mercurynews.com/druggedkids/

hundreds of reports to recapture missing children: Edelman, Susan. "'Disturbed' Kids at City Foster-Care Center 'Drugged' at Hospital" *New York Post* (July 31, 2016). https://nypost.com/2016/07/31/disturbed-kids-at-city-foster-carecenter-drugged-at-hospital/

highly restrictive placements: Latzman, Natasha E. "Examining the Link: Foster Care Runaway Episodes and Human Trafficking." RTI International (October 2020). https://www.acf.hhs.gov/sites/default/files/documents/opre/foster_care_runaway_human_trafficking_oct

CHAPTER 10

TRACING "ANONYMOUS AND CONFIDENTIAL" COMMUNICATIONS

police shootings have occurred: For example: Potts, Shavonne. “Family, Spencer Settle Lawsuit Over Shooting Death.” *Salisbury Post* (April 20, 2012).

now I don’t trust anyone: For example, see comments below “What Happens When You Call the Suicide Hotline?!?” YouTube video. Posted by Kati Morton, May 28, 2014. https://www.youtube.com/watch?v=ykjrjzJsCpU

criticized within the profession: Cavicchia, Marilyn. “A New Look at Character and Fitness: Bar Leaders, Lawyers, Others Urge Elimination of Mental Health Questions.” *Bar Leader* Vol. 44, No. 3. American Bar Association (January-February 2020). https://www.americanbar.org/groups/bar_services/publications/bar_leader/2019_20/january-february/a-new-look-atcharacter-and-fitness-bar-leaders-lawyers-others-urge-elimination-of-mental-health-questions/

imminent risk and active rescue described: Draper, John. “Helping Callers to the National Suicide Prevention Lifeline Who Are at Imminent Risk of Suicide: The Importance of Active Engagement, Active Rescue, and Collaboration Between Crisis and Emergency Services.” *Suicide & Life-Threatening Behavior* 45, no. 3 (June 2015). https://doi.org/10.1111/sltb.12128

not improved across 50 years: Franklin, Joseph. “Risk Factors for Suicidal Thoughts and Behaviors: A Meta-Analysis of 50 Years of Research.” *Psychological Bulletin* 143, no. 2 (February 2017). https://doi.org/10.1037/bul0000084

unacceptably high false positive rate: Large, Matthew Michael. “The Role of Prediction in Suicide Prevention.” *Dialogues in Clinical Neuroscience* 20, no. 3 (September 2018). https://doi.org/10.31887/dcns.2018.20.3/mlarge

lack of clarity and imprecision: Gould, Madelyn. “Helping Callers to the National Suicide Prevention Lifeline Who Are at Imminent Risk of Suicide: Evaluation of Caller Risk Profiles and Interventions Implemented.” *Suicide & Life-Threatening Behavior* 46, no. 2 (April 2016). https://doi.org/10.1111/sltb.12182

finally handed over a survey: For documents about the NSPL that I obtained from SAMHSA, see https://robwipond.com/documents/samhsa-national-suicide-prevention-lifeline-call-tracing-documents-and-data

descriptions of call-tracing processes: PSAP Operations Committee. “NENA Suicide Prevention Standard.” National Emergency Number Association (June 15, 2013). https://988lifeline.org/wp-content/uploads/2016/09/NENA-STA-001_Suicide_Prevention.pdf

Denton, Timothy. Commissioner. “A Report on Matters Related to Emergency 9-1-1.” Canadian Radio-television and Telecommunications Commission (July 5, 2013). https://crtc.gc.ca/eng/publications/reports/rp130705.htm

used it to track suspects without warrants: “EFF To Maine, Massachusetts Courts: Rule Requiring Warrants to Access Cell Phone Location Data Applies to Real-Time Searches.” Electronic Frontier Foundation Press Release (August 30, 2018). https://www.eff.org/press/releases/eff-maine-massachusetts-courts-rule-requiring-warrants-access-cell-phone-location

still hospitalized 50 percent of the time: “B-Heard: Transforming NYC’s Response to Mental Health Crises—First Three Months of Operations.” City of New York (2021). https://mentalhealth.cityofnewyork.us/wp-content/uploads/2021/10/FIRST-QUARTER-OF-OPERATIONS-FINAL.pdf

and when they want it: “John Draper, PhD, Person-Centered Care in Suicide Prevention.” YouTube video posted by SPRC—Suicide Prevention Resource Center (December 15, 2014). https://www.youtube.com/watch?v=k3DGSdJ7R8Y

more suicidal after hospitalization: For discussion and links to various studies, see for example: Whitaker, Robert. "Suicide in the Age of Prozac." *Mad in America* (August 6, 2018). https://www.madinamerica.com/2018/08/suicide-in-the-age-ofprozac/

Simons, Peter. "Involuntary Hospitalization Increases Risk of Suicide." *Mad in America* (June 24, 2019). https://www.madinamerica.com/2019/06/involuntary-hospitalization-increases-risk-suicide-study-finds/

NSPL Lived Experience Committee comments: Wipond, Rob. "Roll-Out of 988 Threatens Anonymity of Crisis Lines." *Mad in America* (January 29, 2022). https://www.madinamerica.com/2022/01/roll-988-threatens-anonymity-crisis-hotlines/

geolocation to within three meters: "Designating 988 for the National Suicide Prevention Lifeline." Federal Communications Commission (July 17, 2020). https://docs.fcc.gov/public/attachments/FCC-20-100A1.pdf

Canadian hotlines also lobbied: "Telecom Regulatory Policy CRTC 2022-234," Canadian Radio-Television and Telecommunications Commission (August 31, 2022). https://crtc.gc.ca/eng/archive/2022/2022-234.htm

air force anti-suicide program: Knox, Kerry L. "Risk of Suicide and Related Adverse Outcomes after Exposure to a Suicide Prevention Programme in the US Air Force: Cohort Study." BMJ (Clinical Research Ed.) 327, no. 7428 (December 13, 2003). https://doi.org/10.1136/bmj.327.7428.1376

CHAPTER 11

FAMILY CONFLICTS WHERE PSYCHIATRISTS TAKE A SIDE

Gary Greenberg interview: Reese, Hope. "The Real Problems With Psychiatry." *Atlantic* (May 2, 2013). https://www.theatlantic.com/health/archive/2013/05/the-real-problems-with-psychiatry/275371/

Justina Pelletier story: Donaldson James, Susan. "Justina Pelletier Heading Home After 16-Month Medical Custody Battle." ABC News (June 18, 2014). https://abcnews.go.com/Health/justina-pelletier-heading-home-16-month-medical-custody/story?id=24191396

Associated Press. "Boston Children's Hospital Wasn't Negligent in Pelletier Case, Jury Finds." NBC Boston (February 20, 2020). https://www.nbcboston.com/news/local/jury-findings-justina-pelletier-boston-childrens-hospital/2079394/

does not include medical decisions: "Public Policy Platform." National Alliance on Mental Illness (Twelfth Edition, December 2016). https://www.nami.org/getattachment/About-NAMI/Policy-Platform/Public-Policy-Platform-up-to-12-09-16.pdf

WSH scandals: Shapiro, Emily. "Washington State Hospital CEO Fired 1 Week After Patients' Escape." ABC News (April 12, 2016). https://abcnews.go.com/US/washington-state-hospital-ceo-fired-week-patients-escape/story?id=38345015

Brand, Natalie. "Western State Hospital Loses $53 Million in Federal Funding." King 5 News (June 25, 2018). https://www.king5.com/article/news/local/western-state-hospital-loses-53-million-in-federal-funding/281-567340805

O'Sullivan, Joseph. "Western State Hospital CEO Ordered to Jail for Keeping Dementia Patient on Waitlist." *Seattle Times* (June 10, 2016). https://www.seattletimes.com/seattle-news/health/court-orders-new-western-state-hospital-ceo-to-jail-over-failure-to-admitpatient/

Associated Press. "Western State Hospital Described as 'Going into Hell.'" Fox13 Seattle (July 6, 2018). https://www.q13fox.com/news/western-state-hospital-described-as-going-into-hell

CHAPTER 12

PRISONS WITHOUT WALLS

chemical prisons: Fabris, Erick. *Tranquil Prisons: Chemical Incarceration Under Community Treatment Orders*. (University of Toronto Press, Toronto, 2011).

AOT and ACT numbers: New York State publishes statistics on AOT and ACT online. https://omh.ny.gov/omhweb/statistics/ California statistics were provided by the state government health department media relations office.

ACT team surveys: Moser, Lorna. "Practitioner Attributes as Predictors of Restrictive Practices in Assertive Community Treatment." *Journal of the American Psychiatric Nurses Association* 17, no. 1 (February 2011). https://doi.org/10.1177/1078390310394360

SSA, housing, and other leverage: Monahan, John. "Mandated Psychiatric Treatment in the Community—Forms, Prevalence, Outcomes and Controversies," in *Coercive Treatment in Psychiatry: Clinical, Legal and Ethical Aspects, First Edition*. Eds. Thomas Kallert et al (Wiley, 2011).

no broad consensus: "Position Statement on Involuntary Outpatient Commitment and Related Programs of Assisted Outpatient Treatment." American Psychiatric Association (December 2020). https://www.psychiatry.org/File%20Library/AboutAPA/Organization-Documents-Policies/Policies/Position-Involuntary-Outpatient-Commitment.pdf

CHAPTER 13

"AN ASSEMBLY LINE OF FRAUD"

Canadian gravy train: McCann, Wendy. "US Viewed Canada as Gravy Train in Health Fraud Scheme." *Canadian Press* (April 6, 1998).

sunny vacation promised: Whitham, Lyn. "Half Million Dollar Man." *CBC at Six* (April 17, 1991).

charge anything they liked: Freudenheim, Milt. "The Squeeze on Psychiatric Chains." *New York Times* (October 26, 1991). https://www.nytimes.com/1991/10/26/business/the-squeeze-on-psychiatric-chains.html

Lock them in. Bill their insurer: Adams, Rosalind. "'What The Fuck Just Happened?'" *BuzzFeed News*

(December 7, 2016). Also see related stories in series by other authors. https://www.buzzfeednews.com/article/rosalindadams/intake

You're Trapped. They're Cashing In: Bedi, Neil. "North Tampa Behavioral Health Is Cashing in on Florida's Baker Act." *Tampa Bay Times* (September 18, 2019). https://projects.tampabay.com/projects/2019/investigations/north-tampa-behavioralhealth/

told to deviate from the truth: Kovaleski, Tony. "Clear View Investigation." Denver7 and TheDenverChannel.com (Series of articles from 2019 to 2020). https://www.thedenverchannel.com/news/investigations/clear-view-investigation

American Therapeutics Corporation: "Twenty People Indicted in Florida for Health Care Fraud Scheme Involving Approximately $200 Million in Medicare Billing." Department of Justice Press Release (February 15, 2011). https://www.justice.gov/opa/pr/twenty-people-indicted-florida-health-care-fraud-scheme-involving-approximately-200-million

"Miami-Area Certified Nursing Assistant Sentenced to 150 Months in Prison for Role in $200 Million Medicare Fraud Scheme." Department of Justice Press Release (December 8, 2014). https://www.justice.gov/usao-sdfl/pr/miami-area-certified-nursingassistant-sentenced-150-months-prison-role-200-million

Healthcare Solutions Network: "President of Miami-Based Transportation Company Sentenced to 60 Months in Prison for Role in $70 Million Health Care Fraud Scheme." Department of Justice Press Release (March 25, 2016). https://www.justice.gov/opa/pr/president-miami-based-transportation-company-sentenced-60-months-prison-role-70-million

"Medical Director and Three Therapists Convicted in $63 Million Health Care Fraud Scheme." Department of Justice Press Release (August 25, 2015). https://www.justice.gov/opa/pr/medical-director-and-three-therapists-convicted-63-million-health-carefraud-scheme

questionable billing: Levinson, Daniel R. Inspector General. "Questionable Billing by Community Mental Health Centers." Department of Health and Human Services (OEI-04-11-00100, August 2012). https://oig.hhs.gov/oei/reports/oei-0411-00100.pdf

gathered and detained substance users and homeless people: "Owner Sentenced to More Than 27 Years in Prison for Multi-Million Dollar Health Care Fraud and Money Laundering Scheme Involving Sober Homes and Alcohol and Drug Addiction Treatment Centers." Department of Justice Press Release (May 17, 2017). https://www.justice.gov/usao-sdfl/pr/ownersentenced-more-27-years-prison-multi-million-dollar-health-care-fraud-and-money

quadrupled to $8.5 billion: Schulte, Fred. "Doctors Make Big Money Testing Urine For Drugs, Then Ignore Abnormal Results." *Kaiser Health News* (November 29, 2017). https://khn.org/news/doctors-make-big-money-testing-urine-fordrugs-then-ignore-abnormal-results/

2019 series of articles: Allen, Marshall. "We Asked Prosecutors If Health Insurance Companies Care About Fraud. They Laughed at Us." *ProPublica* (September 10, 2019). https://www.propublica.org/article/we-asked-prosecutors-if-healthinsurance-companies-care-about-fraud-they-laughed-at-us

Columbia/HCA Healthcare Corp: Sherman, Amy. "Rick Scott 'Oversaw the Largest Medicare Fraud' in U.S. History, Florida Democratic Party Says." PolitiFact, Poynter Institute (March 3, 2014). https://www.politifact.com/factchecks/2014/mar/03/florida-democratic-party/rick-scott-rick-scott-oversaw-largest-medicare-fra/

OIG found high rates of noncompliance: Grimm, Christi. Deputy Inspector General. "An Estimated 87 Percent of Inpatient Psychiatric Facility Claims with Outlier Payments Did Not Meet Medicare's Medical Necessity or Documentation Requirements." Department of Health and Human Services (A-01-

16-00508, April 2020). https://oig.hhs.gov/oas/reports/region1/11600508.pdf

legal only 28 percent of the time: "Committed to Change: Protecting the Rights of Involuntary Patients Under the Mental Health Act." Office of the Ombudsperson (Special Report No. 42, March 2019). https://bcombudsperson.ca/investigative_report/committed-to-change-protecting-the-rights-of-involuntary-patients-under-the-mental-health-act/

improper and excessive: "Universal Health Services, Inc. to Pay $117 Million to Settle False Claims Act Allegations." Department of Justice Press Release (July 10, 2020). https://www.justice.gov/usao-edpa/pr/universal-health-services-inc-pay-117million-settle-false-claims-act-allegations

increased stock price: Bannow, Tara. "UHS' Stock Price up More than 10% after $127M DOJ Settlement News." *Modern Healthcare* (July 25, 2019). https://www.modernhealthcare.com/legal/uhs-stock-price-up-more-10-after-127m-doj-settlement-news

CHAPTER 14

MENTAL HEALTH AND THE LIMITS OF ACCEPTABLE SPEECH

like a zombie: Jon Elizarraras (@johnyelizar). "You Do Not Need Them, You Can Do It. I Did It and I Want to Help Everyone Do the Same." Twitter, April 7, 2019, 1:48 PM. https://twitter.com/johnyelizar/status/1114978291197173760

psychiatrist Philip Muskin: O'Connell, John. "Local Man Shares Controversial Message on Mental Health Meds in Viral Video." *Idaho State Journal* (April 18, 2019). https://www.idahostatejournal.com/news/local/local-man-shares-controversialmessage-on-mental-health-meds-in-viral-video/article_98971a64-a8dc-5c65-a38e-13764e7967e7.html

prisoner of conscience: "Detention and Imprisonment—Overview." Amnesty International. Accessed June 5, 2022. https://www.amnesty.org/en/what-we-do/detention/

CHAPTER 15

"A 'BEHAVIOR' IS NOT BEING QUIET": FORCE-TREATING THE ELDERLY

short-term delirium in 76 percent of cases: Anderson, Eric L. "American Association for Emergency Psychiatry Task Force on Medical Clearance of Adults Part I." *Western Journal of Emergency Medicine* 18, no. 2 (February 2017). https://doi.org/10.5811/westjem.2016.10.32258

a person knows her rights: "*'They Want Docile'": How Nursing Homes in the United States Overmedicate People with Dementia.*" Human Rights Watch (February 5, 2018). https://www.hrw.org/report/2018/02/05/they-want-docile/how-nursing-homes-unitedstatesovermedicate-people-dementia

perfectly acceptable practice: Flamm, Hannah. "Why Are Nursing Homes Drugging Dementia Patients Without Their Consent?" *Washington Post* (August 10, 2018). https://www.washingtonpost.com/outlook/2018/08/10/8baff64a-9a63-11e88d5e-c6c594024954_story.html

14 percent prescribed antipsychotics: Levinson, Daniel R. Inspector General. "Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents." Department of Health and Human Services (May 2011). https://oig.hhs.gov/oei/reports/oei-07-08-00150.pdf

Risperdal kickbacks: For example: "Johnson & Johnson to Pay More Than $2.2 Billion to Resolve Criminal and Civil Investigations." Department of Justice Press Release (November 4, 2013). https://www.justice.gov/opa/pr/johnson-johnson-paymore-22-billion-resolve-criminal-and-civil-investigations

goal to reduce antipsychotic use: "National Partnership to Improve Dementia Care in Nursing Homes." Centers for Medicare & Medicaid Services. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/National-Partnership-to-Improve-Dementia-Care-in-Nursing-Homes

finding raises concerns: "CMS Could Improve the Data It Uses to Monitor Antipsychotic Drugs in Nursing Homes." Department of Health and Human Services (May 2021). https://oig.hhs.gov/oei/reports/OEI-07-19-00490.pdf

no actual decreases: Thomas, Katie. "Phony Diagnoses Hide High Rates of Drugging at Nursing Homes." *New York Times* (September 11, 2021). https://www.nytimes.com/2021/09/11/health/nursing-homes-schizophrenia-antipsychotics.html

avoid labeling patients: "Joint Summary Statement—Diagnosing Schizophrenia in Skilled Nursing Centers." The Society for Post-acute and Long-Term Care Medicine Press Release (February 21, 2017). https://paltc.org/newsroom/jointsummary-statement-diagnosing-schizophrenia-skilled-nursing-centers

39 percent of clients: "Use of Antipsychotics Among Seniors Living in Long-Term Care Facilities, 2014." Canadian Institute for Health Information (February 25, 2016). https://secure.cihi.ca/estore/productFamily.htm?locale=en&pf=PFC3094

70 to 80 percent of residents: Maust, Donovan. "Association of the Centers for Medicare & Medicaid Services' National Partnership to Improve Dementia Care with the Use of Antipsychotics and Other Psychotropics in Long-Term Care in the United States from 2009 to 2014." *JAMA Internal Medicine* 178, no. 5 (May 2018). https://doi.org/10.1001/jamainternmed.2018.0379

Vasudev, Akshya. "Trends in Psychotropic Dispensing Among Older Adults with Dementia Living in Long-Term Care Facilities: 2004–2013." *American Journal of Geriatric Psychiatry* 23, no. 12 (December 2015). https://doi.org/10.1016/j.jagp.2015.07.001

CHAPTER 16

"IT'S NEARLY IMPOSSIBLE TO ESCAPE A GUARDIANSHIP EXCEPT IN A COFFIN"

after two successive psychiatrists: Farrow, Ronan. "How Britney Spears Got Free, and What Comes Next." *New Yorker* (November 13, 2021). https://www.newyorker.com/news/news-desk/how-britney-spears-got-free-and-what-comes-next

Farrow, Ronan. "Britney Spears' Conservatorship Nightmare." *New Yorker* (July 3, 2021). https://www.newyorker.com/news/american-chronicles/britney-spears-conservatorship-nightmare

lawyer Adam Streisand: Stark, Samantha, Director/Producer. "'Framing Britney Spears.'" *New York Times* video documentary aired online October 1, 2021 (Minute 45:00). https://www.nytimes.com/article/framing-britney-spears.html

without having to be evaluated: Loh, Matthew. "Read the Full Text of Britney Spears' Bombshell Testimony at Her Conservatorship Hearing." *Yahoo! News* (June 23, 2021). https://news.yahoo.com/read-full-text-britney-spears-053052056.html

NCD issued two reports: "Turning Rights into Reality: How Guardianship and Alternatives Impact the Autonomy of People with Intellectual and Developmental Disabilities." National Council on Disability (June 10, 2019). https://ncd.gov/sites/default/files/NCD_Turning-Rights-into-Reality_508_0.pdf

"Beyond Guardianship: Toward Alternatives That Promote Greater Self-Determination for People with Disabilities." National Council on Disability (March 22, 2018). https://ncd.gov/sites/default/files/NCD_Guardianship_Report_Accessible.pdf

two hundred thousand every year: Blake, Heidi. "Beyond Britney: Abuse, Exploitation, And Death Inside America's Guardianship Industry." *BuzzFeed News* (September 17, 2021). https://www.buzzfeednews.com/article/heidiblake/conservatorshipinvestigation-free-britney-spears

exploitation by guardians in 45 states: "Guardianships: Cases of Financial Exploitation, Neglect, and Abuse of Seniors." Government Accountability Office (September 2010). https://www.gao.gov/products/gao-10-1046

Fierle charged: "Guardian Rebecca Fierle-Santoian Arrested and Charged." Florida Department of Law Enforcement Press Release (February 10, 2020). http://www.fdle.state.fl.us/News/2020/February/Guardian-Rebecca-Fierle-Santoian-arrested-and-char

Orange County Comptroller reports: Diamond, Phil. "Investigation of Payments Made to Professional Guardian Rebecca Fierle by Advent Health." Orange County Comptroller (September 2019). https://www.occompt.com/download/Audit%20Reports/rpt479.pdf

Diamond, Phil. "Audit of the Orange County Clerk of Court's Administration of the Guardianship Program." Orange County Comptroller (March 2021). https://www.occompt.com/download/Audit%20Reports/rpt489_2.pdf

VCU story: Balch, Bridget. "She Wanted to Bring Her Husband Home. VCU Health System Took Her to Court (Part 1 of 3)." *Richmond Times-Dispatch* and Richmond.Com (November 16, 2019). https://richmond.com/news/virginia/she-wanted-tobring-her-husband-home-vcu-health-system/article_cce04586-b680-5db0-bb98-e29cdeeb26b8.html

sold her house to a facility employee: Walser, Adam. "Florida Woman Escapes Guardianship Using Social Media, Secret Phone." ABC Action News, WFTS Tampa Bay (November 16, 2020). https://www.abcactionnews.com/news/local-news/iteam-investigates/florida-woman-escapes-guardianship-using-secret-phone-and-facebook-to-contact-media

demographics of guardianships: Fields, Linda. "Rethinking Guardianship: Building a Case for Less Restrictive Alternatives. Final Report." School of Social Work, the University of North Carolina at Chapel Hill (January 31, 2018). https://rethinkingguardianshipnc.org/wp-content/uploads/sites/1731/2021/07/2017-Rethinking-Guardianship-Year-3-and-Final-Report.pdf

there are few safeguards: “Ensuring Trust: Strengthening State Efforts to Overhaul the Guardianship Process and Protect Older Americans.” United States Senate Special Committee on Aging (November 2018). https://www.aging.senate.gov/press-releases/senate-aging-committee-examines-ways-to-strengthen-guardianship-programs

Guardianship Accountability Act: “Casey, Collins Introduce Bipartisan Bill to Protect Americans from Guardianship Abuse.” United States Senate Special Committee on Aging Press Release (September 28, 2021). https://www.aging.senate.gov/press-releases/casey-collins-introduce-bipartisan-bill-to-protect-americans-from-guardianship-abuse

CHAPTER 17

CAREERS DESTROYED: ENFORCING WORKPLACE WELLNESS

seek therapy or take medical leave: Glaser, April. “Complaints to Google about Racism and Sexism Met with Therapy Referrals.” *NBC News* (March 7, 2021). https://www.nbcnews.com/tech/tech-news/google-advised-mental-health-carewhen-workers-complained-about-racism-n1259728

paucity of evidence: Chisholm, Dan. “Scaling-Up Treatment of Depression and Anxiety: A Global Return on Investment Analysis.” *Lancet Psychiatry* 3, no. 5 (May 1, 2016). https://doi.org/10.1016/s2215-0366(16)30024-4

MHFA’s website touts: “Research and Evidence Base.” Mental Health First Aid. Accessed June 21, 2021. https://www.mentalhealthfirstaid.org/about/research/

programs as inherently coercive: Wipond, Rob and Jakubec, Sonya. “Creating the Better Workplace in Our Minds: Workplace “Mental Health” and the Reframing of Social Problems as Psychiatric Issues,” in *Psychiatry interrogated: An institutional ethnography anthology*, ed. B. Burstow. (New York: Palgrave, 2016).

Yolanda Ng: Herb. “Doctor Loses Medical License for Legally Treating Her Menstrual Cramps with Cannabis.” *420 Intel* (October 9, 2018). https://420intel.com/articles/2018/09/10/doctor-loses-medical-license-legally-treating-her-menstrualcramps-cannabis

potentially impairing illness: “Policy on Physician Illness and Impairment: Towards a Model That Optimizes Patient Safety and Physician Health.” Federation of State Medical Boards. Accessed October 20, 2021. https://www.fsmb.org/siteassets/advocacy/policies/policy-on-physician-impairment.pdf

poor hygiene or not returning calls: Committee for Physician Health. “Referrals.” Medical Society of the State of New York. Accessed June 5, 2022. http://www.mssny.org/MSSNY/CPH/%20Referrals/MSSNY/Physician_Advocacy/CPH-Physician_Health/%20Referrals.aspx?hkey=393fe21c-cfa6-4e75-9b9e-19cc94ad92a7

your wildest dreams: Anonymous. “PHP Participant Stories—My Story Is a Miracle. February 1, 2016.” Federation of State Physician Health Programs. Accessed October 21, 2021. https://www.fsphp.org/php-participant-stories

return them to patient care: Randhawa, PJ. “Doctors Fear Controversial Program Made to Help Them.” Healthcare Alliance for Regulatory Board Reform (February 14, 2019). https://harbr-usa.org/doctors-fear-controversial-program-made-tohelp-them/

independently audited: Wood, Beth A. “Performance Audit North Carolina Physicians Health Program.” Office of the State Auditor North Carolina (April 2014). https://www.auditor.nc.gov/documents/reports/performance/per-2013-8141-0/open

surveys and studies of social workers and nurses: For example: Poole, J. “The professional regulation of madness in nursing and social work practice.” in *The Routledge Handbook of Mad Studies: Critical International Perspectives on Doing Mad Studies*, eds. P. Beresford, J. Russo, and K. Boxall (New York: Routledge, 2021).

CHAPTER 18

ORDERS FROM MILITARY COMMAND: REPORT TO BEHAVIORAL HEALTH

one in six active duty service members: “Medicating the Military—Use of Psychiatric Drugs Has Spiked; Concerns Surface About Suicide, Other Dangers.” *Military Times* (March 29, 2013). https://www.militarytimes.com/2013/03/29/medicating-the-military-use-of-psychiatric-drugs-has-spiked-concerns-surface-about-suicide-other-dangers/ Alternatively, see http://web.archive.org/web/20190703160916/https://www.militarytimes.com/2013/03/29/medicating-the-military-use-of-psychiatric-drugs-has-spiked-concerns-surface-about-suicide-other-dangers/

740,000 veterans: “VA MENTAL HEALTH: VHA Improved Certain Prescribing Practices, but Needs to Strengthen Treatment Plan Oversight.” Government Accountability Office (June 2019). https://www.gao.gov/pdf/product/699775

26 percent in veterans hospitals: “National Mental Health Services Survey: 2018. Data on Mental Health Treatment Facilities.” Substance Abuse and Mental Health Services Administration (2018). https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NMHSS-2018.pdf

CHAPTER 19

“THE PSYCHIATRIC EVALUATION ATTACK METHOD”: MAKING WHISTLEBLOWERS CRAZY

during public hearings: “Whistleblower Protection in the Military. Hearing Before the Acquisition Policy Panel of the Committee on Armed Services House of Representatives” (One Hundredth Congress, First and Second Sessions. Hearings Held November 19, 1987, and March 16, 1988.)

fake review sent to investigators: Benjamin, Mark. “Navy Supervisor Doctored Whistle-Blower’s Records.” *Salon* (February 1, 2010). https://www.salon.com/2010/02/01/camp_lejeune_2/

Ian Fishback story: Steinhauer, Jennifer. “Army Whistle-Blower’s Lonely Death Highlights Toll of Mental Illness.” *New York Times* (November 24, 2021). https://www.nytimes.com/2021/11/24/us/politics/ian-fishback-veteran-mental-health-crisis.html

Stiffler, Carol. “Major Ian Fishback has died at age 42.” *Newberry News* (November 24, 2021). https://mynewberrynews.com/features/major-ian-fishback-has-died-at-age-42/

CHAPTER 20

DETAINING PROTESTERS AND PREGNANT WOMEN: OTHER POLITICAL USES OF PSYCHIATRY

less severe or immediate: “25.4.2 ‘Caution Upon Contact’ Taxpayer.” Internal Revenue Manuals Part 25—Special Topics. https://www.irs.gov/irm/part25/irm_25-004-002

two audits identified thousands: “Potentially Dangerous Taxpayer and Caution Upon Contact Cases Are Adequately Controlled, but Improvements in Training and Outreach Are Needed.” Treasury Inspector General for Tax Administration (January 18, 2013). https://www.treasury.gov/tigta/auditreports/2013reports/201340014fr.html

“Improvement Is Needed to Better Enable Frontline Employee Identification of Potentially Dangerous and Caution Upon Contact Designations.” Treasury Inspector General for Tax Administration (March 20, 2014). https://www.treasury.gov/tigta/auditreports/2014reports/201440020fr.html

Chinese government involuntary hospitalizations: Zhao, X. “The New Chinese Mental Health Law.” *Psychiatry, Psychology and Law* 21, no. 5 (September 3, 2014). https://doi.org/10.1080/13218719.2014.882248

collaborations between psychiatrists and orthodox religious leaders: Batya Ungar-Sargon. “Healing Hasidic Masturbators and Adulterers—with Psychiatric Drugs.” *Narratively* (August 23, 2016). https://narratively.com/healing-hasidicmasturbators-and-adulterers-with-psychiatric-drugs/

bad science and racist stereotypes: The Editorial Board. “A Woman’s Rights Part 4: Slandering the Unborn.” *New York Times* (December 28, 2018). https://www.nytimes.com/interactive/2018/12/28/opinion/crack-babies-racism.html

contradictory approaches on NAPW website: “Medical Groups Oppose Prosecution.” National Advocates for Pregnant Women (June 1, 2021). https://www.nationaladvocatesforpregnantwomen.org/medical_and_public_health_group_statements_op

no sanctions came: Wynn, A. “The Soviet Union and the World Psychiatric Association.” *Lancet* (London, England) 1, no. 8321 (February 19, 1983). https://doi.org/10.1016/s0140-6736(83)91514-3

superpower for her activism: Lee, Bruce. “Greta Thunberg: Why She Called Aspergers Her Superpower.” *Forbes* (September 27, 2019). https://www.forbes.com/sites/brucelee/2019/09/27/greta-thunberg-why-she-called-aspergers-hersuperpower/

caught up in a doomsday scenario: Mazzoni, Alana. “Psychologist Says He’s Worried About the Mental Wellbeing of Climate Change Activist Greta Thunberg.” *Daily Mail Online* (September 25, 2019).

https://www.dailymail.co.uk/news/article-7501829/Psychologist-says-hes-worried-mental-wellbeing-climate-change-activist-Greta-Thunberg.html

frame rising worry about climate change: Wipond, Rob. “Will the Mental Health Industry Undermine the Community-Based Climate Change Revolution?” *Mad in America* (September 13, 2020). https://www.madinamerica.com/2020/09/community-climate-change-revolution/

combined community resilience–building and mental health services: Clayton Whitmore-Williams, Susan. “Mental Health and Our Changing Climate: Impacts, Implications, and Guidance.” American Psychological Association, ecoAmerica, and Climate for Health (March 2017). https://www.apa.org/news/press/releases/2017/03/mental-health-climate.pdf

curb internet searches: Woodward, Burns. “Climate Disruption and the Psychiatric Patient.” *Psychiatric Times* Vol 36, Issue 3 (March 25, 2019). https://www.psychiatrictimes.com/view/climate-disruption-and-psychiatric-patient

living in a shared psychosis: Lewis, Tanya. “The ‘Shared Psychosis’ of Donald Trump and His Loyalists.” *Scientific American* (January 11, 2021). https://www.scientificamerican.com/article/the-shared-psychosis-of-donald-trump-and-his-loyalists/

science says liberals: Fears, Danika. “Science Says Liberals, Not Conservatives, Are Psychotic.” *New York Post* (June 9, 2016). https://nypost.com/2016/06/09/science-says-liberal-beliefs-are-linked-to-pyschotic-traits/

CHAPTER 21

THE THANK-YOU THEORY

will later be very thankful: Zeller, Scott. “Understanding Crisis Services: What They Are and When to Access Them.” *Psychiatric Times* (August 5, 2020). https://www.psychiatrictimes.com/view/understanding-crisis-services-what-they-arewhen-access-them

UK study on perceptions of coercion: Katsakou, Christina. “Coercion and Treatment Satisfaction Among Involuntary Patients.” *Psychiatric Services* 61, no. 3 (March 1, 2010). https://doi.org/10.1176/ps.2010.61.3.286

left them feeling angry and aggrieved: Katsakou, Christina. “Patient’s Experiences of Involuntary Hospital Admission and Treatment: A Review of Qualitative Studies.” *Epidemiology and Psychiatric Sciences* 16, no. 2 (June 2007). https://doi.org/10.1017/S1121189X00004802

usually would not have helped: Priebe, Stefan. “Patients’ Views and Readmissions 1 Year After Involuntary Hospitalisation.” *British Journal of Psychiatry* 194, no. 1 (January 2009). https://doi.org/10.1192/bjp.bp.108.052266

ambivalently and with little gratitude: Swartz, M. S. “Endorsement of Personal Benefit of Outpatient Commitment Among Persons with Severe Mental Illness.” *Psychology, Public Policy, and Law, 9* (2003). https://doi.org/10.1037/1076-8971.9.1-2.70

in a Washington Post op-ed: Kenigsberg, Sara Pearl. “You Can’t Stop Mass Shootings by Punishing People with Mental Illnesses.” *Washington Post* (August 7, 2019). https://www.washingtonpost.com/outlook/2019/08/07/you-cant-stop-massshootings-by-punishing-people-with-mental-illnesses/

CHAPTER 22

DOES FORCED TREATMENT IMPROVE MENTAL HEALTH?

"Position Statement on Voluntary and Involuntary Hospitalization of Adults with Mental Illness." American Psychiatric Association (July 2020). https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-Voluntary-Involuntary-Hospitalization-Adults.pdf

do not improve clinically: Katsakou, C. "Outcomes of Involuntary Hospital Admission—a Review." *Acta Psychiatrica Scandinavica* 114, no. 4 (2006). https://doi.org/10.1111/j.1600-0447.2006.00823.x

only a few studies of good quality: Luciano, Mario. "Use of Coercive Measures in Mental Health Practice and Its Impact on Outcome: A Critical Review." *Expert Review of Neurotherapeutics* 14, no. 2 (February 2014). https://doi.org/10.1586/14737175.2014.874286

not associated with improved outcome: Molodynski, Andrew. "Coercion in Mental Healthcare: Time for a Change in Direction." *BJPsych International* 13, no. 1 (February 2016). https://doi.org/10.1192/S2056474000000854

from controlled studies Georgieva, Irina. "Patients' Preference and Experiences of Forced Medication and Seclusion." *Psychiatric Quarterly* 83, no. 1 (March 2012). https://doi.org/10.1007/s11126-011-9178-y

remarkable lack of evidence: Mayoral, F. "Use of Coercive Measures in Psychiatry." *Actas Espanolas De Psiquiatria* 33, no. 5 (October 2005). https://pubmed.ncbi.nlm.nih.gov/16155816/

serious adverse effects: Sailas, E. "Seclusion and Restraint for People with Serious Mental Illnesses." *Cochrane Database of Systematic Reviews*, no. 2 (2000). https://doi.org/10.1002/14651858.CD001163

difficult to justify: Muralidharan, Sudha. "Containment Strategies for People with Serious Mental Illness." *Cochrane Database of Systematic Reviews*, no. 3 (2006). https://doi.org/10.1002/14651858.CD002084.pub2

PRN no good evidence: Douglas-Hall, P. "'As Required' Medication Regimens for Seriously Mentally Ill People in Hospital." *Cochrane Database of Systematic Reviews* Issue 12. No.: CD003441 (2015). https://doi.org/10.1002/14651858.CD003441.pub3

toxic impacts on patient attitudes: McLaughlin, Paul. "Use of Coercive Measures During Involuntary Psychiatric Admission and Treatment Outcomes: Data from a Prospective Study Across 10 European Countries." *PLOS ONE* 11, no. 12 (December 29, 2016). https://doi.org/10.1371/journal.pone.0168720

enlightened stage" in modern psychiatry: Jacobsen, Torsten. "Involuntary Treatment in Europe: Different Countries, Different Practices." *Current Opinion in Psychiatry* 25, no. 4 (July 2012). https://doi.org/10.1097/YCO.0b013e32835462e3

highly distressing and even traumatic: Sashidharan, S. "Reducing Coercion in Mental Healthcare." *Epidemiology and Psychiatric Sciences* 28, no. 6 (December 2019). https://doi.org/10.1017/S2045796019000350

dearth of literature on inpatient treatment: Gerolamo, Angela. "State of the Science: Outcomes of Acute Inpatient Psychiatric Care." *Archives of Psychiatric Nursing* 18, no. 6 (December 1, 2004). https://doi.org/10.1016/j.apnu.2004.09.003

mental health report cards: "About Using BHRD Data and Available Plans and Reports." King County

Behavioral Health and Recovery Division. Accessed October 11, 2021. https://kingcounty.gov/depts/community-human-services/mentalhealth-substance-abuse/data-dashboard.aspx Alternatively see http://web.archive.org/web/20201126065409/https://kingcounty.gov/depts/community-human-services/mental-health-substance-abuse/data-dashboard.aspx

implementation of clearly measurable standards: Knickman, James. "Improving Access to Effective Care for People Who Have Mental Health and Substance Use Disorders: A Vital Direction for Health and Health Care." *NAM Perspectives* (September 19, 2016). https://doi.org/10.31478/201609v

CHAPTER 23

"SAFE" AND "EFFECTIVE"?

damage caused by brain illnesses: "What Are the Long-Term Effects of Taking Medication for Mental Illness?" National Alliance on Mental Illness. Accessed October 18, 2021. https://www.nami.org/FAQ/Mental-Health-Medication-FAQ/What-are-the-long-term-effects-of-taking-medicatio

like insulin for diabetes: Amador, Xavier. *I Am Not Sick, I Don't Need Help!—How to Help Someone with Mental Illness Accept Treatment* (Vida Press, New York. 2012), p.106. https://nami.org/About-Mental-Illness/Related-Conditions/Anosognosia/I-AmNot-Sick-I-Don-t-Need-Help

just like heart disease or diabetes: "What Is Mental Illness?" American Psychiatric Association. Accessed October 19, 2021. https://www.psychiatry.org/patients-families/what-is-mental-illness

balancing chemicals in your brain: Greenlaw, Ellen. "How Antidepressants and Depression Medication Can Affect Your Life." WebMD. Accessed October 18, 2021. https://www.webmd.com/depression/features/antidepressant-effects

serotonin 5-HT2A receptor activity: Ghoshal, Malini. "What Is a Psychotropic Drug? Types, Uses, Side Effects, Risks & More." Healthline. Accessed October 18, 2021. https://www.healthline.com/health/what-is-a-psychotropic-drug

simply no longer possible: Angell, Marcia. "Drug Companies & Doctors: A Story of Corruption." *New York Review of Books* (January 15, 2009). https://www.nybooks.com/articles/2009/01/15/drug-companies-doctorsa-story-of-corruption/

unlikely to outweigh long-term harms: Angell, Marcia."'The Illusions of Psychiatry': An Exchange." Letters in the *New York Review of Books* (August 18, 2011). https://www.nybooks.com/articles/2011/08/18/illusions-psychiatry-exchange/

mechanisms of action are unknown: Complete FDA drug labels are available at the website DailyMed: https://dailymed.nlm.nih.gov. Either the word "unknown" or a version of the concept appears in the key section discussing clinical pharmacology and mechanism of action for essentially every psychotropic and any mental disorder. For example, the drug label for the antipsychotic Abilify states, "The mechanism of action of aripiprazole in schizophrenia or bipolar mania is unknown." The drug label for Ritalin states, "There is neither specific evidence which clearly establishes the mechanism whereby Ritalin produces its mental and behavioral effects in children, nor conclusive evidence regarding how these effects relate to the condition of the central nervous system."

violating the law: "Warning Letters and Notice of Violation Letters to Pharmaceutical Companies." Food and Drug Administration (FDA has moved its historical records to Archive.org). https://www.fda.gov/drugs/enforcement-activities-fda/warning-letters-and-notice-violation-letters-pharmaceutical-companies

Paxil effectiveness: "Drug Approval Package—Paxil (Paroxetine Hydrochloride)—Medical Review." Food and Drug Administration (April 13, 2001). http://www.accessdata.fda.gov/drugsatfda_docs/nda/2001/20-031S026_Paxil.cfm

Klonopin effectiveness: Rosenbaum, J. F. "Clonazepam in the Treatment of Panic Disorder with or Without Agoraphobia." *Journal of Clinical Psychopharmacology* 17, no. 5 (October 1, 1997). https://www.ncbi.nlm.nih.gov/pubmed/9315990/

Zoloft effectiveness: "Drug Approval Package—Zoloft (Sertraline Hydrochloride)—Medical Review Part 1." Food and Drug Administration (1999), p. 41. http://www.accessdata.fda.gov/drugsatfda_docs/nda/99/19-839S026_Zoloft_Clinr_P1.pdf

Lamictal effectiveness: "Medical Review: Lamictal." Food and Drug Administration (June 2003). http://www.accessdata.fda.gov/drugsatfda_docs/nda/2003/020241_S017_LAMICTAL%20TABLETS%2

Antidepressant effectiveness: Kirsch, I. "The Emperor's New Drugs: An Analysis of Antidepressant Medication Data Submitted to the U.S. Food and Drug Administration." *Prevention & Treatment*, 5(1), Article 23 (July 15, 2002). https://doi.org/10.1037/1522-3736.5.1.523a

Kirsch, I. "Listening to Prozac but hearing placebo: A Meta–Analysis of Antidepressant Medication." *Prevention & Treatment*, 1(2), Article 2a (June 26, 1998). https://doi.org/10.1037/1522-3736.1.1.12a

Kirsch, I. "Initial Severity and Antidepressant Benefits: A Meta–Analysis of Data Submitted to the Food and Drug Administration." *PLOS Medicine* 5, no. 2 (February 26, 2008). https://doi.org/10.1371/journal.pmed.0050045

Antipsychotic effectiveness: Gopalakrishnan, Mathangi. "The Trend of Increasing Placebo Response and Decreasing Treatment Effect in Schizophrenia Trials Continues: An Update from the US Food and Drug Administration." *Journal of Clinical Psychiatry* 81, no. 2 (March 3, 2020). https://doi.org/10.4088/JCP.19r12960

adverse drug effects: Adverse psychotropic effects come mainly from FDA drug labels and journal reviews. For example: Moore, Thomas J. "The Harms of Antipsychotic Drugs: Evidence from Key Studies." *Drug Safety* (November 19, 2016). https://doi.org/10.1007/s40264-016-0475-0

Bendz, H. "Kidney Damage in Long–Term Lithium Patients: A Cross-Sectional Study of Patients with 15 Years or More on Lithium." *Nephrology Dialysis Transplantation* 9, no. 9 (January 1, 1994). https://doi.org/10.1093/ndt/9.9.1250

drug interactions and metabolizing: For an introduction to drug interactions relating to CYP450-related enzymes, see for example: English, B. A. "Clinically significant psychotropic drug–drug interactions in the primary care setting." *Current Psychiatry Reports* 14(4) (2012). https://doi.org/10.1007%2Fs11920-012-0284-9

Preskorn, Sheldon H. "Cytochrome P450 Enzymes and Psychopharmacology." American College of Neuropsychopharmacology (2000). https://www.acnp.org/g4/GN401000086/CH085.html

do not show long-term benefits: Ghaemi, S. Nassir. "Symptomatic Versus Disease-Modifying Effects of Psychiatric Drugs." *Acta Psychiatrica Scandinavica* (Early View). https://doi.org/10.1111/acps.13459

CHAPTER 24

ELECTROSHOCK AND PSYCHOSURGERY

naturally reduce depression: "Electroconvulsive Therapy (ECT)." Harris County Psychiatric Center, University of Texas. Accessed November 27, 2021. https://hcpc.uth.edu/pages/outpatient-services/ect-clinic

what is used for stunning pigs: Castleman, Kenneth R. "Court Affidavit: Expert Report on Electroconvulsive Therapy" (September 13, 2018). https://www.madinamerica.com/wp-content/uploads/2021/01/3Castleman_2018_ExpertReport.pdf.

FDA staff review of scientific research: "FDA Executive Summary Prepared for the January 27–28, 2011 Neurological Devices Panel Meeting to Discuss the Classification of Electroconvulsive Therapy Devices (ECT)." Food and Drug Administration. https://downloads.regulations.gov/FDA-2014-N-1210-3436/content.pdf

devastating cognitive consequences: Task Force Report of the American Psychiatric Association. "The Practice of Electroconvulsive Therapy" (2001), as cited in "User Manual Thymatron® System IV." Somatics, LLC. http://www.thymatron.com/downloads/System_IV_Instruction_Manual_Rev21.pdf

railed against this recommendation: For example, see Kellner quotes in Lutz, Amy S.F. "Why the FDA's Move to Restrict ECT Should Alarm Us All." *Psychology Today* (January 29, 2016). https://www.psychologytoday.com/us/blog/inspectrum/201601/why-the-fdas-move-restrict-ect-should-alarm-us-all

cry of brain damage: Kellner, Charles H. "Electroconvulsive Therapy: The Second Most Controversial Medical Procedure." *Psychiatric Times* (February 9, 2011). https://www.psychiatrictimes.com/view/electroconvulsive-therapy-second-mostcontroversial-medical-procedure

with questionable motives: Coffey, Justin, and Kellner, Charles H. "A Spirited Defense of ECT: From Our Readers." *Psychiatric Times* (June 9, 2021). https://www.psychiatrictimes.com/view/spirited-defense-ect

never be required to undergo testing: Food and Drug Administration. "Neurological Devices; Reclassification of Electroconvulsive Therapy Devices." Fed. Reg. 83, 246 (December 26, 2018). https://www.govinfo.gov/content/pkg/FR-2018-1226/pdf/FR-2018-12-26.pdf

reviewed regulations on psychosurgery: Nadler, Roland. "Legal Regulation of Psychosurgery: A Fifty-State Survey." *Journal of Legal Medicine* Vol 39, No 4 (2019). https://doi.org/10.1080/01947648.2019.1688208

burn away mental illness: Stockton, Nick. "Psychosurgeons Use Lasers to Burn Away Mental Illness." *Wired* (June 25, 2015). https://www.wired.com/2015/06/laser-psychosurgery/

psychosurgery is undergoing a renaissance: Cabrera, Laura Yenisa. "Clinical Perspectives on Psychiatric Neurosurgery." *Stereotactic and Functional Neurosurgery* 97, no. 5–6 (2019). https://doi.org/10.1159/000505080

resurgence in psychosurgeries: Nuttin, Bart. "Consensus on Guidelines for Stereotactic Neurosurgery for Psychiatric Disorders." *Journal of Neurology, Neurosurgery, and Psychiatry* 85, no. 9 (September 2014). https://doi.org/10.1136/jnnp-2013-306580

CHAPTER 25

TORTURE

absolute ban and prohibited: Méndez, Juan E. “Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.” United Nations General Assembly Human Rights Council, Twenty-second Session (2013). https://digitallibrary.un.org/record/745862

Working Group on Arbitrary Detention. “Report of the Working Group on Arbitrary Detention on Its Visit to the United States of America.” United Nations Office of the High Commissioner for Human Rights (July 2017). https://digitallibrary.un.org/record/1655103

captured by radical elements: Appelbaum, Paul S. “Protecting the Rights of Persons With Disabilities: An International Convention and Its Problems.” *Psychiatric Services* 67, no. 4 (April 1, 2016). https://doi.org/10.1176/appi.ps.201600050

ignore or amend: Appelbaum, Paul S. “Saving the UN Convention on the Rights of Persons with Disabilities—from Itself.” *World Psychiatry* 18, no. 1 (2019). https://doi.org/10.1002/wps.20583

Canadian Psychiatric Association supported: Dufour, Mathieu. “The United Nations Convention on the Rights of Persons with Disabilities.” *Canadian Journal of Psychiatry* 65, no. 9 (September 1, 2020). https://doi.org/10.1177/0706743720919291

psychiatrist Loren Mosher: Much of the content in this section was drawn from “The Voices of Soteria: Loren Mosher” in Mosher, Loren R. and Hendrix, Voyce, with Fort, Deborah C. *Soteria: Through Madness to Deliverance* (Xlibris, 2004).

1979 Washington Post article: Colen, B.D. “Doctors to Try Kidney Machines in Schizophrenia.” *Washington Post* (October 19, 1979). https://www.washingtonpost.com/archive/local/1979/10/19/doctors-to-try-kidney-machines-inschizophrenia/067a06a6-de62-4a65-ae45-4214e0522d2e/

legally enforced tranquilization: Mosher, Loren R. “Letter of Resignation from the American Psychiatric Association” (December 4, 1998). http://www.moshersoteria.com/articles/resignation-from-apa/

forever after marginalized: De Wyze, Jeannette. “Still Crazy After All Those Years; Local Shrink Assails the Schizophrenia Racket.” *San Diego Weekly Reader* (January 9, 2003). Accessed October 17, 2021 via http://www.peter-lehmann-publishing.com/articles/mosher/dewyze.htm

bizarre intimidation: Associated Press. “Psychiatrist Says Panel Cleared Him.” *New York Times* (September 24, 1987). https://www.nytimes.com/1987/09/24/us/psychiatrist-says-panel-cleared-him.html

full-scale war against Breggin: Gorman, Christine. “Prozac’s Worst Enemy.” *Time* (October 10, 1994). http://content.time.com/time/subscriber/article/0,33009,981579,00.html

$12 million to over $4 billion: Thomaselli, Rich. “Ten Years Later: Direct to Consumer Drug Advertising.” *AdAge* (October 1, 2006). https://adage.com/article/news/ten-years-direct-consumer-drug-advertising/112215

Donohue, Julie M. et al. “A Decade of Direct-to-Consumer Advertising of Prescription Drugs.” *New England Journal of Medicine* 357, no. 7 (August 16, 2007). https://doi.org/10.1056/NEJMsa070502

identified himself to Cochrane simply as: Peter Gøtzsche has posted copies of many emails and other related documents at https://www.deadlymedicines.dk. “Wilson Opines that Gøtzsche Broke the Cochrane Spokesperson Policy.” https://www.deadlymedicines.dk/wp-content/uploads/2018/09/1-

Wilson-to-G%C3%B8tzsche-about-complaints-by-Torrey-andPottegaard-15-March.pdf

Peter's head on a platter: Demasi, Maryanne. "The Cochrane Tapes." Blog post (September 13, 2021). https://maryannedemasi.com/publications/f/the-cochrane-tapes

one of the greatest scientists: Ioannidis, John P.A. "Re Peter Gøtzsche – Nordic Cochrane Centre – Rigshospitalet." Public Letter (November 16, 2018). https://work.cochrane.org/sites/work.cochrane.org/files/public/uploads/john_ioannidis_letter_to_danish_

coercive practices remain all too common: "New WHO Guidance Seeks to Put an End to Human Rights Violations in Mental Health Care." World Health Organization Press Release (June 10, 2021). https://www.who.int/news/item/1006-2021-new-who-guidance-seeks-to-put-an-end-to-human-rights-violations-in-mental-health-care

CHAPTER 26

ALTERNATIVES, AND THEIR SUPPRESSION

landscaped courtyards throughout the day: Margolies, Jane. "A New Tool in Treating Mental Illness: Building Design." *New York Times* (January 5, 2021). https://www.nytimes.com/2021/01/05/business/mental-health-facilities-design.html

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

"health systems' reticence to implement: For example: Swartz, Marvin S. "Implementing Psychiatric Advance Directives: The Transmitter and Receiver Problem and the Neglected Right to Be Deemed Incapable." *Psychiatric Services* (Washington, D.C) 72, no. 2 (February 1, 2021). https://doi.org/10.1176/appi.ps.202000659

Kemp, Kathleen. "Embedding Advance Directives in Routine Care for Persons with Serious Mental Illness: Implementation Challenges." *Psychiatric Services* 66, no. 1 (January 1, 2015). https://doi.org/10.1176/appi.ps.201400276

WHO released a collection of guides: "Guidance and Technical Packages on Community Mental Health Services." World Health Organization (May 26, 2021). https://www.who.int/publications-detail-redirect/guidance-and-technical-packages-oncommunity-mental-health-services

suppression of alternatives unconstitutional: *Myers v. Alaska Psychiatric Institute*, 138 P.3d 238 (Alaska 2006). http://psychrights.org/States/Alaska/CaseOne/MyersOpinion.pdf

CHAPTER 27

THE RISING PSYCHIATRIC SURVEILLANCE STATE

bail on Google-sized money: Rogers, Adam. "Star Neuroscientist Tom Insel Leaves the Google-Spawned Verily for . . . a Startup?" *WIRED* (May 11, 2017). https://www.wired.com/2017/05/star-neuroscientist-tom-insel-leaves-google-spawnedverily-startup/

monitoring other social media: "Why We Need to Fund Suicide Prevention Research." YouTube video. Posted by AFSPNational (April 18, 2016). https://www.youtube.com/watch?v=8u_iU91-2DA

using outdoor surveillance cameras: Mishara, Brian. "Can CCTV Identify People in Public Transit Stations Who Are at Risk of Attempting Suicide?" *BMC Public Health* 16, no. 1 (December 15, 2016). https://doi.org/10.1186/s12889-016-3888-x

before violence erupts: Gillum, Jack. "The Unproven, Invasive Surveillance Technology Schools Are Using to Monitor Students." *ProPublica* (June 25, 2019). https://features.propublica.org/aggression-detector/the-unproven-invasivesurveillance-technology-schools-are-using-to-monitor-students/

Hub Model of Community Safety: Robertson, Kate. "To Surveil and Predict: A Human Rights Analysis of Algorithmic Policing in Canada." Citizen Lab, University of Toronto (September 1, 2020). https://citizenlab.ca/wp-content/uploads/2020/09/To-Surveil-and-Predict.pdf.

combine and analyze records: Herold, Benjamin. "To Stop School Shootings, Fla. Will Merge Government Data, Social Media Posts." *Education Week* (July 27, 2018). https://www.edweek.org/technology/to-stop-school-shootings-fla-will-mergegovernment-data-social-media-posts/2018/07

wellness checks shared with FBI and Homeland Security: Cavoukian, Ann. "Crossing the Line: The Indiscriminate Disclosure of Attempted Suicide Information to U.S. Border Officials via CPIC." Ontario Information and Privacy Commissioner (April 2014). https://www.ipc.on.ca/resource/crossing-the-line-the-indiscriminate-disclosure-of-attempted-suicideinformation-to-u-s-border-officials-via-cpic/

flagging in Automatic License Plate Recognition systems: Wipond, Rob. "Hidden Surveillance." *Focus* (February 2012). https://robwipond.com/archives/864

Facebook's algorithm: Marks, Mason. "Suicide Prediction Technology Is Revolutionary. It Badly Needs Oversight." *Washington Post* (December 20, 2018). https://www.washingtonpost.com/outlook/suicide-prediction-technology-is-revolutionary-itbadly-needs-oversight/2018/12/20/214d2532-fd6b-11e8-ad40-cdfd0e0dd65a_story.html

likened Mindstrong to fire alarm: "Testing a 'Fire Alarm' App for Imminent Behavioral Health Crises." American Hospital Association. Accessed October 9, 2021. https://www.aha.org/aha-center-health-innovation-market-scan/2019-06-25testing-fire-alarm-app-imminent-behavioral

without user consent: Simons, Peter. "Mental Health Apps: AI Surveillance Enters Our World." *Mad In America* (March 21, 2020). https://www.madinamerica.com/2020/03/mental-health-apps-ai-surveillance/

2,300-student Michigan school district: Chambers, Jennifer. "Michigan Schools Surveil Student Emails for Suicide Risks, Raising ACLU Concerns." *Detroit News* (January 23, 2020). https://www.detroitnews.com/story/news/education/2020/01/23/surveillance-service-aids-michigan-schools-but-worries-aclu/4477372002/

more than 273,000 interventions: "Students Disrupted: One Year Into the Pandemic." Gaggle Net Inc. Accessed October 9, 2021. https://news.gaggle.net/students-disrupted-year-into-pandemic

Guardian report: Beckett, Lois. "Under Digital Surveillance: How American Schools Spy on Millions of Kids." *The Guardian* (October 22, 2019). https://www.theguardian.com/world/2019/oct/22/school-student-surveillance-bark-gaggle

the real mental health crisis: Post Editorial Board. "Chinatown Murders Prove ThriveNYC Is a Sickening Failure." *New York Post* (October 9, 2019). https://nypost.com/2019/10/06/chinatown-murders-prove-thrivenyc-is-a-sickening-failure/

CHAPTER 28

WHAT CAN BE DONE

psychocracy: Dineen, Tana. "The Psychological Sphere of Influence," in *Modernity and Its Discontents*, ed. Petteri Pietikainen. (Stockholm: Ax:son Johnson, 2005). https://tanadineen.com/writer/articles/ForDistribution/Psychocracy.pdf

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