Forced hospitalization

From The Report on Improving Mental Health Outcomes:

https://psychrights.org/ReportOnImprovingMentalHealthOutcomes.pdf

"[C]ourts accept…testimonial dishonesty…, specifically where witnesses, especially expert witnesses, show a "high propensity to purposely distort their testimony in order to achieve desired ends." … Experts frequently…and openly subvert statutory and case law criteria that impose rigorous behavioral standards as predicates for commitment…. This combination…helps define a system in which (1) dishonest testimony is often regularly (and unthinkingly) accepted; (2) statutory and case law standards are frequently subverted; and (3) insurmountable barriers are raised to ensure that the allegedly "therapeutically correct" social end is met…. In short, the mental disability law system often deprives individuals of liberty disingenuously and upon bases that have no relationship to case law or to statutes. **As a result, it has been estimated no more than 10% of the people psychiatrically incarcerated actually meet commitment criteria.** "

Perlin, Michael L. (1993). "The ADA and Persons With Mental Disabilities: Can Sanist Attitudes be Undone." Journal of Law and Health 8(1): 15–45.

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

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

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

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

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

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

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

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

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

Under Articles 12 and 14 of the United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD), governments are prohibited from denying people decision-making authority, from confining people, or administering any unwanted psychiatric intervention on the basis of a disability, including being diagnosed with a mental illness. Because there was a general misunderstanding of the scope of Article 12 of the CRPD, **the United Nations Committee on**

the Rights of Persons with Disabilities issued General Comment No. 1 (2014) to clarify that taking away someone's decision making rights and forced psychiatric interventions are prohibited. See also Guidelines on the right to liberty and security of persons with disabilities (*the practice of detaining people on the grounds of actual or perceived impairment provided there are other reasons including that they are deemed dangerous to themselves or others is incompatible with article 14*). **The UN has also repeatedly stated such unwanted psychiatric interventions can amount to torture.**"

United Nations General Assembly. (2006). Convention on the Rights of Persons With Disabilities (CRPD). A/RES/61/106. New York: United Nations.
UN Committee on the Rights of Persons with Disabilities (11th Session). (2014). "General Comment No. 1 (2014): Article 12, Equal Recognition Before the Law." CRPD/C/GC/1. Geneva: United Nations.
UN Committee on the Rights of Persons with Disabilities. (2017). "Guidelines on the Right to Liberty and Security of Persons With Disabilities." In Report of the Committee on the Rights of Persons With Disabilities (13th Through 16th Sessions (2015–2016), pp. 16–21. A/72/55. Geneva: United Nations.
UN Human Rights Council. (19 June 2020). "Mental Health and Human Rights: Resolution 43/13 Adopted 19 June 2020." A/HRC/RES/43/13. Geneva: United Nations; UN Human Rights Council. (20 Mar 2020). Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment: Report of the Special Rapporteur. A/HRC/43/49. Geneva: United Nations; Méndez, Juan E. (4 Mar 2013). "Statement By Mr. Juan E Méndez, Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 22nd Session of the Human Rights Council of the United Nations." Geneva: United Nations. See also the related Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Juan E. Méndez (2013), A/HRC/22/53. Geneva: United Nations.

"We should invest in parents' and children's and youths' success, not abusive children and youth-drugging prisons. **So-called residential treatment facilities for children and youth have been exposed as abusive. Children and youth should not be psychiatrically incarcerated or drugged.**"

The very profitable abuse by what is called the Troubled Teen Industry has been the subject of recent exposés. See, e.g., Stockton, Alexander (11 Oct 2022). "Can You Punish a Child's Mental Health Problems Away?" New York Times. See, e.g., The National Youth Rights Association on "The 'Troubled Teen' Industry" (2023) and the American Bar Association's "Five Facts About the Troubled Teen Industry" (2021).

From "Your Consent Is Not Required" by Rob Wipond

Patients interviewed are only "very occasionally" grateful for their detentions; most come out more traumatized. Rates of coercion have been going up since the 1990s, exactly predicting the rising suicide rates. *Numerous studies have shown people become "dozens or even hundreds of times more likely to kill themselves" after forced hospitalization, even if they were not suicidal before.* Force and coercion may explain the vast majority of those "treated" in inpatient facilities; furthermore, this happens to over 2 million Americans per year, and not just the same people repeatedly. There is no good evidence for "chemical imbalance hypotheses of mental illness, and there are no biological tests to verify these disorders. Diagnosis is arbitrary, vague, and unreliable. According to the NIMH and US Secret Service numbers, the majority of Americans will have a mental illness at some point.

Rejection of the process of civil commitment out of knowledge it will harm you is considered a "lack of insight" and therefore more proof of need; this is peddled despite patients virtually always being correct to reject it.

The most sensitive and empathetic workers often leave quickly, leaving a negative selection bias in inpatient facilities. The homeless who are labeled with mental illness avoid the "treatments" because they know they aren't helpful, and they would rather be homeless than committed. Housing first has also proven wildly successful. **Criminals have more rights than civil commitment subjects; sexual assault and racism are routine. Commitments only follow legal standards a small minority of the time (~5%), and victims are often forced to pay for the abuse. Victims often lose parental, medical, military, driving, and legal rights, as well as sometimes their housing, jobs, and credibility.**

The NIMH, SAMHSA, APA, and all other sources have been unable to provide evidence for the effectiveness of coercive treatment. All quality outcome data shows no direct benefit, and many studies show harm. According to Dr. Torsten Jacobsen, "these practices are based on tradition rather than evidence." He found "no reliable evidence forced treatment helps people." **WHO authors found the same, that coercive measures were not evidence-based and tend to be traumatic.**

From "Deadly Psychiatry and Organized Denial" by Peter Gotszche, MD

"The fact that forced treatment can be fatal was recently underlined in a Danish register study of 2,429 suicides.It showed that the closer the contact with psychiatric staff — which often involves forced treatment — the worse the outcome. Compared to people who had not received any psychiatric treatment in the preceding year, the adjusted rate ratio for suicide was six for people receiving only psychiatric medication, eight for people with psychiatric outpatient contact, 28 for people with psychiatric emergency room contacts, and 44 for people who had been admitted to a psychiatric hospital. Patients admitted to hospital would of course be expected to be at greatest risk of suicide because they were more ill than the others (confounding by indication), but the findings were robust and most of the potential biases in the study were actually conservative, i.e. favoured the null hypothesis of there being no relationship. **An accompanying editorial noted that there is little doubt that suicide is related to both stigma and trauma and that it is entirely plausible that the stigma and trauma inherent in psychiatric treatment — particularly if involuntary — might cause suicide.**"

Hjorthøj, Carsten Rygaard, et al. (2014). "Risk of Suicide According to Level of Psychiatric Treatment: A Nationwide Nested Case–Control Study." Social Psychiatry and Psychiatric Epidemiology 49(9): 1357–1365.
Large, Matthew M.; & Ryan, Christopher J. (2014). "Disturbing Findings About the Risk of Suicide and Psychiatric Hospitals." Social Psychiatry and Psychiatric Epidemiology 49(9): 1353–1355.

More Research

https://pubmed.ncbi.nlm.nih.gov/31162700/ **Suicidal behavior increases after forced hospitalization, even if it was not present before.**

https://www.madinamerica.com/2016/06/forced-treatment-is-torture/ **Here is a mental health professional describing the lack of evidence for the procedure, how it likely *increases* suicide and homicide, how it is worse than prison, and why it is torture.**

https://ps.psychiatryonline.org/doi/full/10.1176/ps.62.5.pss6205_0465. A 2011 review of 27 articles found most subjects were deeply traumatized, and the minority of reviews that reported positive outcomes discussed intent and social norms regarding need for treatment, rather than benefit of the treatment itself. **Studies showed forced treatment produced negative social and mental health outcomes.**
The few who thought it necessary appeared to have done so believing the only option for treatment was forced hospitalization, which is not true. **There is no evidence supporting forced hospitalization over getting help from family, friends, social workers, outpatient services etc., or even over leaving the person entirely alone. The actual "care" was not generally looked at fondly even by those who thought it was the only option.**
//Anecdotally, from those I met and the many people the earlier linked expert has treated over the years, this is the worst way of dealing with it and likely worsens the situation in regards to suicide. In fact, I have met someone like this, who changed his mind well after the fact because of the perceived reasons for the ward, not the ward itself. He was one of the few people I managed to sneak through the system to stay in contact with. While in the ward, he felt completely dehumanized, just like me and the others, and wanted to sue. He maintained this feeling for a long time. However, after another near-death experience with alcohol, rehab, and his brother dying of alcohol-related issues, he changed his perspective on the entire thing. He seemed to view it in hindsight as a necessary evil, because he saw how affected his mother was at the death of his brother. He was grieving. He felt like that was the only alternative to being left on his own, and that it was a necessary evil. However, as harsh as it feels to point this out, he was not being rational with this; he continued his bender life-threatening behavior where he didn't care if he lived or died anymore even after he got out. He still felt he needed extensive rehab after all of this. There was no evidence, from studies or his own experience, that he was helped at all by the ward itself. He should have been given other options for treatment that were less invasive and would allow him to stay with people he knew and loved.

https://onlinelibrary.wiley.com/doi/10.1111/j.1600-0447.2006.00823.x The only study I found that produced positive-looking results for involuntary treatment was older, reviewed fewer studies, and on further inspection, actually produced very mixed results: They did not distinguish between people who were forced or coerced and those who were not, which muddies the waters. (*“Involuntary” means treating a subject as though they are unconscious; that is to say, whether the person wants it or not, they will be treated.*) "Retrospectively, between 33% and 81% of patients regard the admission as justified and/or the treatment as beneficial." However, the biggest thing to note is most people (52-72%) in the study agreed with their hospitalization while it was happening, meaning that they likely would have voluntarily gone regardless of the hold. **There is still no evidence of any benefit for people who did not agree with their "treatment," nor any randomized or controlled trial showing benefit of forced commitment.**

https://www.absoluteprohibition.org/robert-whitaker-medical-science-argues-against-forced-treatment-too/ Whitaker writes, “[The Danish study concluded] that ‘it would seem sensible, for example, all things being equal, to regard **a non-depressed person undergoing psychiatric review in the emergency department as at far greater risk [of suicide] than a person with depression, who has only ever been treated in the community.’”** Forced admission and treatment “are not a means for providing necessary ‘medical help’ to an individual. “

https://www.absoluteprohibition.org/jolijn-santegoeds-why-forced-psychiatric-treatment-must-be-prohibited/ **Disability rights activist clarifies forced treatment is not care, but abuse, and constitutes torture.**

https://www.absoluteprohibition.org/peter-gotzsche-forced-admission-and-forced-treatment-in-psychiatry-causes-more-harm-than-good/ **Dr. Gotszche makes a case that many more patients are harmed than helped by forced treatment, and the treatments themselves are lethal.**

https://www.who.int/news/item/10-06-2021-new-who-guidance-seeks-to-put-an-end-to-human-rights-violations-in-mental-health-care **The WHO opposes forced admission, treatment, and restraints, and views them as human rights violations.**

https://www.reimaginingcrisissupport.org/reparations "Reparation for violations of human rights and humanitarian law is recognized as an obligation of states in a resolution of the UN General Assembly, https://undocs.org/es/A/RES/60/147. The forms of reparation are satisfaction, guarantees of non-repetition, restitution, rehabilitation and compensation. This framework can be helpful for us in thinking about what we want and need as survivors." **The UN views force in psychiatry as a human rights abuse, and advocates reparation.**

https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(20)30381-3/fulltext **Clinicians currently struggle to predict self-harm and suicide, "risk assessment should not be seen as a way to predict future behaviour and should not be used as a means of allocating treatment," and carers and patients both report "a lack of clarity on what to do in a crisis."**

https://www.mentalhealth.va.gov/docs/data-sheets/2019/2019_National_Veteran_Suicide_Prevention_Annual_Report_508.pdf, www.madinamerica.com/2019/11/screening-drug-treatment-increase-veteran-suicides/ **Using controlled data from the 2019 VA report on veteran suicides, Robert Whitaker and Derek Blumke make the case that many of them are driven by the psychiatric treatment model.**

Forced drugging

https://psychrights.org/Litigation/ForcedDruggingDefensePkg.pdf, https://psychrights.org/ReportOnImprovingMentalHealthOutcomes.pdf **Long term outcomes are worse on medication, including death rates**, and forcing them is not in patients' or governments' interest. (Many studies are cited in these.)

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4756604/ **Court-ordered forced treatment shows "no evidence of patient benefit" in international meta-analyses and systematic reviews.**