Heidi Henkel
My Proposed Revisions of S.287:

1. Require legal REPRESENTATION within 5 days, rather than a hearing within 5 days, for forced hospitalization. This will move the judicial process faster WITH REPRESENTATION. The current bill would create lots of hearings without representation. Legal Aid cannot keep up, even now, which is why a lot of people are not getting to request hearings in a timely manner. Fund Legal Aid a lot better so they can hire more staff to get the representation together faster.

2. Before a forced medication application and hearing is considered, extensive attempts shall be made in collaboratively working and discussing with the person to explore as well as offering alternatives with the emphasis being on what they find works best for them. Whenever possible, this is best left to either peers working in the field, the person's attorney or others the person might be most comfortable working with.

This would solve the problem of patients languishing in hospitals without treatment, prior to forced drugging hearings. The hospitals would be required to make an effort to attempt to TREAT patients via other alternatives, before a forced drugging hearing.

Treatments offered prior to a forced medication hearing shall include Open Dialogue, testing for and treatment of medical causes of psychiatric symptoms, naturopathy, and cognitive therapy, peer support, WRAP, and any reasonable request made by the patient. (The treatments listed have very high success rates with unmedicated psychotic people, in research and in practice.)

All inpatient psychiatrists shall be trained in Functional Medicine. No inpatient psychiatrist not trained in this may ever have anything to do with any part of a forced medication process, and by 2016, this training or better, shall be required for licensure to work as an inpatient psychiatrist.

All inpatient psychiatry departments shall have on staff a naturopathic physician as well as therapists who are fully trained and experienced in open dialogic practice, by 2016. In the meantime, no psychiatry department without at least a naturopath and several staff who are in the process of training in dialogic practice, may accept involuntary patients.

3. All forced medication shall carry the stipulation that the facility that force drugs the patient is financially responsible for getting

the patient back off the drugs. The facility may gradually taper the patient off the drug, while providing the necessary medical care and emotional support, or they may pay for some other facility, such as Alternatve to Meds Center in Sedona AZ, to do it. (There are also two other such facilities in the US that I know of.)

4. The forced commitment and forced medication hearings shall be two different hearings. Patients shall have legal representation.

5. If the patient is taking a drug that could be causing psychosis, mania, or violent or suicidal tendencies (for example, an ADHD drug, a sleeping medication, a benzodiazepine, an antidepressant, or an antipsychotic) it must be explored whether or not the patient's current problem is being caused by the drug(s) the patient is already taking. If there is any chance that this might be the case, the psychiatrist must fix this problem before any forced medication will be allowed. Courts shall not approve forced medication in patients already taking a psychiatric drug that could be causing their problem. If a court does approve forced medication in a patient already taking another psychiatric drug, there is automatically an appeal and a stay pending appeal, and the state of Vermont shall pay for an expert witness who has expertise on this issue, to participate in the appeal.

6. Before any forced medication hearing, the facility shall test the patient for the gene 2D6, and if the patient has it, the patient cannot be forced to take a psychiatric drug.

7. Forced medication is limited to FDA-approved dosages and FDA-approved drug combinations. If the COMBINATION of two or more drugs is not FDA-approved as a combination, the combination cannot be forced on the patient. (This is to prevent dangerous drug interactions, including ones that are not told to doctors due to their never having been studied.)

8. The facility wanting to force a medication shall bring to the hearing the complete scientific study data on the drug they want to force upon the patient. (This is to prevent the forcing of fraudulent products on patients.)

9. There is an automatic stay pending appeal. The court cannot waive it unless there is substantial positive evidence that the patient has in fact gone cold turkey off of an antipsychotic within the past month, or the patient has in fact done an extremely violent thing (proven at a level equal to that of criminal court) and was not under the influence of another prescription drug at the time.

10. All inpatient psychiatric facilities in Vermont shall maintain at least a one to one staff to patient ratio at all times.
All inpatient psychiatric facilities in Vermont are required to maintain a full daily schedule of interesting, therapeutic, and fun things patients may choose to participate in, which include artistic activities, emotional expression, social activities, recreation, support groups, physical activity, contact with nature, and daily visitation. (This will also help a lot with safety issues.)

11. A person being forced to take a psychiatric drug may request a hearing at any time, to advocate to be released from the forced medication or to have the dosage reduced. The hearing must be scheduled within one week of the request. Legal Aid shall be funded to provide representation at all such hearings.

12. All health insurances shall be required to pay for pharmacy-compounded psychiatric medications (to create small enough increments of dosages, for getting safely, gradually, off the drugs), and by 2017 there shall be an inpatient facility dedicated to helping Vermonters taper off of psychiatric drugs. (This will reduce the number of cases of psychiatric emergencies caused by people trying to get off of psychiatric drugs all by themselves and too quickly.)

How Expedited Forced Drugging Could Happen Via My Revision of S.287:

The hospital could be very quick to get all the medical testing done to figure out what, if any, medical causes are contributing to the patient's problem, and be very quick to initiate a dialogue with the patient about alternatives, and also be very quick to offer alternatives in action.

Legal Aid could be funded in such a way that they have enough staff time to be very quick to put together a legal representation for the patient.

The hospital would have to get their homework done, in order to be able to make the process move along faster. This would put some responsibility on the hospital, to do their best to provide good medical care, an element that is missing in current law and in the S.287 bill as currently proposed by the committees. The hospital could have what they say they want, a quicker process, if they do their job promptly and well. If they don't do their job, the patient cannot be force medicated in compensation for the hospital being neglectful, as is currently the case.

The bill as I proposed it would solve all of the stated problems, without enabling or exacerbating any of the wrongs and abuses in the current system.

It would also gradually reduce the need for inpatient mental hospital beds. You will understand why this is, if you read the book "Anatomy of an Epidemic" by Robert Whitaker. I loaned it to Willem. It's around the state house somewhere. Ask Willem where it is. The escalating rates of mental illness and of relapse are caused primarily by the overdependence on the part of the system, on psychiatric medication. By requiring hospitals to learn and practice other types of mental health care, this trend would be reversed.

Scientific Resources for Legislators

This is a successful study on cognitive psychotherapy in unmedicated psychotic patients. Cognitive psychotherapy works extremely well in this situation.
http://download.thelancet.com/flatcontentassets/pdfs/S0140673613622461.pdf

This is a successful study on exercise in schizophrenic patients, showing that the major brain structure feature involved in schizophrenia, lowered hippocampal volume, is reversed via consistent aerobic exercise.
http://www.ncbi.nlm.nih.gov/pubmed/20124113

Lowered hippocampal volume is caused by stress, and is seen consistently in people who have endured long periods of continuous or repetitive high stress, especially in childhood (abuse, etc). Here is a weblink to some research on that:
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3229101/

Here is a meta-analysis dispelling the belief, which is not based in legitimate science, that schizophrenia is genetic. Psychosis and other mental illness is caused by medical problems, drugs, and/or
stress. There is no inherent genetic chemical imbalance. That is a made-up concept that has no basis in legitimate scientific research. There are only problems that are temporary and can be solved.
http://www.ncbi.nlm.nih.gov/pubmed/18423075

Psychiatric drugs are not reliable ways to make people safer, less suicidal, or less violent. In fact, a lot of horrible violent acts are done due to the influence of these drugs, including most school shootings. Here is a link to a blog about the situation with Adam Lanza: http://www.behaviorismandmentalhealth.com/2014/01/06/sandy-hook-massacre-the-unanswered-question/

Here is an article that explains some of how medications can cause harm to the brain, suicide, and violence.
http://breggin.com/index.php?option=com_content&task=view&id=243

Legislators can also read any of the books I lent to Willem Jewett, "Anatomy of an Epidemic" by Robert Whitaker, "Rethinking Psychiatric
Drugs: A Guide for Informed Consent" by Grace Jackson, MD, "Medication Madness" by Peter Breggin, MD (how medications cause suicide and violence), "The Myth of the Chemical Cure" by Johanna Moncrieff, MD. I also recommend "Drug-Induced Dementia," by Grace Jackson, MD, which shows that the psychiatric drugs, especially the neuroleptics, cause brain damage, and "Overcoming Depression Without Drugs" by John Snyder, PhD, which explains the emotional and artistic
sides of mental health recovery. I can mail these to the state house if desired. I also loaned Willem a hard copy of a powerpoint by a

professor at UCLA, David Cohen, PhD, showing research on the long term outcomes of the use of psychiatric drugs in hospitalization vs the long term outcomes of not doing so. I will send out a scanned version to each of you, also.

Pages 28-30 of Grace Jackson's book, "Rethinking Psychiatric Drugs: A Guide for Informed Consent," are important in understanding the attached document. The researchers who did that study (attached) wondered why patients taking the newer antipsychotics, which were supposedly safer than the older ones, were dying even younger than the patients taking the older antipsychotics. The answer is in these pages of Grace Jackson's book. The research showing the newer antipsychotics to be safer was fraudulent. The study, combined with these pages of Grace Jackson's book, show very strong evidence that the modern antipsychotic drugs are killing patients 25 years earlier than they would otherwise die, on average.

A good source of information about deadly side effects is drugs.com, the list of side effects that is for professionals, written in medical language. Look up what those words mean.

Information on the destructive effects of psychiatric drugs on people with traumatic brain injuries can be found in Grace Jackson's book "Drug Induced Dementia," pages 29-30.

Here is an article about 2D6 abnormalities, drug metabolism, and drug interactions. People with 2D6 abnormalities can quickly get severe adverse reactions to very small amounts of psychiatric drugs. Drugs can interact with other drugs because of the drugs' effects on liver enzymes.
http://en.wikipedia.org/wiki/CYP2D6

Here is an article on Serotonin Syndrome, a frequent result of interactions between psychiatric drugs and medical drugs, and a frequent result of giving psychiatric drugs to people with TBI.
http://en.wikipedia.org/wiki/Serotonin_syndrome

general effects of antipsychotics
http://www.huffingtonpost.com/dr-peter-breggin/antipsychotic-drugs-their_b_341108.html

antipsychotics cause akathisia, tardive akathisia, and tardive dyskinesia
http://www.tardivedyskinesia.com/common-associations/akathisia.php

akathisia causes violent crime
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3513220/

psych drugs influence recreational drug abuse http://www.huffingtonpost.com/dr-peter-breggin/xanax-whitney-houston_b_1288122.html

Giving people these drugs is often an irreversible act. The person's brain is changed by the drug. This does not necessarily go away when the person stops taking the drug, even if the drug is discontinued fairly soon. People are often left with brain damage that causes problems ranging from motor tics, to mood and sleep problems, to psychosis or mania that makes them dependent on the drug that did the damage, starting a cycle of ever-increasing brain damage from the drug. When the person tries to stop taking the drug, they have worse symptoms than they ever had to begin with, because the drug has caused dependency. From the outside, they look as though they need the drug due to mental illness. The reality is they need the drug due to the drug having caused a dependency. There is also the common phenomenon where the patient is prescribed more and more various psychiatric drugs concurrently, each one to manage the brain-damaging "side effects" of one of the other psychiatric drugs. This, too, is a snowballing situation, sometimes involving drug interactions on top of the regular side effects of the drugs. There are side effects of the drugs that damage the person's body in ways that change their life.

The antipsychotics cause coordination problems, immune impairment, diabetes, obesity, heart disease, and other life changing physical problems. These effects accumulate over the time the patient takes the drug(s). The drugs also cause dementia type problems that interfere with the person's ability to perform basic activities of independent living such as cooking, cleaning, grocery shopping, driving, and time management. This is devastatingly life changing.

Forced drugging may sometimes look rosy to family members in the short term, but the long term is not rosy. Starting a person on a psychiatric drug must be approached with utmost caution, and should be avoided if it is at all possible to successfully help them recover via other methods.

Open Dialogue is close to 100% effective in leading to complete recovery in patients. No more symptoms, no more drugs. Open Dialogue includes the use of other modalities, including naturopathic and other medical care, massage, acupuncture, and so on, in the context of its social framework; it doesn't cure the patient by itself. In fact, some patients even voluntarily use very low dosages of psychiatric medications for short time periods, in the context of Open Dialogue.

Functional Medicine or naturopathic care, in the absence of a psychosocial treatment such as Open Dialogue, 70-80% rate of complete recovery. Antipsychotic drugs result in a less than 20% rate of success in even creating a level of recovery that includes basic normal life activities such as having a job. I am not talking about complete recovery; I am talking about a rudimentary, compromised definition of "recovery" with a long term decline in mental functioning, and on average, a 25-year premature death.

I was told by a sponsor of this bill that the above type of information is not relevant to whether or not to have an expedited process of forcing psychiatric drugs upon patients. I think a discussion about whether or not a treatment is helpful and non-harmful, and how that treatment compares to other available treatments, in those regards, is relevant to any

discussion about forcing that treatment upon patients. Mental health care is supposed to be a form of health care, which is governed by the Hippocratic Oath. I thought the intention was to create good mental health care.
I think it's also relevant in another way. There is a tendency for professionals and courts to assume that refusing medication is an irrational decision that is made due to mental illness and is
equivalent to "refusing treatment". In light of the scientific data,
refusing medication can be a rational, informed, intelligent choice made by a person with sound mental faculties. Likewise, there are many people who refuse psychiatric medication but will gladly accept other treatment options if they are made available. There is an assumption by some legislators that offering other treatment options won't work with these patients unless those alternative treatment options can be forced on the patients. This is not accurate; the patients are not necessarily categorically refusing treatment.
Choosing not to take psychiatric drugs is a sensible decision that is made by many people who are capable of making good decisions about their health, and who are interested in other treatments.

I can provide lots of other scientific information to back up what I have said about how Vermont should proceed on this issue, and am glad to do so upon request and/or answer any questions.
heidikhenkel@gmail.com

There is also money involved in the desires of some constituents. For example, hospitals get reimbursed by insurance, for drugging patients.
It costs them money to hire more staff or better-trained staff,
and/or train the staff better. This may be an important issue to
address, such as by finding funding sources to support how mental health care should be carried out. Where would the money for adequate staffing come from? Some hospitals appear to have tight budgets; for example, RRMC, which recently laid off a bunch of nurses. The Brattleboro Retreat also recently laid off a lot of staff- psychotherapists, believe it or not.

Violence and Mental Health Care issues and options

(I have tried to make this so you can get the gist of it by reading the first sentence of each paragraph.)

1. Arraignment-like hearings without a competent defendant should take place for the purpose of weeding out the cases where there isn't evidence of the defendant having done the thing they are accused of doing.

2. Keeping all convicts with mental health needs in Vermont, not shipping them to other states, and prioritizing rehabilitation in the criminal justice system; favoring probation and parole over incarceration whenever possible. Moving toward a lot more probation and parole and a lot less incarceration, so all VT convicts stay in VT.

3. Case management, community support specialists, and so on, can be part of probation and parole. People who have done small violent things and are unlikely to reoffend if they are given the right community supports, should be given the right community supports and a probation/parole. This especially includes people with developmental disabilities and people who are graduates of the foster care system, who have often been deprived of adequate therapeutic services for their trauma.

Violent criminals with mental health needs need to be dealt with in the criminal justice system, even if it doesn't involve incarceration, and even if there is a significant mental health reason for their behavior. Because they will have a better chance of recovery by using the mechanisms of that system, including the accountability for behavior.

4. People who cannot be tried in criminal court because they are not competent to stand trial, but it's clear that they did the act, and that's not being disputed; people who are "innocent for reasons of
insanity" but did a heinous crime. There need to be architected ways
to work with these people in the mental health system, without danger to others.

Physical but not visual/auditory isolation, is one option for awhile until they improve. This would involve an area in the hospital where they can have freedom to move, and a phone, and visual and auditory contact with others, but they cannot physically touch others.

Courts should be very hesitant to make these types of rulings because it can put defendants into a limbo where there isn't an adequate rehabilitation strategy. Sometimes the defendant is given a better chance at rehabilitation, with a guilty plea deal that involves agreeing to extensive rehabilitation.

5. Getting TBI treatment to people with TBI who have in fact done something dangerous

6. Safety on mental health units, via strategies other than drugging patients.

A. Make sure the architecture is designed so staff can always see patients. If not, fix it. Staff should never have their backs to patients. If this is not possible, anytime staff have a situation in which the back is to the patient, there should be another staff with them whose back is not to the patient.

B. More training in how to recognize distress in patients at earlier stages and de-escalate.

C. Make sure new staff are filled in by out-going staff on shifts, as to what is going on, especially if there's a patient who is having a hard time, so that the new staff can tend to that proactively. Don't ever have a staff member on the floor interacting with patients, who isn't up to speed on any distress that's going on.

D. Decrease the stress level. Create a relaxed, kind culture. (This involves staff having a kind manner toward patients.) The overall general culture of the "ward" should be as low-stress as possible.
Physical activity, in a range from gentle to vigorous, is really
important. Try some other ways to mitigate stress. Music?
Natural sunlight and/or outdoor time? Yoga? Comedy? Different patients will benefit from different things. (Meditation is a really mixed bag with people with mental health issues- helps some, makes others worse. Don't push it as an activity for everyone.)

E. Let patients participate in decisions about their care. Listen to
them about what they want and need and how they feel, and try to meet them half way at least some of the time. Even solicit that information from them. Let them co-participate in creating some of the "culture"
and activities- they can be active participants in creating the social environment they want (leadership). Create opportunities for them to do nice things to help each other. Cultivate, and even teach, peer support among patients. Also, have some hired recovered peers working with them. If people feel like they have some power, and they feel like there are two way mutual relationships, and they feel appreciated and valued and understood, and they are learning what to do via role models and not just by being ordered around, they are a lot less likely to be violent. (A reliable way to create escalation to violence is to make a person feel powerless.)

F. Give patients outlets for their feelings. There needs to be sometime, somewhere, in their day, when it is OK to cry, or express strong feelings in other ways, without it being seen as a "symptom"
and without it being seen as "bad behavior." This could be in individual psychotherapy, or in group art therapy, or some other thing. Preferably one such opportunity would be an organized activity with a beginning and an end and a fun activity afterward that gets
their mind off of it. it also should not be something where they are
"expected" to do that or "expected" to dredge up old traumas. There just needs to be some outlet where it's OK to unload some pent-up feelings and have it be welcome and accepted, and they are even given guidance in how to do that in a way that is not scary to others and does not get them in too deep (and make them feel worse). There are

psychotherapists who are skilled in how to do this. (If people have no opportunity for emotional release and it is stored up and stored up, sometimes they eventually explode.)

G. Make realistic behavior expectations for each patient. This means "everyone has to follow the same rules" may need some modification if some patients are not psychosocially capable of whatever that entails.

A sense of equality is a nice thing to value, but expectations also need to be things that don't guarantee failure and conflict. Fairness partly entails having reasonable expectations that people are capable of. An example when I taught math in Corrections: completely illiterate students weren't required to fill out forms they could not read.

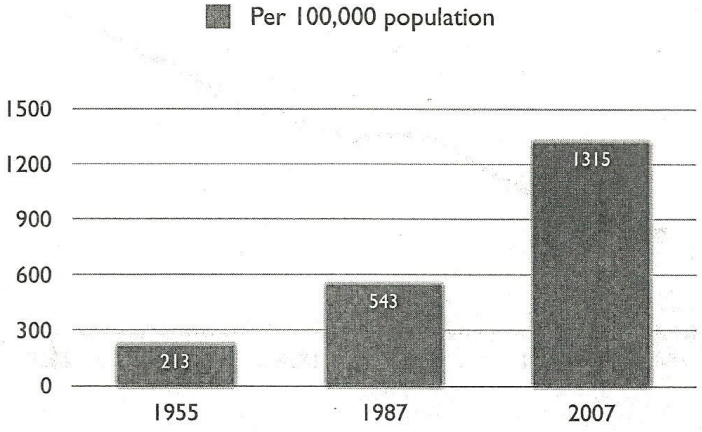
H. High staff to patient ratios.

I. Interesting things to do.

J. Conflict resolution facilitation when needed, and a grievance process for conflicts between patients and staff. The grievance process would have a tier that draws on resources from outside the facility.

The Disabled Mentally Ill in the United States, 1955-2007

(under government care)



Source: Silverman, C. *The Epidemiology of Depression* (1968): 139. U.S. Social Security Administration Reports, 1987-2007.

Summary of Cross-Cultural Studies With Medication as a Variable

1) In 1970s and 1980s, WHO investigators found that outcomes were significantly better in developing countries, where only 16% were regularly maintained on antipsychotics.

2) In recent global Eli Lilly Study, where all patients are maintained on antipsychotics, patients in developing countries do not have better functional outcomes than patients in developed countries.

Eli-Lilly's Global Study

Study details

- 11,078 schizophrenia patients in 37 countries
- All patients treated with olanzapine or another antipsychotic
- Symptoms and functional remission assessed for three years

Outcomes

Region	Clinical Remission	Functional Remission
East Asia	84.4%	24.6%
North Africa and Middle East	79.6%	17.8%
Latin America	79.4%	28.7%
Central and Eastern Europe	65.1%	21.6%
North Europe	60.1%	35.0%
South Europe	61.3%	20.7%
Total	66.1%	25.4%

Source: Haro, "Cross-national clinical and functional remission rates." *Brit J of Psychiatry* 2011, 1999: 194-201.

WHO Findings, Continued

Medication usage:

16% of patients in the developing countries were regularly maintained on antipsychotics, versus 61% of the patients in rich countries.

15-year to 20-year followup:

The "outcome differential" held up for "general clinical state, symptomatology, disability, and social functioning." In the developing countries, 53% of schizophrenia patients were "never psychotic" anymore, and 73% were employed.

Source: Jablensky, A. "Schizophrenia, manifestations, incidence and course in different cultures." Psychological Medicine 20, monograph (1992):1-95. See table on page 64 for medication usage. For followup, see Hopper, K. "Revisiting the developed versus developing country distinction in course and outcome in schizophrenia." *Schizophrenia Bulletin* 26 (2000):835-46.

WHO Cross-Cultural Studies, 1970s/1980s

- In both studies, which measured outcomes at the end of two years and five years, the patients in the three developing countries had a "considerably better course and outcome."

- The WHO researchers concluded that "being in a developed country was a strong predictor of not attaining a complete remission."

- They also found that "an exceptionally good social outcome characterized the patients" in developing countries.

Source: Jablensky, A. "Schizophrenia, manifestations, incidence and course in different cultures." *Psychological Medicine* 20, monograph (1992): 1-95.

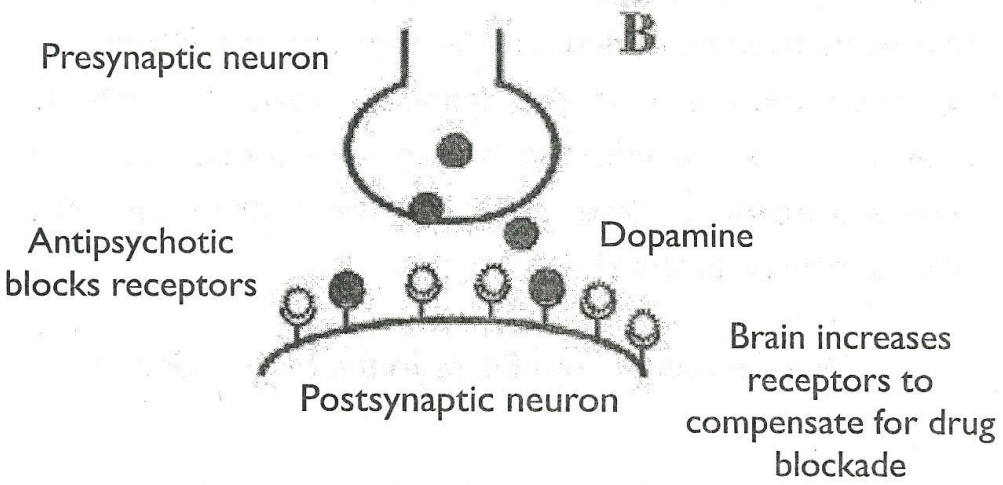
The Dopamine Supersensitivity Theory

"Neuroleptics can produce a dopamine supersensitivity that leads to both dyskinetic and psychotic symptoms . . . An implication is that the tendency toward psychotic relapse in a patient who has developed such a supersensitivity is determined by more than just the normal course of the illness."

Guy Chouinard and Barry Jones, McGill University

Source: Chouinard, G. "Neuroleptic-induced supersensitivity psychosis," *Am J Psychiatry* 135 (1978): 1409-10; and "Neuroleptic-induced supersensitivity psychosis," *Am J Psychiatry* 137 (1980): 16-20.

Dopamine function after exposure to antipsychotics



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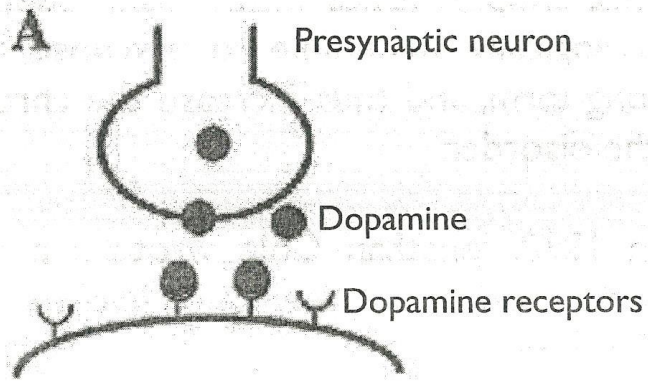


Rethinking Antipsychotics: What Does the Evidence Show Would Best Promote Recovery?

My Opinion:

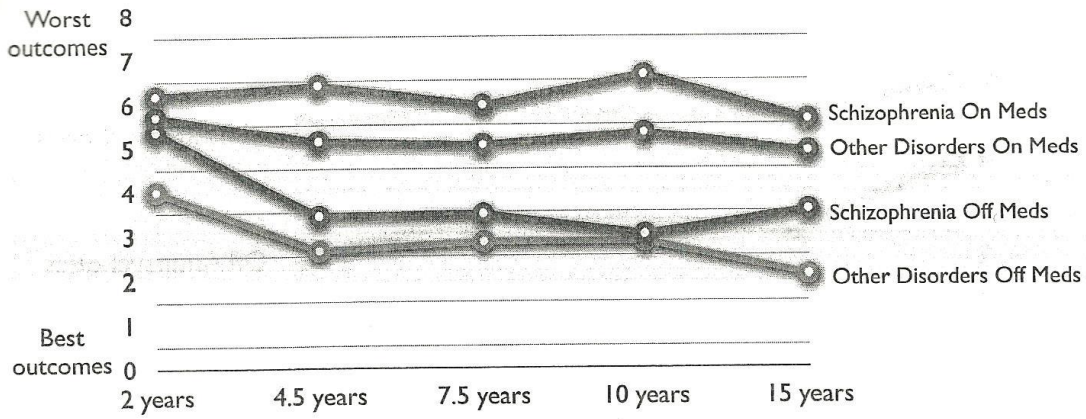
- Avoid immediate use of antipsychotics to identify those who can recover without use of the medications.
- Minimize long-term use.

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

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

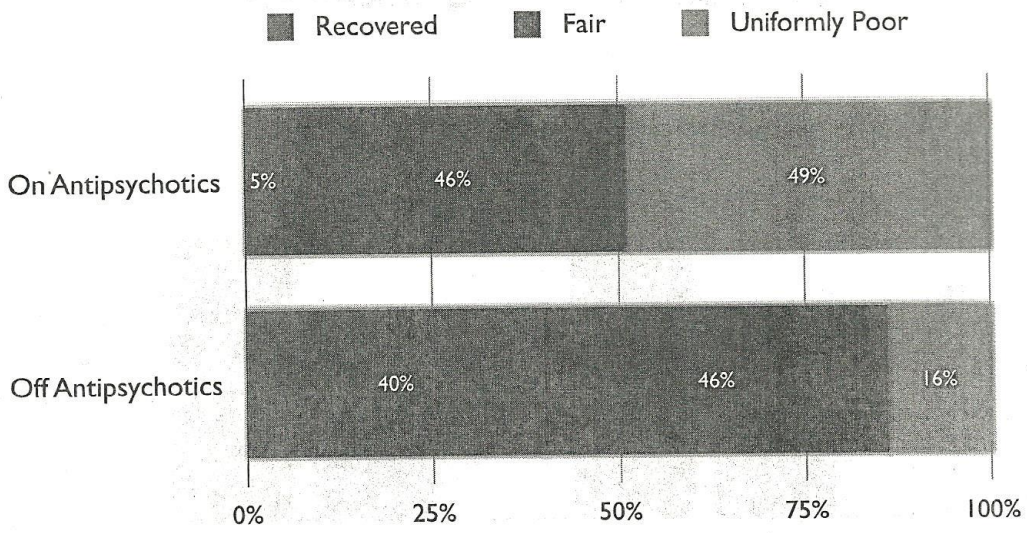
Source: Seikkula, J. "Five-year experience of first-episode nonaffective psychosis in open-dialogue approach." *Psychotherapy Research* 16 (2006):214-28.

Global Adjustment of All Psychotic Patients



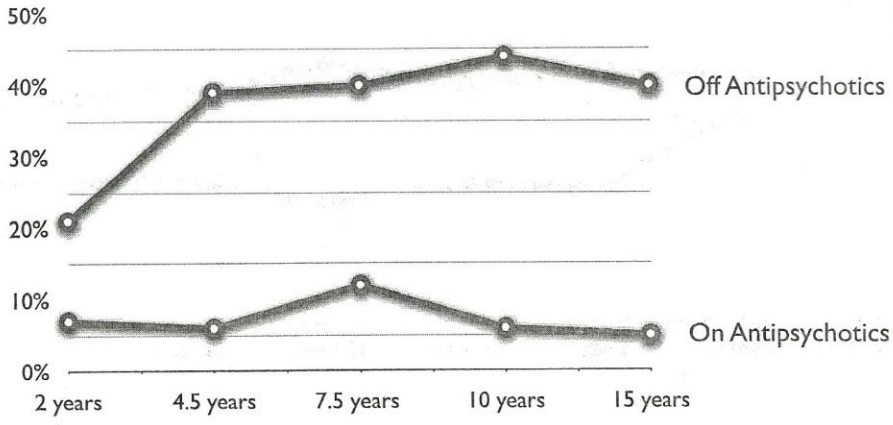
Source: Harrow M. "Factors involved in outcome and recovery in schizophrenia patients not on antipsychotic medications." *Journal of Nervous and Mental Disease* 195 (2007):406-14.

Spectrum of Outcomes in Harrow's Study



Source: Harrow M. "Factors involved in outcome and recovery in schizophrenia patients not on antipsychotic medications." *Journal of Nervous and Mental Disease* 195 (2007):406-14.

Long-term Recovery Rates for Schizophrenia Patients



Source: Harrow M. "Factors involved in outcome and recovery in schizophrenia patients not on antipsychotic medications." *Journal of Nervous and Mental Disease* 195 (2007):406-14.

Summary of First 25 Years

Outcome studies led researchers to worry that antipsychotics might make people more biologically vulnerable to psychosis over the long-term, and thus increase the chronicity of the disorder.

In 1978, Jonathan Cole wrote a provocative article titled: "Is the Cure Worse than the Disease?"

William Carpenter's In-House NIMH Study, 1977

Results

- Those treated without drugs were discharged sooner than drug-treated patients in a comparison group.

- At the end of one year, only 35 percent of the non-medicated group relapsed within a year after discharge, versus 45% of the medicated group.

- The unmedicated group also suffered less from depression, blunted emotions, and retarded movements.

Source: Carpenter, W. "The treatment of acute schizophrenia without drugs." *Am J Psychiatry* 134 (1977):14-20.

Rappaport's Conclusion:

"Our findings suggest that antipsychotic medication is not the treatment of choice, at least for certain patients, if one is interested in long-term clinical improvement. Many unmedicated-while-in-hospital patients showed greater long-term improvement, less pathology at follow-up, fewer rehospitalizations, and better overall functioning in the community than patients who were given chlorpromazine while in the hospital."

Rappaport's Study: Three-Year Outcomes

Medication use (in hospital/after discharge)	Number of Patients	Severity of Illness (1 = best outcome; 7 = worst outcome)	Rehospitalization
No meds/off	24	1.70	8%
Antipsychotic/off	17	2.79	47%
No meds/on	17	3.54	53%
Antipsychotic/on	22	3.51	73%

Source: Rappaport, M. "Are there schizophrenics for whom drugs may be unnecessary or contraindicated?" *Int Pharmacopsychiatry* 13 (1978):100-11.

The First Hint of a Paradox

NIMH's First Followup Study (1967):

At the end of one year, patients who were treated with placebo upon initial hospitalization "were less likely to be rehospitalized than those who received any of the three active phenothiazines."

Source: Schooler, C. "One year after discharge." *Am J of Psychiatry* 123 (1967):986-95.