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WHAT EVERYONE SHOULD KNOW ABOUT PSYCHIATRIC MEDICATION

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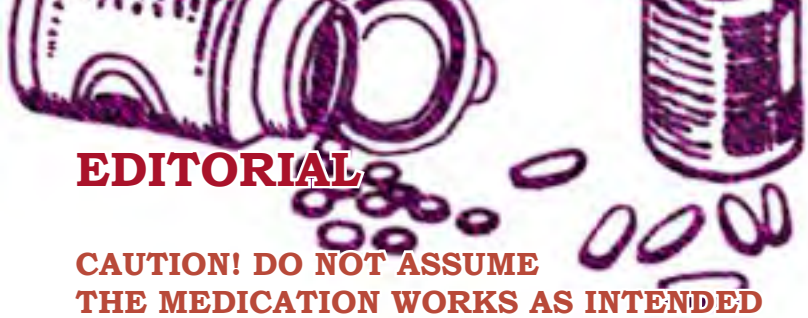


EDITORIAL

CAUTION! DO NOT ASSUME THE MEDICATION WORKS AS INTENDED

Modern societies are highly medicated. You have a health problem? Pop a pill. While ever-inflating health budgets may sometimes benefit patients, they always benefit the drug companies. Since the Second World War, pharmaceuticals have proved even more profitable than the arms industry, the next highest performing sector in the economy. Mental health products make up a significant part of pharmaceuticals. And all manner of political and professional parties have an interest in the unquestioned growth of drugs sales.

In this issue we explore the dubious status of mental health medication. At last, with the arrival of global meta-studies of the drugs in the field (sometimes comparing over one hundred pieces of research on one drug) what for many years was known from a small number of studies is now becoming crystal clear: psychiatric medication is actually inappropriate or ineffectual for most patients most of the time. But for decades it has also been known that too often psychiatric drugging is also positively harmful.

Now science is making it clearer why some patients do seem to respond well enough to psychiatric medication but a greater number show no positive response or a definitely negative mental or physical health response. Pharmacogenetics is the clinical testing of genetic variations which give rise to differing responses to the various prescribed medications – it is the study of how our differently constituted bodies are able or unable to take up drugs. There is now clear evidence that many mental health patients – and probably the neediest – are simply unable to metabolise their medications, and are, in fact, poisoned by them.

This is the topic of Catherine Clarke's important article, towards the back of this issue. She notes that pharmacogenetic tests are routinely carried out prior to treatment in general medicine, for example, with the medications prescribed for arthritis, HIV, cancer, Crohn's and heart disease. This is to assess the degree of efficacy or inefficacy of the proposed drug for each particular patient, and to reduce seriously adverse reactions. In those areas of medicine, the tests only take about 90 seconds and can be done at an out-patient clinic for just £10.

So it seems that testing for the capacity for each mental health patient to metabolise and excrete a proposed medication could be fairly cheap, and it would soon pay off by vastly improving treatment and cutting the rate of iatrogenic illness. And yet there are no plans to introduce pharmacogenetic tests into mental health medicine in the UK. Mental health remains the Cinderella of medicine. Just as in the 1960s and 1970s, when they closed their eyes to the medically induced epidemic of tardive dyskinesia, policy makers in the NHS do not seem interested in the uselessness of their treatments or the continuing drug-induced harm and suffering caused to this particular kind of patient.

Phil Virden, Executive Editor

1: SEVERAL INCONVENIENT TRUTHS

The Truth about Psychiatric Drugs

Dr Joanna Moncrieff

For decades we have been sold a myth about the nature of psychiatric drugs. We have been told that they can compensate for chemical imbalances or help to correct particular psychiatric conditions. This myth suggests that taking a drug is necessarily a good thing because the drug helps to reverse an underlying disease that is the cause of the symptoms or problems. This idea of what psychiatric drugs do has been used to convince millions of people worldwide that they need to take psychiatric drugs to function normally. In my most recent book I show that not only is there little or no evidence to support this way of thinking but, in addition, this view has blinded us to the real nature of psychiatric drugs. It obscures the fact that, like cannabis, alcohol and heroin, psychiatric drugs are psychoactive: while taking them, they alter the way the brain functions – and sometimes forever.

In order to provide a clear way to think about the nature of psychiatric drugs I have outlined two alternative ways of understanding how they might affect people with psychiatric problems. I have called these different 'models' of drug action the 'disease-centred' model and the 'drug-centred' model. Their contrasting features are summarised in Table 1.

The disease-centred model is the standard view that psychiatric drugs work by correcting an underlying disease of the brain. According to this model, drug treatment makes your brain more normal by helping to rectify the underlying problem. This model is based on the way most drugs work in physical medicine. For example, insulin therapy compensates for the underlying deficiency of insulin in diabetes, antibiotics target bacteria, and anti-asthma drugs help to reverse the lung problems that cause wheezing. Even painkillers, although they do not target the underlying disease, work by acting on the biological pathways that give rise to pain.

Table 1: Alternative Models of Drug Action

Disease-centred model	Drug-centred model
Drugs help correct an abnormal brain state	Drugs create an abnormal brain state
Therapeutic effects of drugs derived from their effects on an underlying disease process	Therapeutic effects derive from the impact of the drug-induced state on behavioural and emotional problems
Paradigm: insulin for diabetes	Paradigm: alcohol for social anxiety

Psychiatric drugs are presented as acting in the same way. This is reflected in the way those drugs are named: thus antidepressants are thought to help correct the disease process that leads to depression, antipsychotics are thought to rectify the abnormality that gives rise to the symptoms of schizophrenia or psychosis, and mood stabilisers are believed to correct an underlying instability of mood.

The alternative way of thinking about psychiatric drugs is

to see them first and foremost as psychoactive substances. Like all psychoactive drugs, they distort the functioning of the nervous system and by doing so they produce altered mental states. When we think of recreational drugs we refer to these altered mental states as 'intoxication'. Psychiatric drugs also produce states of intoxication. The features of these states vary according to what sort of drug is taken. Just as the effects of cannabis differ from those of alcohol or heroin, so the effects produced by neuroleptics are different from those produced by the benzodiazepines or SSRIs, for example. The characteristic features of the intoxicated or drug-induced state depend on the chemical structure and nature of each drug.

What the drug-centred model suggests, therefore, is that drugs can sometimes be helpful because the features of the drug-induced state superimpose themselves onto the manifestations of the mental disorder. The accepted example of this is the effects of alcohol upon people with social phobia or social anxiety. Alcohol is not thought to be helpful because it corrects a deficiency of alcohol within the brain, nor because it corrects another chemical imbalance. It is thought to help because one of the characteristic features of alcohol intoxication is that it weakens social inhibitions. And when we know the drug-induced effects of psychiatric drugs we can start to understand their effects in the same way.

Before the 1950s the drugs that were used in psychiatry were regarded as acting in a drug-centred way. They were mostly sedative-type drugs like barbiturates, and they were believed to work as a sort of chemical restraint. When modern psychiatric drugs like the neuroleptics and the antidepressants were introduced in the 1950s, at first they were also viewed in a drug-centred light. However, views about them transformed over the course of a few years. They went from being seen as drugs that produced interesting and useful states, to being seen as chemical cures.

However, this transformation did not come about because of compelling new scientific data. It happened because it suited the interests of the psychiatric profession, the pharmaceutical industry and successive governments to be able to present psychiatric drugs as modern medical treatments. Once the new way of thinking was established, no one remembered that the drugs could be thought of in any other way.

For example, in the 1950s many psychiatrists commented on the remarkable state that was produced by the new neuroleptic drugs such as chlorpromazine (Largactil). Observers commented on the ability of these drugs to restrict activity without simply sending someone to sleep. It was also noted that they reduced emotional responsiveness, and they were described as producing a state of 'psychic indifference'. The French psychiatrist Pierre Deniker, one of the first psychiatrists to use these drugs, described how they produced 'a neurological disease' which replaced and suppressed the symptoms of schizophrenia.

Very early it was recognised that, when taken at high doses, neuroleptics drugs produce obvious symptoms of Parkinson's disease. And Parkinson's disease is caused by reduced activity of the brain chemical called dopamine, in a part of the brain which controls movement and influences thinking (the basal ganglia). Characteristic features of the early stages include a slowing up of movement and mental processes. In particular, there seems to be an inhibition of the will or motivation to act, and a reduction of the normal range of emotional responses. Neuroleptics produce similar effects. These effects have been recorded both by patients and by volunteers who have taken them as part of research studies.

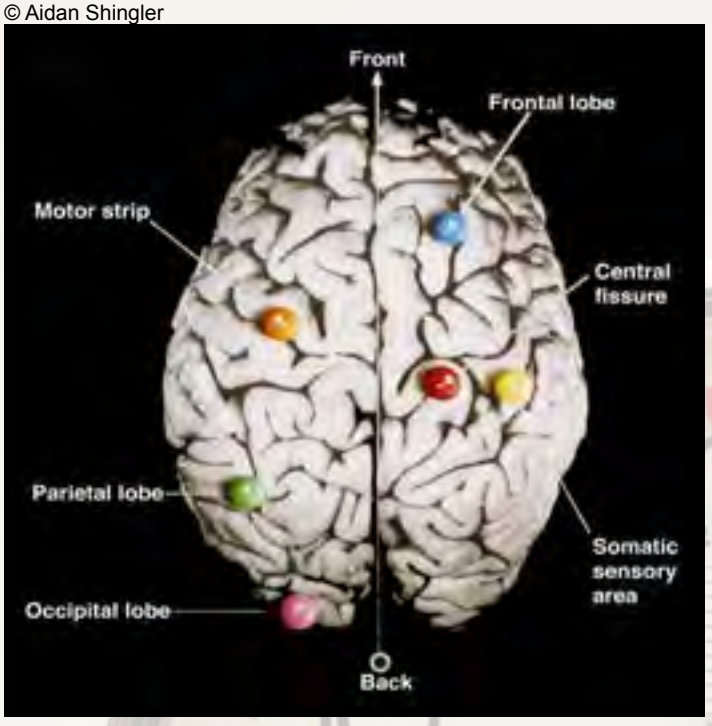
In the early days of the neuroleptics, many psychiatrists attributed their therapeutic effects to their ability to induce Parkinson's disease. Some psychiatrists believed it was necessary to use doses that were high enough to produce the physical symptoms of muscle stiffness and rigidity. However, subtle effects on mental and physical activity are likely to occur long before the overt physical signs of Parkinson's disease appear. It is easy to see how a drug that reduces mental and physical activity may appear to be useful in someone who is preoccupied with intrusive psychotic experiences, and may as a consequence be physically agitated. The emotional effects of the drugs may also be important. Patients and observers often comment on how emotional responses appear to be blunted or flattened under the influence of neuroleptics. These effects may reduce the impact of psychotic symptoms. People may still experience strange beliefs and hallucinations, but they will be less troubled by them. The drugs produce an emotional detachment that enables people to distance themselves from their internal experiences and engage better with the outside world.

Looking at psychiatric drugs in this way can pinpoint when they might be useful, but it also highlights the negative effects of taking psychoactive drugs. Drugs do not simply target the psychiatric symptoms, they produce a global neurological condition. The suppression of mental activity and emotional responsiveness induced by the drugs may be useful in relation to psychotic experiences, but in other realms of life it is likely to be unpleasant and impeding. For example, studies using volunteers and animals show that the neuroleptics impair mental functions such as learning and memory. Using psychiatric drugs is therefore a subtle balancing act that involves comparing the relative disadvantages of the underlying problems or symptoms with the adverse effects of the drug-induced state.

The drug-centred model also stresses the fact that drugs are chemicals that alter the normal functioning of the body. If they are used over long periods the body adapts to try and counteract their effects. For example, neuroleptic drugs reduce the effects of dopamine by blocking the special receptors on brain cells that communicate dopamine's effects. To counteract this effect the body makes more dopamine receptors. This has several consequences. Firstly, the useful effects of taking the drugs may be neutralised. In other words they may no longer produce the mental and emotional restriction that can help reduce the impact of psychotic symptoms. Secondly, withdrawal symptoms occur because if the drug is stopped, the bodily adaptations are no longer opposed by the drug and they go into overdrive. Thirdly, the body may overcompensate and produce too many dopamine receptors. This is thought to be the mechanism by which neuroleptic treatment causes tardive dyskinesia, a condition that consists of repetitive twitching-type movements usually affecting the face.

What all this means is that although there are good reasons to think that antipsychotic drugs (and possibly other sorts of drugs) may be helpful in suppressing symptoms in the short term, we are less certain that those benefits will be maintained in the long term.

For it seems that long-term drug use may also directly damage brain cells. Several studies have been conducted in which repeated brain scans are performed on people with mental disorders (usually psychosis or schizophrenia) who are taking neuroleptic drugs. Most of these studies show that



parts of the brain shrink over time, to a greater extent than in the comparison group of people without a mental disorder. Traditionally, this has been interpreted as evidence that schizophrenia or psychosis leads to a reduction of brain matter. However, it may be the drug treatment that is responsible for this shrinkage. No studies have yet ruled out this possibility.

The existence of tardive dyskinesia is evidence that drug treatment seriously disrupts brain function. Although it is usually portrayed as a relatively trivial movement disorder, several research studies show that it is usually associated with general mental impairment. In some cases, it is also known to be irreversible: when the drugs are stopped the movements may reduce or disappear, but sometimes they remain. In such cases the drug-induced change or damage appears permanent.

Despite these indications that the long-term use of antipsychotic drugs may be associated with severe neurological consequences, the subject has not been well researched. No one has yet set up research to look specifically at the effects of neuroleptic drugs on brain structure using brain scans, despite the fact that numerous studies have been done to look at the presumed effects of having schizophrenia or psychosis. The mechanisms of tardive dyskinesia have not been thoroughly mapped out, and there has been little interest in examining whether long-term use of neuroleptics is associated with more general mental impairments.

The new atypical antipsychotics are claimed to be more benign. It is thought that they are less likely to cause tardive dyskinesia, and it has been claimed that they improve mental functioning compared to the older drugs. It is too early to say whether this is true or not. Some of them, like olanzapine and clozapine, seem to have a different mechanism of action from the older neuroleptics. They are less likely to induce Parkinson's symptoms, and probably they have weaker effects on the dopamine system. However, they do affect numerous other systems, in ways that are not well worked out. We know that they induce severe metabolic disturbance leading to extreme weight gain, and probably diabetes and other complications. Scanning studies have also shown them to cause reduction of brain matter, although to a lesser extent than the previous generation of drugs.

What we should take from this discussion is the recommendation that psychiatric drugs should not be used without good justification, including careful consideration of their negative impact. They may be helpful in some circumstances but they are no panacea. At present our understanding of how they act as drugs – in other words, what they do to the body in the long and short term – is woefully inadequate. We need to know much more about them in order to use them safely and wisely. We also need to recognise the limitations of drug treatment. Drugs produce drug-induced states, they do not make people happier or 'more normal'. Therefore we need to prioritise finding other ways to help people who suffer the burdens of a mental disorder.

Joanna Moncrieff: *The Myth of the Chemical Cure*, was published in paperback by Palgrave Macmillan in 2009.

Book Review

ALL PSYCHOACTIVE MEDICATION CAUSES DEMENTIA

Drug-Induced Dementia: A perfect crime
Grace Jackson, MD (2009), authorhouse.co.uk

Under the influence of declining birth rates, expanding longevity and changing population structures around the world, the global prevalence of senile dementia is expected to increase more than four-fold in the next forty years. In the USA alone, the number of affected individuals over the age of 65 is expected to rise from 8 million cases in the year 2000 (2% of the population) to 18 million retirees in 2040 (roughly 4.5% of the population). Although this is striking, it is quite likely that this underestimates the scope of the coming epidemic since statistics fail to consider the impact of under-diagnosis, early-onset disease and the potential for an increased incidence of the illness in an increasingly toxic environment.

In the face of this imminent crisis, concerned observers

have called for policies and practices which aim to prevent, limit or reverse dementia. *Drug-Induced Dementia: A perfect crime* is a timely resource which reveals why and how medical treatments themselves – specifically, psychopharmaceuticals – are a substantial cause of brain degeneration and premature death.

For patients and clinicians, this resource is the first of its kind. So as to demonstrate the dementing and deadly effects of psychiatric drugs, the book integrates research findings from epidemiology (observational studies of patients in 'the real world'), basic biology (animal experiments) and clinical science (neuro-imaging and autopsy studies).

Highlighted by more than 100 neuro-images, slides of tissue specimens and other illustrations, the book uniquely describes:

- the societal roots of the problem (target-organ toxicity, regulatory incompetence, and performativity);
- the subtypes and essential causes of dementia;
- the patterns, prevalence, and causes of dementia associated with antidepressants, antipsychotics, anxiolytics, mood stabilisers, and stimulants; and
- the actions and reforms which patients, providers, and policy makers might immediately pursue, so as to mitigate the causes and consequences of this iatrogenic disaster.

Catherine Clarke comments: This is another battle to fight since most mental health 'experts' and GPs don't seem to have a clue about this looming crisis. For instance, they put withdrawal symptoms down to 'stress' and 'the underlying illness'. One carer showed the above information (on a flyer) to the psychiatrist, who did then decide to reduce the prescribed drugs.

PSYCHIATRY AND THE TOXIC DRUG INDUSTRY

by Justice Lover

There is no tyranny so great as that which is practised for the benefit of the victim. (C.S. Lewis)

Prescribing guidelines are known to be toxic. They are dictated by the drug companies which pay psychiatrists to endorse them.

Two recent British epidemiological studies of medical records examined the clinical outcomes of patients prescribed antipsychotics (neuroleptics) compared to those not. Both studies confirm that 'the major tranquillisers' increase the risk of stroke and diabetes. These are severely disabling medical conditions which cause greater incidence of premature death.

A report in the *British Medical Journal* (by Ian Douglas and Liam Smeeth) examined the records of 6,790 patients who had suffered a stroke and were taking antipsychotic drugs. They found that the ingestion of any antipsychotic significantly increased the incidents of stroke in elderly patients, with or without dementia. Older patients prescribed any neuroleptic or antipsychotic drug were 1.73 times more likely to have a stroke than those in the cohort not taking such a drug. And patients with dementia who were prescribed antipsychotics were 3.5 times more likely to have a stroke.

These findings confirm other reports about the toxicity of those drugs. Indeed, the findings overturn the medical justification for the current paradigm of care for the elderly: the aggressively marketed 'second generation neuroleptics' – promoted as 'atypical antipsychotics' – were found to pose the greatest danger for patients. Risperdal and Zyprexa (in that order) were the most popular amongst the 'atypicals'. And patients taking those drugs were at 2.32 times greater risk of stroke compared to patients prescribed one of the old neuroleptics, who experienced only 1.69 times increased risk.

The other study, reported in *BMC Psychiatry* compared the incidence and prevalence of diabetes in patients with a serious mental illness in North West Wales.

This study compared two cohorts, during the years 1875–1924 and 1994–2006. Here, the research invalidates the unsubstantiated claims made by psychiatrists and the manufacturers of antipsychotics about the prevalence of diabetes among patients with schizophrenia prior to the use of a neuroleptic or antipsychotic.

The prevalence of Type 2 diabetes among patients with psychoses at time of first admission in both the historical and the recent samples was 0%.The incidence of diabetes remained 0% in the historical sample throughout the fifteen years of follow-up studies. But the incidence of diabetes rose in the contemporary sample after 3, 5 and 6 years of treatment, and with an incidence rate double the norm for the general population, so that the 15-year prevalence is likely to be over 8%.

Doesn't the growing body of medico-scientific evidence documenting drug-induced health hazards suggest that it's time to change the paradigm of care in psychiatry?

Neuroleptics (so-called antipsychotic drugs) are administered widely by psychiatrists, GPs and paediatricians, who variously assign a diagnosis such as psychosis, schizophrenia, paranoia, bipolar disorder, post-traumatic stress disorder, aggression, hysteria, sleep disturbances, asthma, ADHD, 'misbehaviour in children', or any other reimbursable/funded label. Drugs such as Risperdal, Zyprexa, Seroquel, Abilify and the other newly packaged major tranquillisers – sold as 'atypical antipsychotics' – are dispensed in the same way that any aggressive animal is given a powerful drug so as to restrain its stress-related reactions. Court documents show that the elderly and children – that is, vulnerable non-consenting dependants – are particularly at high risk, especially since the drugs industry has targeted them in campaigns to expand their market (see, for example, Eli Lilly's 'Viva Zyprexa' marketing campaign, and the Connecticut Attorney General's lawsuit charging Eli Lilly with fraud under federal racketeering law). Psychiatry under the influence of drug manufacturers embraces the toxic prescribing guidelines dictated by industry and its paid psychiatrists.

Beyond the life-shortening treatments forced on the elderly, in the USA, the Texas Medication Algorithm Project (TMAP) prescribing guidelines serve as the model adopted by State mental health systems. These treatment guidelines undermine the health of both the young and the old. Indeed, in America, those 'treated' within the public mental health sector can look forward to a lifespan shortened by twenty-five years. (See, Colton CW & Manderscheid RW, 'Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states.' *Preventing Chronic Disease*, April 2006.)

Good Old Boy George W Bush had a hand in this when he was Governor of Texas. The Texas Medication Algorithm Project (TMAP) is a corporate-sponsored set of psychiatric management guidelines designed to enable doctors to systematically screen and treat patients for diagnosed mental disorders within the state's publicly funded mental health care system. TMAP was initiated in 1997 so as to provide more uniform early intervention screening and treatment for children. The project is supported by the pharmaceutical companies, the psychiatric establishment and mainstream, and consumer and parents' groups (or drug company fronts). But it is controversial amongst those who support civil liberties, parents of children harmed or killed by psychiatric drugging (usually for ADHD) and those caring for similarly affected adult relatives.

Opponents of TMAP and similar mental health screening programmes view them as fraudulent and invasive mind control techniques. However, in 2002 TMAP was recommended by President Bush's New Freedom Commission on Mental Health as a model for implementing similar mental health screening programmes throughout the USA. According to a 2004 report in the *British Medical Journal*, similar programmes had by then been implemented in about a dozen states.

TMAP emerged from a collaboration that began in 1995 between pharmaceutical companies, the University of Texas Southwestern and the Texas Department of Mental Health and Mental Retardation (TDMHMR). According to the *British Medical Journal*, the TMAP project was funded by a grant from Robert Wood Johnson and money from several drug companies. In fact, the companies funding the development of TMAP include Janssen Pharmaceutica, Johnson & Johnson, Eli Lilly, AstraZeneca, Pfizer, Novartis, Janssen-Ortho-McNeil, GlaxoSmithKline, Abbott Laboratories, Bristol Myers Squibb, Wyeth-Ayerst and Forrest Laboratories.

TMAP is billed as a 'decision-tree medical algorithm', the design of which was based on the expert opinions of prescribers. And, hey presto, the drugs recommended as 'first-line treatment' happen to be manufactured by the companies which sponsored the guidelines: drugs such as Risperdal, Zyprexa, Seroquel, Geodon, Depakote, Paxil, Zoloft, Celexa, Wellbutrin, Zyban, Remeron, Serzone, Effexor, Buspar, Adderall, and Prozac.

In the USA, a successful no-drug paradigm of care for schizophrenia patients – for whom the neuroleptics were first marketed – was developed years ago by Dr Loren Mosher. See Bola, JR & Mosher, LR (2003) 'Treatment of acute psychosis without neuroleptics: Two-year outcomes from the Soteria Project', *Journal of Nervous and Mental Disease 191*, 219–29. See also: Mosher, LR, Hendrix, V & Fort, DC (2004): *Soteria: Through madness to deliverance*. Xlibris.

COMBATING THE DRUG COMPANIES' DRUG-PUSHING:

Zyprexa Cat Out Of The Bag

Evelyn Pringle

The drug company Eli Lilly was recently caught out illegally promoting a dangerous and useless drug for uses not approved as safe and effective by the Federal Drugs Agency.

A drug company uses the full force of the law to protect its corrupt and damaging practices

Documents acquired by The New York Times from attorney Jim Gottstein, show that Eli Lilly ran a 'Viva Zyprexa' marketing campaign to convince doctors to prescribe the drug, 'off-label', for unapproved purposes. The campaign was very successful: between 1999 and 2002 Zyprexa sales doubled from $1.5 billion to $3 billion.

Although most people would recognise that the Zyprexa cat cannot be stuffed back in the bag, nonetheless on December 15, 2006, in an attempt to get the documents returned, Lilly got a judge to issue an order stating:

> James Gottstein, Esquire, is in possession of documents produced by Eli Lilly and Company in the above-captioned action in violation of CMO-3, and has been so notified by counsel for Eli Lilly and Company without response by Mr. Gottstein. Mr. Gottstein has further disseminated these documents to additional third parties in violation of CMO-3. Mr. Gottstein shall immediately return any and all such documents (including all copies of any electronic documents, hard copy documents and CDs/DVD).

In addition, although Lilly does not mention how hard it was working behind the scenes in the courts to get the Zyprexa documents back in the bag, in a press release on December 18, 2006, the drug-maker denied all wrongdoing and stated that Lilly "vigorously objects to the characterization of company practices in a New York Times article based upon selective documents illegally leaked by plaintiffs' lawyers." Lilly also says that it "deplores the illegal release of select confidential documents."

So what's new? A drug company gets busted red-handed illegally promoting a dangerous and useless drug for uses not approved as safe and effective by the FDA, and it's always denial, even in cases such as this where the documents are indisputable. It's difficult to believe that the person who wrote this press release did it with a straight face. One wonders how much Big Pharma pays for an out-and-out fraudulent press release these days.

The company said, "This illegal and selective disclosure of incomplete information will cause unwarranted concern among patients that may cause them to stop taking their medication without consulting a physician."

I say, we can only hope.

Lilly whined, "The Times failed to mention that these leaked documents are a tiny fraction of the more than 11 million pages of documents provided by Lilly as part of the litigation process."

This begs the question of how reading 11 million other pages would change what is said in the documents quoted by The NY Times. Picturing somebody trying to read eleven million pages simply indicates that Lilly tried to send the plaintiffs' legal team on a wild goose chase to find a few needles in a haystack. And apparently some diligent attorneys were up to the task because they caught the goose and found the needles!

But there must be a lot more needles to find because Lilly showed signs of outright paranoia and desperation in wanting those documents out of the public domain. In fact, on December 19, 2006, Lilly got the court to issue an Order for Mandatory Injunction directed at Mr Gottstein. This stated:

> Mr. Gottstein shall immediately, upon receipt of this Order, provide to Special Master Woodin and the parties a listing of all persons, organizations or entities to whom any documents covered by this Order, or any subset thereof, were provided. Mr. Gottstein shall, within 24 hours of this Order, identify to Special Master Woodin and the parties, by specific bates stamp, those the particular documents to any person, organization or entity noted above, which shall also include the date and location such documents were disseminated. Mr. Gottstein shall immediately take steps to retrieve any documents subject to this Order, regardless of their current location, and return all such documents to Special Master Woodin. This shall include the removal of any such documents posted at any website. Mr. Gottstein shall take immediate steps to preserve, until further Order of the Court, all documents, voice mails, emails, materials, and information, including, but not limited to all communications, that refer to, relate to or concern Dr. Egilman or any other efforts to obtain documents produced by Eli Lilly and Company.

For his part, Mr Gottstein was not an attorney in the lawsuit in which Lilly got the judge to allow the company to hide the documents in the first place. He obtained them in another case and therefore, surely he would not be covered by any protective order.

In fact, Mr Gottstein is an advocate for patients' rights. He sits at the helm of The Law Project for Psychiatric Rights (PsychRights), a public interest law firm that has mounted a legal campaign against forced psychiatric drugging all around the country. His only interest in disclosing the documents appears to be a noble one: to alert unwitting doctors and Zyprexa patients about the high risk of injuries and death associated with the drug – risks that Lilly successfully concealed for a decade. However, it now looks like Lilly has not been acting alone, but rather with accomplices embedded in the US court system.

In addition to a compilation of published studies, the website PsychRights has a wealth of information about psychiatric medications. However, in light of the injunction against James Gottstein, who knows how long it will be permitted to provide information about the dangers of Zyprexa?

The internal Lilly documents that Mr Gottstein provided to NY The Times cover the period 1995 to 2004. They clearly show that Lilly tried to hide information about Zyprexa's link to drastic weight gain, even after it knew that 30% of patients on Zyprexa (olanzapine) for more than a year gained 22 pounds, and some as much as 100 pounds – a factor known to cause Type 2 diabetes.

As far back as November 1999, emails show that Lilly was worried that if the risks became known, sales would be hurt.

"Olanzapine-associated weight gain and possible hyperglycemia is a major threat to the long-term success of this critically important molecule," Dr Alan Breier wrote to Lilly employees when announcing the formation of "an executive steering committee for olanzapine-associated weight changes and hyperglycemia." In 2000, a group of diabetes doctors retained by Lilly to consider a possible link between diabetes and Zyprexa gave the company a warning: "Unless we come clean on this, it could get much more serious than we might anticipate" (an email from one Lilly manager to another, quoted in The NY Times). In March 2002, a document shows that Lilly turned down a plan to give psychiatrists information about how to treat diabetes, worrying that it would remind them of the risk. A Lilly manager wrote an email (quoted in The NY Times): "Although MDs [doctors] like objective, educational materials, having our reps provide some with diabetes would further build its association to Zyprexa."

During 1999 and 2000, Lilly considered ways to convince primary care doctors to prescribe Zyprexa, but not for patients with schizophrenia or manic depression. In one document reported by The NY Times, an unnamed Lilly marketing executive wrote that these doctors "do treat dementia" but "do not treat bipolar; schizophrenia is handled by psychiatrists." As a result, "dementia should be first message" of a campaign to primary doctors. The document also noted that some primary care doctors "might prescribe outside of label."

If an epidemic of adult schizophrenia and manic-depression occurred since Zyprexa came on the market in 1996, amazingly I somehow missed it. Yet I must have done because The NY Times describes a 2001 Lilly company meeting with Zyprexa sales representatives, where a Mr Bandick praised some sales reps for the number of prescriptions they had convinced doctors to write, according to a script prepared in advance of the meeting. The NY Times reported that: "More than a hundred other representatives had convinced doctors to write at least 16 extra prescriptions" and so, according to Mr Bandick, "they maxed out on a pretty sweet incentive."

The question is, if they were not promoting the drug for other uses, how could more than one hundred sales reps get doctors to write prescriptions for at least 16 patients for a drug only approved for schizophrenia or manic depression? Apparently, Lilly expects us to be so stupid as to believe that all these doctors, in every state in the US, many of whom were general practitioners, suddenly and out of the blue came up with the idea to prescribe Zyprexa to every Tom, Dick and Mary for every other indication under the sun.

A patients' advocate uses the full force of the law to win a landmark case against compulsory drugging

The aforesaid Mr Gottstein's legal pursuits, on the other hand, do not involve chasing the almighty dollar. His or-

ganisation helps people who ordinarily have little or no money. For instance, in 2006 Mr Gottstein also won a landmark case before the Alaskan Supreme Court. This declared Alaska's forced drugging regime unconstitutional, (Myers v Alaska Psychiatric Institute, 138 P3d 238, Alaska 2006). Mr Gottstein says he took on that case because he was concerned about the rights of those people who find the drugs like Zyprexa both unhelpful and intolerable.

"No other field of medicine allows this sort of forced treatment," he points out. "For people who want to try non-drug approaches, the research is very clear that many will have much better long-term outcomes, including complete recovery after being diagnosed with serious mental illness." Mr Gottstein maintains that massive forced drugging is turning many patients into drooling zombies and preventing them from going on to live the full lives they could otherwise enjoy.

On appeal, Mr Gottstein argued that the provisions governing authorisation of treatment with psychotropic medications violate the Alaska Constitution's guarantees of liberty and privacy.

The Supreme Court agreed:

> In our view, before a state may administer psychotropic drugs to a non-consenting mentally ill patient in a non-emergency setting, an independent judicial Best Interests Determination is constitutionally necessary to ensure that the proposed treatment is actually the least intrusive means of protecting the patient.

In this landmark decision, the Court addressed the class of drugs known as psychotropic medications,

> Because psychotropic medication can have profound and lasting negative effects on a patient's mind and body, Alaska's statutory provisions permitting non-consensual treatment with psychotropic medications implicate fundamental liberty and privacy interests.

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2: A PECULIAR KIND OF MEDICINE

PSYCHIATRIC MEDICATION: SHOOTING IN THE DARK

Phil Virden

More than words could ever have done, taking those pills indoctrinated me with the notion that I was a defective person whose only claim to uniqueness consisted of a bio-chemical defect, probably genetic in origin … What I had been taking did not 'cure' anything but was merely a chemical lobotomy or strait-jacket whose sole virtue stemmed from the fact that it tranquillized the people around me, and thus kept them from locking me up.

John Modrow: *How to Become a Schizophrenic*, Apollyon Press, 1995

The peculiar nature of psychiatric medicine

It is a matter of 'common sense' that doctors can usually prescribe a remedy whenever they diagnose an illness. According to 'the medical model of mental illness', it seems obvious that this will usually be some kind of medication. However, when it comes to 'mental illness' and its treatment, this belief is not based in sound logic or medical science.

First of all, and by definition, none of the diagnostic categories of 'mental illness' are based in discoveries by medical science of real illnesses. If someone thinks or behaves with worrying irrationality and a definite organic cause is found, then we know that he suffers from a real medical condition – one or other particular brain disease. But, as distinct from a real (neurological) illness, someone is said to 'have a mental illness' only when there is no evident organic cause for his worryingly irrational ideas or behaviour.

Unlike diagnosis in general medical science – which is based in the discovery of objective, organic pathologies – the categories of 'mental illness' are purely imaginative constructs: they are part of a medical fantasy which creates an ever-expanding taxonomy of what are thought to be discrete kinds of irrational ideas or behaviour. The 'discovery' of 'the mental illnesses' really only began in the 20th century. First of all was the psychiatric profession's purely wishful decision that certain forms of psychotic behaviour may be grouped together as one asserted disease, to be called schizophrenia. Since there are so very many different ways of thinking and behaving irrationally, thereafter 'medical model' psychiatry was bound to throw up a multitude of diagnostic categories – and there are always new ones to 'discover'.

This difference between really discovered (organic, neurological or brain) illness and imaginatively constructed 'mental illnesses' means that psychiatric medicine is actually carried out quite differently from general medicine, and in a manner which is strange in various ways.

First, as just indicated, when someone is diagnosed with a 'mental illness', this is because there is no sign of an actual

neurological or brain disease. The notion of 'mental illness' is thoroughly confusing: really, it is only accurate to say that a person suffers from a 'functional mental disorder' – that is, not from any discernible real illness but from an apparent inability to function adequately. This may well be due to a disabling psychological condition. Most mental health patients suffer from psychological problems, not an organic condition.

Secondly, although general medicine does take certain powers to isolate people with dangerous contagious illnesses, psychiatry is medically strange in that it is based on the legal possibility of compelling anyone diagnosed with 'a mental illness' to submit to treatment.

Thirdly, in actual practice, and in the name of 'good practice', psychiatry is also medically peculiar in that if a patient complains about the ill effects of the medical treatment, very often this is either ignored or construed as a good reason for increasing the dose. The reasoning is that either the ill effects he reports do not outweigh the expected good effect of restoring him to sound reason or the patient fabricates about the ill effects – and that is considered a sign of the continuation of his mental illness and therefore of his need for medication.

In order to understand what doctors do when they make a mental health diagnosis – and then go on to prescribe a chemical or physical remedy – we need to be fully aware of these unresolved conundrums, which underlie the whole mental health project.

A strange form of diagnosis

There is no theoretically coherent and scientifically substantiated basis to mental health diagnosis. It is essentially 'rule-of-thumb': based only on speculative ideas and 'what sometimes seems to work'.

In general medicine, any diagnosis – and hence any prognosis and prescription – follows from interpreting symptoms (often by using biochemical tests) which clearly indicate one real (organic) illness rather than another. Prescription is then in accordance with a clear indication for the specific diagnosis. Yet mental health procedures routinely invert this logic: prescription accords rather with contra-indications, i.e., according to whichever drugs do not seem to work for each particular patient. This means that the doctor experiments on the patient with this or that drug and then closes in on a specific diagnosis, when it seems that one drug which is advertised as specific to a certain kind of 'mental illness' produces a beneficial effect while others do not.

Uncontrolled drug experimentation on patients, to 'manage' their mental disorders and at the same time confirm exactly which diagnoses seem to fit, is an integral part of the official mental health project. This is usually carried out without any informed consent. Let alone natural justice or common morality, does this not breach the medical ethic: First, do no harm?

In practice, psychiatric diagnosis is often retrospective. For example, an emotionally overwrought person is delivered to psychiatry: immediately he may appear, say, either very depressed or manic or psychotic. A particular drug is then employed so as to manage his behaviour. If that drug does not elicit the patient's compliance, then another is tried. If or when a particular drug appears to 'work' with that particular patient, the doctor then 'reads back' to whichever type of mental illness the drug is supposed to manage. In this manner the psychiatrist 'discovers' exactly which 'mental illness' the patient therefore 'must' have.

Imagine if hospitals were organised along those lines: a patient is brought in collapsed and, instead of running routine physical checks and scans or blood tests, etc., this or that drug is tried out on him before it is finally decided that he responds to a specific drug and therefore he suffers from diabetes and not perhaps a heart condition!

Apart from this absurdity, whereas there are usually clear and indisputable symptoms or biochemical tests for the real illnesses discerned by general medicine, research shows that there is not even a high degree of agreement between any two doctors about the category of mental illness to which any one patient should be assigned. Furthermore, patients often have the diagnostically dismaying tendency, in their ideas and behaviour, to drift or suddenly jump from one category of mental illness to another. But of course there is bound to be this confusion since the diagnostic categories of mental health do not identify discrete real illnesses – they are simply imaginative constructs based on judgements about the different kinds of disabling psychological troubles that people present.

Besides all this – and also medically bizarre – it is clear that mental health diagnoses are very often made when symptoms are absent. This was shown by a study in which, of a large sample of psychiatric patients, 47% displayed no symptoms prior to re-prescription. In general medicine the absence of symptoms would indicate that the person does not have the suspected illness, or that he has got better. Not necessarily so in psychiatry.

Using the various types of psychiatric drugs

Some doctors still believe that psychotropic drugs can cure mental illnesses, and researchers always hope and expect that organic causes will be found and antidotes concocted. However, the hopes of fifty years ago have more recently abated. Nowadays, most doctors believe in the efficacy of the drugs not as outright cures but for the relief or 'management' of symptoms. Actually, there is no evidence for either cure or better management.

But what has become clear during the last forty years or so is that, for too many psychiatric patients, drugging creates chronic long-term dependency, addiction, disability and often irreversible deterioration of the nervous system. This is an unusual application of medicine. In general medicine, drugs with such strong side effects are not routinely employed or are monitored closely, and the patient is presented with a clear and free choice in the matter.

Still, despite this knowledge – which psychiatry and the drug companies are careful to put to one side with the asser-

tion that the latest drugs on offer will surely prove less damaging – today it is generally taken for granted that psychiatry can usefully administer to almost any kind of mental disorder with one or a mixture of the following types of drugs:

• *Antidepressants*: these are known, for their chemical form, as the tricyclics; for example, amitriptyline and imipramine, or the monoamine-oxidase inhibitors (MAOIs), such as phenelzine and isocarboxazid. The latest development was the selective serotonin re-uptake inhibitors (SSRIs), of which Prozac (fluoxetine) and Seroxat (paroxetene) are the most popular and best known.

• *Antipsychotics*: the major tranquillisers or neuroleptics, used to quieten gross disturbances. These include the phenothiazines, e.g., chlorpromazine, and the butyrophenones, e.g., haloperidol. Unfortunately these drugs can almost immediately produce symptoms 'similar' to an actual physical disease of the nervous system, i.e., they do actually harm the nervous system. During the 1990s hopes focussed on the newly marketed but expensive atypical antipsychotics (e.g. Clozaril, Zyprexa, risperidone and Abilify).

• *Anxiolytics*: the minor tranquillisers used to alleviate anxiety. These are the benzodiazepines, such as diazepam and lorazepam.

• *Mood stabilisers*: the most common example is lithium carbonate, which needs regular monitoring because of its all-round physical dangers. Anticonvulsants, used to control epilepsy, are also employed as mood stabilisers, e.g., sodium valproate.

• *Sedative-hypnotics* ('sleeping pills' and sedatives): psychiatry used to employ the addictive barbiturates but they have now been displaced by types of supposedly safer benzodiazepines. Mogadon (nitrazepam) was the first in the field, then drugs such as the less effective (shorter acting) temazepam were more in favour, and now the most popular is Zopiclone.

• *Anti-Parkinsonians*: mainly used to counter the ill effects of the antipsychotic drugs.

To get an idea of the scale of the psychiatric pharmaceuticals market, by 2006 sales of atypical antipsychotics alone were worth at least $10.5b to the American drug companies; and that type of drug had generated over $100b in sales for them since 1990.

How psychotropic drugs are employed

By implication of the above groupings, the great number of psychiatric diagnostic categories may be reduced to four essential types: depression, psychosis, anxiety and mania. Psychiatrists and GPs believe that, for each of these conditions, if only the dose is big enough, there is always an appropriate medicine.

Or again, according to the essential types of medical response, we might realistically reduce the number of categories to just two: antipsychotics ('downers'), intended to block natural brain chemicals, thereby changing the chemistry and electrics of the brain to cause various degrees of sedation, and antidepressives ('uppers'), which encourage the release of certain brain chemicals (e.g. serotonin) and act as a euphoric. In other words, although there are said to be hundreds of different 'mental illnesses', for which there are marketed an even greater number of different drugs supposed to act specifically on one kind of disorder, there are essentially only two actions intended by psychiatric drugging: either to suppress the patient's symptoms or to elevate his mood.

Moreover, the effects of the mental disorder and the effects of the purported remedy very often overlap. A patient who is thought to suffer from depression and who also cannot sleep is usually given an antidepressant 'upper' to raise his mood and a hypnotic 'downer' in order to get him to sleep. When one drug or combination of drugs does not seem to work, doctors routinely try another. Although doctors do not publicise it, this 'mix-and-match', trial-and-error practice of psychiatric medicine amounts to routine, ongoing experimentation on the patients. A mixture of drugs might result in greatly increased potency; equally, the drugs might act against each other; or they may combine to cause more toxic damage to a vital organ such as the liver. Drug formularies warn against mixing drugs, and doctors should be well aware of the common contra-indications. And yet, in the absence of the desired response, it is common practice to 'mix-and-match' in the search for the required response. If pressed about this blind experimentation, doctors plead that they can do nothing else when a patient needs help and every other medical avenue has been explored.

Patients' experiences of drugging

The most comprehensive recent survey found that 91% of a sample of psychiatric patients had been prescribed some sort of medication for their psychological problems. Confusion and ambivalence reigns amongst the recipients of psychiatric medicine. In this sample the most helpful treatment, reported by 30%, was – no treatment at all. But 33% also reported no treatment as the most damaging medical response: psychiatric patients do tend to expect and demand some kind of tangible treatment. The second most helpful treatment, but reported as such by less than one-third of those given it, was an antidepressant. Something below that proportion felt that the other types of drug had proved useful. Two-thirds of those given antidepressants did feel that they had proved helpful at least sometimes, despite widespread worries about the side effects and the long-term ill effects. The other drugs were experienced as rather less helpful. Many patients were very anxious about the strong and deleterious effects of the major tranquillisers, although half of those with experience of them found them helpful 'at least some of the time'. Generally, across the range of drugs, it appeared that about one-half of the patients felt some benefit, at least sometimes, but about one-quarter reported no help at all and often more or less fearful damage.

Patients are most often given little choice of treatment apart from medication, and today they are as worried as they ever were about the painful and unwanted effects and long-term

consequences. There are no legal safety limits on drug doses, despite routine deaths from overdose and medical knowledge of the high risks of addiction or of damage to the nervous system from all the commonly used drugs. The dangers are compounded by the fact that psychiatry clearly separates the expert who is supposed to know best from the patient whose pain or discomfort is regularly counted as a price worth paying for a cure, or at least so as to reduce the symptoms. As with the reality of much of general medicine (e.g., surgery or cancer treatment), the thinking seems to be: no pain, no gain. And after all, runs the reasoning, you would not expect a patient in general medicine to have any useful ideas about how to treat his illness – say, a heart attack. So why ever listen seriously to a psychiatric patient, especially since his illness is defined precisely by the deficiency in his power of reasoning?

The efficacy and the dangers of psychiatric drugs

Theories to support the use of the various types of psychiatric drug have always arrived after the introduction of the drug concerned, and in relation to the sorts of work it seemed, by chance, to perform. For example, the notion supporting the use of the antipsychotics is that people diagnosed with schizophrenia have nerve-cell receptors which are hypersensitive to certain neurotransmitters: their receptors fire too easily and the drugs reduce this hypersensitivity. On the other hand, the idea about depression is that some people happen to suffer a decrease in the receptivity of their neurotransmitters, and the drugs re-stimulate those cells. And yet, with regard to the conventional belief about the neurochemistry of depression, there are no markers of organic depression amongst the clinically depressed. On the contrary, such patients show signs of heightened arousal: when a person feels very depressed the adrenal glands become hyperactive and produce excessive cortisol, the body's main hormone response to stress. Besides, especially within such a complex organism as the human body, nature does not act in a simple, unilinear fashion: neurotransmitters and hormone production are always in a direct feedback relationship with each other and with psychological-cum-emotional processes. There is simply no easy way to decide directions or quantities of cause and effect. Meanwhile, drugs intended to act on the brain also intervene significantly in many other dynamics within the whole organism.

For these reasons, simplistic notions of the direct brain-chemical causes of the mental disorders do not make scientific sense. Moreover, each psychiatric drug always carries some risks to the whole nervous-hormonal system. For example, not long ago the MAOI inhibitors were most often used to treat anxiety, phobias and depression. Then it was discovered that they severely disrupt the body to the extent of interacting with many common foods to cause dangerously high blood pressure. The most modern medications are no less problematic: selective serotonin re-uptake inhibitors (SSRIs, such as Prozac and Seroxat) which superseded the tricyclics for the treatment of depression, are less sedating and have fewer antimuscarinic and cardiotoxic effects. However, common 'side effects' (i.e., ill effects) include gastrointestinal problems such as nausea, vomiting, dyspepsia, abdominal pain, diarrhoea and constipation; also reported are anorexia with weight loss as well as increased appetite and weight gain, hypersensitivity reactions such as rashes (which may be signs of an impending and serious systemic reaction), urticaria, angioedema, anaphylaxis, arthralgia, myalgia and photosensitivity; other side effects include a dry mouth, nervousness, anxiety, headache, insomnia, tremor, dizziness, asthenia, hallucinations, drowsiness, convulsions, galactorrhoea, sexual dysfunction, urinary retention, sweating, hypomania or mania, movement disorders (dyskinesia), visual disturbance, hypnotraemia and cutaneous bleeding disorders. The SSRIs are also to an extent linked with increased suicidal thoughts and actual suicides.

Nevertheless, most doctors would argue that the drugs they use do have some desirable psychotropic effects in that they do alleviate symptoms, to a degree. However, in tests run by medical researchers themselves, no psychiatric drug proves convincingly more effective than non-medical interventions such as psychotherapy or even simply 'caring human association', or placebo.

Placebo is an interesting form of faith healing which works all the better to the extent that everyone (health care workers included) is oblivious to the magical nature of the medical technique. I suggest that if any kind of psychiatric treatment does seem to work, this has to depend upon the faith that the patient (and those around him) places in it. It is not that the psychoactive drugs 'do not do anything'. Indeed, perhaps the more they affect the patient's nervous and hormonal systems, the more people are led to imagine that 'they must be working' – so long as they do believe in psychiatric medicine. In which case, retarding or 'enhancing' the neurochemistry of the brain and poisoning various of the body's organs – the effects, 'side effects' and 'cautions' catalogued in formularies – might help to persuade the patient and those around him that something really is happening and that this must be part of 'getting cured'. Various scenarios may unfold as a drug treatment proceeds. The patient may begin to feel mentally better due to the influence of other factors. For example, encouraged by the awesome authority of Medicine and despite the discomfort of the drugs, he is given respite and some relief from his anxieties by being given a mental health diagnosis, by being relieved of major responsibilities and being cared for. Or he may become habituated to the 'side effects' of the psychiatric drugs, or build up a drug resistance, and he feels as if he is recovering from his 'illness' whilst not realising (or forgetting) that the drugs made him feel physically ill and debilitated or disorientated in the first place.

In this manner, in the absence of any other good evidence and since any functional mental disorder is entirely a matter of what the patient thinks and feels, it might be true that, by means of somewhat relieving a person's anxieties, by the placebo effect or faith healing, toxic psychiatric drugs may help to make some patients feel better, or at least that

they are 'getting better'.

This is not to deny that in some cases there may well be direct beneficial organic effects from some of the psychotropic drugs. This is especially so when a person who suffers from intolerable stress and insomnia is sedated, or by 'raising the mood' of someone who suffers from depression. But these effects are short term, the drugs are addictive and they often bring with them a host of unwanted and dangerous side effects. Every psychiatric drug has its dangers, and the official drug formularies are explicit about the risks of damage, the ill-effects or the unwanted side effects. For example, the most troublesome side effects of the antipsychotics are extrapyramidal symptoms: dystonia (abnormal face and body movements) which may appear after only a few doses, akathisia (restlessness) which "may resemble a worsening of the condition being treated" [according to the British National Formulary (BNF): but why 'resemble'?], and a parkinsonian-type syndrome which usually takes longer to develop. Psychiatric drugs also fail to address any of a person's real personal or interpersonal problems.

It is not only possible but by all accounts routine for doctors to discount patients' reports of the 'side effects' of psychiatric drugging, on the grounds that the patient is mentally ill and is therefore either deluded or exaggerating. Doctors ignorant of their own drug formularies may even find evidence of mental illness in the very restlessness or 'paranoia' caused by their own medication. Tardive dyskinesia is that later developing neural damage which causes chronic involuntary muscle movements. Hypotension and interference with the body's temperature regulation are dose-related side effects; they are liable to cause dangerous falls and hypothermia in the elderly.

Besides problems like this, there are the risks of the abuse or misuse of the drugs by disturbed patients, of the immediate and dangerous alteration and impairment of brain functioning, of other organ damage, and of physical and mental addiction.

For example, the benzodiazepines (so-called minor tranquillisers) replaced the unacceptably addictive barbiturates as the most widely used hypnotics, sedatives and anxiolitics. 'Benzos' are still prescribed by GPs, though with cautions about long-term use. Yet according to the Home Office they are linked to more deaths each year than all five illegal 'Class A' narcotics put together. They also cause far worse brain damage if taken in excessive doses. And there appears to be twenty-four times the risk of perinatal death with pregnant mothers who regularly use a benzodiazepine. The BNF has cautioned against their addictiveness since the 1980s, yet an estimated one-and-a-half million in the UK are still addicted to benzodiazepines, with at least another one million permanently disabled by years of protracted withdrawal. The risks became well known thirty years ago but until recently no attempt was made to phase out the use of these drugs. Aside from unwanted, uncomfortable and dangerous side effects, those prescribed a benzodiazepine often find themselves sunk into heavy lethargy and commonly not fully conscious of their activity or inactivity. When they try to come off the drug, patients suffer frightening and unbearable withdrawal symptoms such as shakes, palpitations and hot and cold sweats; these are accompanied by mental and behavioural symptoms of anxiety, panic, feelings of going mad and aggressive and suicidal feelings which they and those around them often experience as much worse than the symptoms originally presented to their GPs.

More than this, research shows that these drugs can destroy up to half the benzodiazepine receptors in a foetus. This throws the born child into a permanent state of heightened proclivity to anxiety and panic, thereby predisposing him to compensatory substance addiction. Mothers' use of the drug while pregnant is clearly linked to hyperactivity, attention deficit disorder and alcohol and drug addiction in childhood and youth. Benzodiazepine was introduced in 1960, and up to 2001, in the UK alone an estimated 50,000 babies were born each year addicted to the drug. This makes potentially two million children brain-damaged before birth. These children are most likely to develop with depleted natural serotonin and opiate levels, and with a physically irreversible addiction to benzodiazepine or a similar substance, such as alcohol.

The magnitude of the problem of benzodiazepine damage and addiction became public knowledge as long ago as the mid-1980s, and it certainly ought to be known by doctors. In fact the Government issued guidelines in 1988 strongly advising only a low dose and no more than four weeks of prescription. And yet by 2001 probably one-and-a-half million people had been on a benzodiazepine for over four months – or worse, a mix of such drugs. In 2001, 28% of the Panorama poll sample who were prescribed a benzodiazepine had been on such a drug continuously for more than ten years.

Apart from the scandalous irresponsibility of the many doctors who continued to repeat-prescribe and mix these drugs – estimated at 90% of all GPs – there is the further scandal of Roche, the first drug company to market a benzodiazepine. They were found out not informing UK doctors about the ill effects of the popular drug Mogadon (nitrazepam). To conform to their more stringent regulations, Roche did inform the Scandinavian health services in 1973, yet it was only in 1984 that they revealed this information to authorities in the UK. Besides this, and although the company marketed it as such, Roche was always aware that Mogadon was never a suitable sedative since its half-life is 25 hours. In other words, as long as someone continues taking it, Mogadon acts cumulatively to keep him permanently drugged and chronically dependent.

Actually, and entirely contrary to the standards of good practice or good science, the whole gamut of modern psychiatric drugs has been employed in the absence of proper testing for their efficacy and dangers. When a drug company tests a new product, it is seldom for more than two months, and the published test is only carried out on young and healthy volunteers. The best that can be said here is that the same applies to many drugs and other techniques used in general medicine. This scandal against science and health-

care has recently been challenged by the movement for Evidence Based Practice (EBP) which might now be starting to persuade medical professionals – and their paymasters in Government – that they really ought to properly assess their interventions in order to improve the value of treatments, both to the patients and to the taxpayers. Those pushing for EBP want all clinicians to use proven interventions rather than rely on knowledge which might be simply anecdotal, traditional, out of date or randomly culled from research papers of dubious scientific quality. It is to be hoped that the recently established National Institute for Health and Clinical Excellence (NICE) will address these issues.

Irresponsible drugging and the lack of accountability

Who could object to the judicious use of drugs? Yet of course, what constitutes care or good judgement is a matter of debate in which clear arguments and the evidence of research findings should not be ignored. However, there is almost no debate. Reasonable argument has been stifled by those psychiatric authorities who should encourage it for the sake of scientific enquiry and the welfare of the patients. This is deplorable. Worse still is the routine over-administration of drugs in the face of continual evidence of the dangers. One could say that most doctors are addicted to drugging their mental health patients, and that the habitual prescription of supposedly symptom-relieving drugs has hardened psychiatric workers to the work that they do. 'Care' takes on the odour of a form of social control which either depletes the patient's body and soul or induces a false euphoria. The power of psychiatry is almost total. This is why it should subject itself to the most scrupulous and relentless self-criticism. Yet it does not do so. On the contrary, both the guardians of its orthodoxy and the drug companies which now seem to call the shots have more than once been caught out deliberately fudging the facts, cheating on research findings and stifling criticism.

In relation to the scandal of tardive dyskinesia – medically induced loss of muscle control – Dr Peter Breggin was the first to fully detail the distortions, cover-ups and denials of research findings perpetrated by the drug companies and by those occupying the highest levels of American psychiatry, over decades. It has also come to light recently, both here and in the USA, that many doctors involved in drugs research have been threatened, intimidated, sacked and silenced by threats of legal action for questioning what the drug companies wish reported or not reported. According to a Channel 4 television documentary which interviewed researchers and quoted the fears of *The Editorial* of *The Lancet*, over the decades this has probably happened to thousands of researchers involved in hundreds of trials.

Meanwhile, recent evidence shows that 'diagnostic overshadowing' is normal: serious physical ill health is often masked by diagnosis and treatment for a mental disorder. Research also shows that those diagnosed with a 'mental illness' (and consequently treated with dangerous psychiatric drugs) also run significantly higher risks of developing a serious real illness. In fact, those diagnosed bipolar or schizophrenic have higher rates of hypertension and breast cancer, whilst diagnosed schizophrenics are twice as likely as the norm to contract bowel cancer; those diagnosed with a mental health problem have higher rates of obesity, heart disease, respiratory disease and stroke, are likely to die younger than the average, are twice as likely to contract coronary heart disease or have a stroke before the age of fifty-five, and are less likely to survive five more years if they do. And yet they are also less likely to be given certain tests and treatments (including cholesterol tests and prescriptions of statins for heart disease). Whilst it is true that mental health patients are more likely to smoke (probably because of the stress, inactivity and boredom in their lives), the official report providing these statistics fails to consider any possible connection between the well-known toxicity of mental health medications and the higher incidence of real illnesses amongst those subjected to them.

And, in the mid-1990s, MIND estimated that in the UK at least one psychiatric patient was killed by over-sedation every single week. No member of the NHS has ever been successfully prosecuted for such a death. There is no national audit, but it is unlikely that this situation has improved.

Misreading emotional distress and mental turmoil: mental illness does not exist

Various studies have thoroughly debunked the purported medical-scientific nature of the categories of psychiatric diagnosis, and hence the claims made for the universal need for psychotropic medications, and for their efficacy.

Consider just one, which showed that psychiatric diagnosis is always likely to be arbitrary. In 1973 a famous study was constructed on the premise that if sane people are not detected in mental health facilities then the main determinant of the psychiatric judgement is not the presence or absence of an individual's mental disorder but the way in which the situation and the people within it are already defined.

In this experiment, eight sane people sought admittance to 12 different hospitals. When he presented himself, the only unusual thing that each subject said during his interview was that he had heard an unfamiliar voice say the words 'empty', 'hollow' and 'thud'. The 'medical model' has this as a symptom of psychosis: it is understood to indicate an obsession with the meaninglessness of life. Each subject was admitted with surprising ease. The pseudo-insane subjects felt uneasy on the wards at first, but they soon found that they could relax. They spent an average of 19 days on admission wards (ranging from 7 to 52 days) before they were considered fit for release. At that point, however, all but one were diagnosed not as sane, but 'schizophrenic in remission'.

Some patients and visitors did detect the sanity of these pseudo-patients (35 out of the 118 fellow-patients polled) but not one doctor or member of staff guessed it. Moreover, these pseudo-mentally ill subjects told unexceptional life histories – such as being closer to mother than father in early childhood and the reverse during adolescence; yet in the case-notes the

staff would discover significance in such information and distort it so as to fit with their preconceptions about the dynamics of schizophrenia. On their part, the experimenters took notes to record events on the ward but, fearing it would cause the staff to realise that they were not really insane, they made efforts to hide this note-taking. Yet it soon became clear that this was unnecessary since note-taking was viewed by staff as a symptom of mental illness. Meanwhile, any other kind of behaviour might also be interpreted as abnormal: walking about was called 'pacing' and considered a sign of nervousness, when actually it was a product of inactivity and boredom; because of being mishandled by the staff a real patient might go berserk, but the medical staff would blame his behaviour on something else, such as his reaction to a recent visit from a relative or friend; the patients had so little in their life that many would queue outside the refectory half an hour before food was to be served, and a psychiatrist said that this behaviour demonstrated 'the oral-acquisitive nature of their syndromes'.

At the time, this particular study so upset the psychiatric profession that committees were established tasked with expunging ambiguities, psychobabble and subjectivity, and to tighten up diagnostic criteria with strict rules for the duration and frequency of symptoms. This failed; it simply pushed the diagnostic taxonomy towards the greater complexity of DSM-III. In turn, this led to a greater number of suspects being diagnosed 'mentally ill' because they seemed to exhibit 'symptoms' on one or other of the ever-lengthening lists of diagnostic categories, i.e., types of undesirable behaviour.

Really, all this pseudo-medicalisation of problems of living is a pernicious invasion of the freedom of those who happen, at the moment, to suffer from serious emotional distress and irrationality – which is to say, generally, those who have already had to suffer, and succumbed to trauma, anxiety and oppressive stress. Whatever psychiatrists and psychiatric workers might imagine they do, most of them actually work to enforce the compliance of the patients, and generally by means of drugging. Shock treatment and forms of threat and punishment known as Behavioural Therapy are also employed in this project, and more lately a form of persuasion known as Cognitive Behavioural Therapy (CBT).

Not only are none of the functional mental disorders based in any real (organic) disease or deficiency but psychiatry's diagnostic categories are confusing hindrances which fulfil only ideological, professional-political and commercial purposes. None of them help to explain or remedy the real problems facing those people made into patients. But they do serve to persuade everyone that certain problems of micro-social conflict and mental disorder are only due to mysteriously elusive organic causes located within certain unfortunate individuals: so said 'genetics' and 'chemical imbalance'. In this manner, the diagnostic categories of psychiatry provide both an alibi for misdirected and oppressive social action and an almost limitless field for the employment of doctors and psychiatric workers and the making of pharmaceutical profits.

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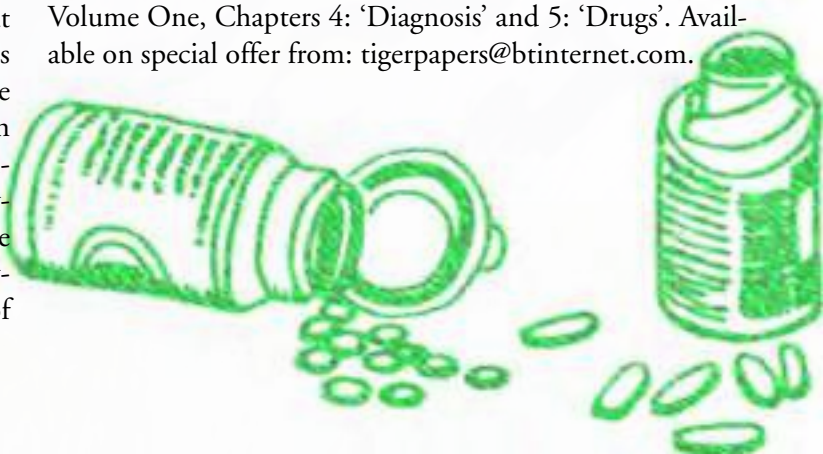
P. Virden, A. Jenner & L. Bigwood: *Psychiatry: The alternative textbook*. Asylum Books/Tiger Papers, 2009. See especially Volume One, Chapters 4: 'Diagnosis' and 5: 'Drugs'. Available on special offer from: tigerpapers@btinternet.com.



3: FROM THE NURSERY TO THE NURSING HOME

THE ADHD FRAUD: CHEMICAL HOLOCAUST FOR CHILDREN

From an interview with Fred A. Baughman Jr., MD

A long-time Fellow of the American Academy of Neurology, Dr Baughman practised both adult and child neurology. He first published research whilst training at Mt. Sinai Hospital in New York, and the Boston Veteran's Administration Hospital, and in the first 15 years of his private practice. He published a considerable body of original research mainly to do with genetically determined brain diseases, including those with chromosome abnormalities. In 1971 he discovered the autosomal recessive, curly hair / ankyloblepharon (eyelids fused at birth) / nail dysplasia (toe and fingernails deformed) syndrome (Baughman's Syndrome). This is a real disease.

Now he sees it as his duty to evaluate and criticise modern psychiatry, especially the fraudulent claim that its diagnoses, such as ADHD, Bipolar, OCD and Depression, refer to diseases of the brain. They do not.

Adverse reactions and deaths from taking the drugs prescribed for Attention Deficit Hyperactivity Disorder (ADHD)

Dr Baughman's current focus is mainly on the psychiatric drugging of children. Recently the USA's Federal Drug Administration (FDA) commenced hearings about reports of deaths, strokes and heart attacks in children and adults who were taking stimulants, most of them amphetamines or amphetamine-like. On February 10, 2005, reports to the FDA MedWatch program of twelve sudden deaths in American children prescribed Adderall XR (a mixture of amphetamine salts) led Canada to suspend sales of the drug. Note that these recorded fatalities were through the voluntary MedWatch system, and usually such schemes identify no more than an estimated 1% of actual occurrences.

But the FDA did not take Adderall off the market, and Dr Baughman learned that behind the scenes it had lobbied Health Canada not to, either. Then, after about a year, Health Canada suddenly allowed Adderall back on the market. Yet this drug had not suddenly become effective and safe.

In fact, Adderall is a trade name for a mixture of the salts of amphetamine, a Schedule II, highly addictive, central nervous system stimulant. The interesting thing about this proprietary drug is that originally it was targeted at weight reduction in adults, and it was called Obetrol. As such it was found so addictive that it was taken off the market. Now the FDA permits this extraordinarily addictive drug for use on children: it was too dangerous for adults but apparently it is not unsafe for children, however small. Worse, there is no benefit to the children – they encourage its use on entirely normal children said to have the bogus disease called ADHD.

Before you can market the drug, first you must invent the diagnoses of Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD)

Dr Baughman was in private practice from 1964 until retiring in 1993. During the 1970s he began to notice, first in his practice in Grand Rapids, Michigan, and then in San Diego (where he moved), an increasing frequency of teachers, school psychologists, family physicians and pediatricians diagnosing 'hyperactivity' also known as 'minimal brain damage'. Then, in 1980, and unable to prove any actual brain damage, the American Psychiatric Association invented a new mental illness which it called Attention Deficit Disorder (ADD). But there was no new organic disease. This diagnostic category, and the criteria for it, was simply added to the American Psychiatric Association's *Diagnostic and Statistical Manual III* (*DSM-III*).

After that, the ADD epidemic seemed to worsen, rising from an estimated 150,000 cases in 1970 to 500,000 in 1985. The frequency of such diagnoses, and their treatment with Ritalin, was steadily increasing. Ritalin is an amphetamine-like drug every bit as addictive as cocaine. It has the same cautions and contra-indications as amphetamine, and it is still the main treatment for childhood ADHD.

At first, Dr Baughman simply took note, but later he became alarmed at the increased frequency with which children were being referred to him by schools, through their physicians, but essentially with the ADD diagnosis decided by teachers.

Yet ADD was only ever the notion of a disease, never a verified or verifiable disease having, as it must, a demonstrable physical abnormality: gross (a mass visible to the naked eye, or palpable), microscopic (cancer cells seen on biopsy or 'Pap' smear), or chemical (as in PKU, with increased blood levels of phenylalanine, or in any one of the more than 100 real inborn errors of body chemistry, i.e. real 'chemical imbalances'; or diabetes, with high blood sugar).

In fact, in psychiatry there is no such thing as an actual disease other than the poisoning/intoxications due to every drug employed by the doctors. Psychiatric diagnoses are illusions of diseases meant to make compliant patients out of normal people – in which they succeed, by the tens of millions. But with child psychiatry repeating the lie often enough the 'disease' has become a reality, especially for the educational establishment and the nation's teachers, and increasingly for the media and the public at large.

Then, in 1994, with the epidemic standing at perhaps 2 million diagnosed American children, the DSM Committee of the American Psychiatric Association (APA) rewrote the diagnostic criteria, adding 'Hyperactivity' to 'Attention Deficit'. Magically – or rather, politically – ADD became ADHD. For the way this purely political process works is that a group of psychiatrists, a DSM Committee, meets and simply makes up whichever behavioural attributes they wish to assign to a particular 'disease' definition.

Now, in general medicine (including Dr Baughman's specialty, neurology), if a curious and observant physician discovers a new, gross, microscopic, or chemical abnormality in a patient,

that previously unobserved abnormality is the new disease. But there has to be an objective abnormality. A subjective assessment will not do. For example, with diabetes there is elevated blood sugar in the blood throughout all the tissues; with cancer, in order to contend that the patient has that particular disease a pathologist has to see cells under the microscope that have abnormal nuclei and chromosomes. And yet in psychiatry, the DSM committee meets in a room and considers each other's favourite constellations or mixture of 'bad' behaviours. Then, by a show of hands, they vote that particular 'syndrome' into existence as 'a disease', and pledge ever-after to speak and write of it as 'a disease'. The new diagnostic category is then given a code number and an entry in the next edition of *DSM*, as a definite psychiatric disorder. And by 'disorder', they do mean disease, in the usual medical sense of the term. This is knowing and wilful fraud.

In the case of Attention Deficit Hyperactivity Disorder (ADHD), the fourteen symptoms that appeared in the *DSM-III-R* for 1987 were 1: 'often fidgets or squirms'; 2: 'trouble staying in one's seat'; 3: 'easily distracted'; 4: 'can't wait one's turn'; 5: 'blurts out answers'; 6: 'trouble following instructions'; 7: 'can't sustain attention'; 8: 'shifts from one activity to another'; 9: 'doesn't play quietly'; 10: 'talks excessively'; 11: 'interrupts'; 12: 'can't listen'; 13: 'loses things'; 14: 'does dangerous things, thrill seeking, and so on'. A child found to have any eight of these 'symptoms' was deemed to have ADHD.

Who gains and who loses from this medical fraud?

Of course, at some time or another, and in one context or another, these so-said symptoms would probably apply to most of the population. If you can get away with it, this diagnostic category is a brilliant marketing scam for any drug which is supposed to be the appropriate treatment.

And they are getting away with it. In 2004, The US Center for Disease Control estimated that, amongst children (aged 17 or under), there were 4 million cases of ADHD. This amounted to 10% of all children in the school system. More than this, Professor William Carey of the University of Pennsylvania testified to Congress that, as of 2003, 17% of all school children were on some type of psychiatric drug (i.e., not all were on ADHD drugs and not all had an ADHD diagnosis). If that is so, Dr Baughman estimates that by now this must have risen to at least one in five, or 20% of America's total public (non-private) school population.

ADD or ADHD does not exist in most countries, and thirty years ago it did not exist anywhere. And yet the psychiatric establishment does not attempt to explain the abrupt emergence of this apparent disease. Since there is no scientific answer to this conundrum, anyone who tries to ask legitimate questions of the establishment is simply ignored. The powerful interests know that ADHD is a big lie, and as long as they get away with it, and as long as they have full access to the US Department of Education and the lobbyists to Congress, they are able to legislate both the diagnosis and its treatment.

Consequently, there are now laws which mandate a certain level of diagnosis in the schools, and even regulations that pay extra funds to school districts for every child diagnosed with one of the bogus and contrived diseases and who is treated as a subject for 'special education'. Yes folks, any school district that gets more of its children diagnosed with ADHD gets rewarded with more funding! And taxpayers end up paying two or three times as much for children labeled ADHD as they do for normal kids. There are even laws that pay parents a stipend for every child who is diagnosed, and thus considered disabled: they get a Social Security disability allowance. A few years ago this stipend was at least $400 a month.

Everybody is on the take, and children's bodies are exploited as profit-making machines. These entirely bogus, junk-science 'diagnostic' labels are like a barcode on the child's forehead, and once the label gets on the record, it sticks. The child cannot get rid of it: he is stigmatised. He is going to have more trouble getting health care insurance and more trouble finding employment. Originally, the Armed Forces would not take anyone who had been on an ADD or ADHD drug. (But when the services failed to meet their quotas for the Iraq war, the standards were 'dropped' and the forces began to accept stigmatised individuals who had been on such drugs.)

Why do people believe in ADDH?

Physicians spend their clinical years in medical schools, learning to tell the difference between all things normal (anatomy, physiology and chemistry) and all things abnormal (pathology, disease). Then they take up positions of authority and, with no good scientific reason, they tell parents that their children have a chemical brain disorder. This is very convincing: what option does a parent have but to trust the doctor? Virtually every physician–patient encounter in the country, regardless of specialty, wholeheartedly embraces this pseudo-scientific notion. It is endorsed by the American Psychological Association, the American Academy of Pediatrics, the Child Neurology Society (of which Dr Baughman is a member), and the American Academy of Family Practice.

In fact, in 1999, The American Academy of Pediatrics republished the *DSM*'s diagnostic criteria for ADHD in its journal. And the following year it published a guideline for the psychostimulant treatment of ADHD. In so doing, along with the other groups mentioned, members of the AAP served notice that they intended to diagnose and drug entirely normal children, for profit. This endorsement is a major factor spurring the current 'epidemic'.

In opposition to this campaign, Dr Baughman feels isolated by the psychiatrists and drug companies. There are some honest physicians who feel as he does, but only a much smaller number who speak out. Dr Baughman has been pressured to censor his views. Back in 1994 he made a formal proposal to the American Academy of Neurology to write parameters for ADHD that would determine the best advisable practices for the disease. The Academy wrote an encouraging response and gave him the go-ahead. But then he presented them with a statement that his review of the world scientific literature found no evidence that ADHD was a disease. In response, he heard from the Quality Assurance Committee that his services would no longer be needed. He has written to no less than five successive presidents of the American Academy of Neurology, urging them to speak out on the untrue, fraudulent claims of psychiatry that the diagnoses they make are of brain disorders/diseases. Only one of the five answered, the other four – parties to the fraud – would not even answer.

Every psychiatric organisation accepts money from the pharmaceutical companies. It seems that there is no such thing as a psychiatric expert, in any kind of mental disorder, who is not wholly owned or operated by the pharmaceutical industry. These experts are really, first of all, the paid promoters of prescription drugs. They have MD degrees and they masquerade as scientific physicians, but they have sold their souls and lost whatever scientific credentials they ever had. Together, these so-called experts take an immense amount of money – millions of dollars. Witness the case of Dr Joseph Biederman of Harvard University, and his colleagues, Dr Timothy Wilens and Dr Thomas Spencer. They disgraced Harvard when they were caught by a Senate probe which revealed their failure to declare receipt of drug company largesse.

It is very difficult for the average American parent or con-

sumer to believe that so many people would be so evil as to sell their souls to the pharmaceutical companies. This has a great deal to do with the magnitude of the psychiatric epidemic in general and the ADHD epidemic in particular. Parents – ordinary laypeople – going with their children at the behest of school officials in the first place, cannot believe that some highly respected and highly paid expert would tell them a complete lie. They cannot imagine it.

Dr Baughman calls our attention to the role of the media in this fraud. It rarely questions anything that the drug companies or the psychiatric establishment assert. On the contrary, it is always willing to take up their refrain and publicise it approvingly. Recently, national news programmes in the USA started talking about a new kind of disability that soldiers in the Iraqi conflict were developing. Lo and behold, this new disease was PTSD, Post-Traumatic Stress Disorder. Granted, there are a lot of troubling visions and experiences that all men in a war are exposed to, and these cause troubling flashbacks and troubled sleep. But that is not an organic disease of the brain, as psychiatry would have us believe, nor are the symptoms inevitable. The psychiatric establishment would have all the soldiers over there believe that PTSD is a disease with a grave prognosis. They tell them they are never going to get rid of these terrible flashbacks without the help of a new drug that they are trying to develop to obliterate those painful memories. That is the way to create a permanent new market.

The next ADHD marketing opportunity

The next great marketing opportunity for the drug companies is 'Adult ADHD'. Actually, this is not for the future: the market is already established, and it has assisted the tremendous year-on-year growth in the billions of prescriptions for Adderall, Ritalin, Concerta, and other amphetamines.

Ironically, Dr Baughman's alma mater, New York University School of Medicine, is at the forefront of this particular fraud. A couple of years ago there was a story in *The New York Times* describing the launch of an Adult ADHD clinic at the university. A large room had been hired at a hotel in New York, and signs on the curb invited people to go in and be checked for ADHD. So people went up and took a behavioural checklist test. And apparently 85% of those taking the test 'had the disease'. So they got labelled and were on their way the next day to their doctors with their brand new label. This was a regular recruiting service.

In fact, anyone who walks into a psychiatrist's these days and says that he has trouble focusing, is easily distracted and fidgets a lot, will most likely be diagnosed ADDH and immediately put on a drug. In 2002 a survey by the American Academy of Child and Adult Psychiatry conducted a survey of the practices of child psychiatrists. It found that 91% of the children seeing a child psychiatrist came out of their initial visit with a drug prescription. And yet Dr Baughman would say that, when he practised as a neurologist, a full one-third to one-half of all the patients he saw had no organic disease at all.

If such well-educated people in these so-called scientific organisations can invent and propagate such a widespread hoax, what does this say about the scientific integrity of the medical schools or teaching hospitals in the USA? Or of Western civilisation in general? The problem is not just with psychiatry but with paediatricians, neurologists, family practitioners, psychologists and teachers. These people have become both pawns and perpetrators, pushers for the drugs establishment. They simply carry out standard practice.

The trouble is that the entire medical profession has been bought. They all had a price. In the USA, drug companies spend $61,000 per year per physician to influence prescribing: doctors get free dinners, free golf, free cruises, etc. But that money is not spread around equally. It is spent strategically so that the top policy makers in medicine – the top psychiatrists and the Heads of Departments – get much more than anyone else. Some of these people are paid off to the tune of $500,000 a year. This is money well spent. It is so successful that no one within academic medicine will speak out about it, and anybody who wants to be academically successful in medicine has to go along with the system – they would be out the next day if they were to stand up and say the things that Dr Baughman says. He knows that NYU has become a hive for disease-inventing psychiatry.

Think of it: in the USA with costs (the cost of doing business) so high that 48 million citizens have no access at all to healthcare, the invented, entirely fraudulent 'disease' ADHD is the most common childhood diagnosis. Total costs for ADHD run at more than $3 billion per year! Think of Americans as rich, if you will. These US citizens, gouged by profiteers, are but one illness away from bankruptcy.

The implications of labelling 'bad' behaviour and drugging child 'deviants'

What about the long-term implications of this systematic poisoning? What happens when one out of five American children grows up on 'speed' or some other kind of psychiatric drug? Clearly, the USA is at that number already. It already drugs well over ten million of its children, and there is no sign that the numbers will fall. In fact, by all appearances, drugging one child in every five appears to be not enough for them. Now they seek through their lobbyists and friends in Congress (the House and Senate) to legislate mandatory psychiatric screening, which in previous trials is shown to lead to psychiatric diagnoses of between 50 and 60%. This is purely predatory. Meanwhile, ADHD in adults is also a rapidly growing market sector.

First of all, when you are normal they tell you that you have a disease, and you are psychologically harmed and made forever poorer simply by being labelled. Next, when you are given a drug to normalise an abnormality in your body or brain which does not actually exist, that is poisoning: you are going to be damaged by that drug every time you are given it. So the 'side-effect' rate for Ritalin, Adderall, or any psychiatric drug, is really 100%. There is no child who gets put on these drugs who is not altered by them. His perceptions, behaviour, feelings and emotions are always changed, even if not always noticeably. And there are terrible long-term physical and psychological consequences which cannot be fully predicted – and which bought-off psychiatry and medicine would anyway never speak or write about.

For example, Health Canada found 20 to 30 cases of strokes in young children, and about 10 or 12 sudden deaths; also heart abnormalities. Just before the recent FDA hearings, there were 51 cases of complications, deaths, strokes and heart attacks reported to the MedWatch programme. And, as we have seen, these figures probably under-calculate by a factor of 100.

Back in the 1990s, in Kansas City, Dr Baughman testified for Mr Gary Bell on behalf of his daughter, Stephanie. She underwent heart surgery for what Dr Baughman thinks was a complication of long-term Ritalin use. At any rate, Gary Bell and Dr Baughman did a Freedom-of-Information (FOI) request for all the reported deaths and injuries related to Ritalin or amphetamine methylphenidate, from 1990–1997. There were 160 deaths from Ritalin. There were another 26 deaths for 1998 to 2000, making a total of 186 reported deaths for the decade. Yet these were only the voluntary reports to MedWatch, estimated by the FDA as probably only 1% of the actual number of incidents. This means there may have been a staggering 18,600 deaths for the decade of the 1990s!

Dr Baughman was personally consulted in about a dozen cases of death, including Matthew Smith of Royal Oak, Michi-

gan. He and his parents had been coerced to keep him on Ritalin from first grade to the age of thirteen. (According to the *British National Formulary*, Ritalin must not be administered to children under the age of six.) One day, while playing with friends, Matthew suddenly fell over and died. Autopsy revealed that his heart muscle was diffusely enlarged, scarred and infiltrated with fat. The highly respected Oakland County (Michigan) Medical Examiner, Dr Ljubisa J Dragovic, said there was no doubt in his mind that Matthew Smith died of long-term chronic poisoning by amphetamine methylphenidate (Ritalin).

So we have a population that is potentially setting itself up for high risks of long-term harm and premature death, just like any other set of drug addicts. Nowadays there are frequent reports of high school and college athletes suddenly dropping dead. One was a pro baseball player who had been on supplements that contained ephedrine, which is very similar to the amphetamines. Dr Baughman thinks that steroid and amphetamine use is very common in athletes at and above the level of high school. And consequently it is likely that such sudden deaths are very often the result of a prescription drug, most of which have startling coronary or cardiac consequences. Not just amphetamines but all of the so-called antipsychotics are horrible poisons that the pharmaceutical industry is busy foisting on the population. Almost every psychotropic drug has well-known cardiac side effects.

A report by Ray et al., in the *New England Journal of Medicine* (January 15, 2009), found that the rate of sudden cardiac death in persons on typical and atypical antipsychotics was twice that of the normal (control) population. Research by Whang, et al., published in the *Journal of the American College of Cardiology* (March 17, 2009), found an increased rate of sudden cardiac death and coronary heart disease in women, with the risk of sudden cardiac death associated more strongly with taking antidepressant drugs than with the subjective symptoms of clinical depression. And an article in *The American Journal of Psychiatry* (Gould et al., June 19, 2009) found evidence of an association between the use of stimulants and sudden unexplained death among children and adolescents. Most of the stimulant use in that study was prescribed for ADHD – an imaginary disease.

In other words, almost every major group of psychotropic medication is now proved to increase the frequency of sudden cardiac death, while not a single psychiatric 'disorder' in any edition of the *DSM* has been shown to be a real disease. And still psychiatry is allowed to get away with calling their diagnoses 'diseases' and with poisoning normal people of all ages, for profit.

The pharmaceutical-psychiatric complex pushes for even more drugging

Meanwhile, there are various front groups which promote psychiatric medicine, such as Teen Screen and CHADD (Children and Adults with Attention-Deficit Disorders). Teen Screen comes from Columbia University, once an esteemed medical school uptown from NYU, which was also once a proud scientific institute. David Schaefer, the psychiatrist who authored Teen Screen, along with his pharmaceutical sponsors, is not content with the present rate of growth of psychiatric poisoning in America. He and the drug companies want to make it mandatory that every schoolchild takes a mental health diagnostic test. Like the Adult ADHD screen run by New York University, such screening would be bound to generate a positive diagnostic rate of 60 or 70%. As long as they have enough friends in Congress and in the White House to write these things into law, those people are going to carry on. Teen Screen was very much a product of the White House. President Bush's Freedom Commission on Mental Health launched the notion of Teen Screen: mandatory mental health screening.

Dr Baughman thinks that Illinois has already passed this idea and made it law. It does not ask parents whether or not they want their children screened: it is mandatory. This is Big Brother incarnate – as bad as anything Stalin could dream up. The implications go far beyond the drugging of normal school children, which is bad enough. We had better all wake up.

Yet if the pharmaceutical companies are so powerful and control so many big players, how does this hoax ever get exposed? Right now there is one pharmaceutical company lobbyist for every member of Congress, and probably three or four for every senator. And who knows how many for the president? This is really a horror story unfolding. When Dr Baughman started out in medicine in 1964, he thought he was entering a wonderful profession. He did not have to compromise himself by inventing illnesses and pushing drugs. That has changed completely. Today, he considers the medical profession a total disgrace.

Fighting back

This is really about crimes against humanity, a chemical holocaust. The psychiatric establishment has taken entirely normal children and, by 'diagnosing' them with a fictional chemical imbalance of the brain, made them patients and poisoned them. It is a complete fraud.

The following is just one of many heart-rending email messages to Dr Baughman and posted on his website. It is from a father who happens to be a neurologist, someone who understands the fraud but is powerless against it:

> *Today is Father's Day. It has been 1 year and 5 months since I was able to see my son without restrictions. I am not a drug dealer, spousal abuser or criminal. I am a frustrated Neurologist who is trying to help and protect his son from drug poisoning for an invalid diagnosis.*
>
> *For this reason alone my son has been taken away from me. And short of suing everyone involved, there doesn't seem to be any way this situation will change because of the bias of the judge in this matter.*
>
> *Walter X, MD*

At the moment, Dr Baughman is working with individuals to put together a consumer fraud suit in the state of California, based on the fraudulent diagnosis of ADHD and subsequent drugging. If you have been lied to – told you have a disease when you do not, and then drugged – that is battery. Keep an eye on his website because if they can get the lawsuit going he will be posting notes as to the progress (or lack of it). If they can set a precedent in California, opposition to the psychiatrisation of children could sweep the nation. It is necessary to put an end to this fraud. Of course, so far the experts have had such obscene amounts of drug company money to defend themselves that no one has succeeded against them.

Dr Fred Baughman is the author of *The ADHD Fraud: How Psychiatry Makes Patients of Normal Children* (available from www.trafford.com). Also available is his video, *ADHD Total 100% Fraud*, containing footage from the 1998 ADHD conference. Also, a DVD by Gary Null Associates, NY City, *Drugging Our Children*, which contains an interview with Dr Baughman. Get these from his website: www.adhdfraud.org

ADHD: Attention Deficit Hyperactivity Disorder
ADDH: Attention Deficit Disorder with Hyperactivity
ADD: Attention Deficit Disorder

TURNING CHILDREN INTO MENTAL PATIENTS: ADHD IN THE UK

by George Fowler

Problems with medicating ADHD

It is estimated that more than ½ million children in Britain have the behavioural condition known as Attention Deficit Hyperactivity Disorder (ADHD). The diagnosis indicates a child who is persistently uncontrollable. Like most other mental health diagnoses, this is really a non-medical category. It seems medical since the diagnosis (judgement) is supposed to be made only by a doctor. But, as Dr Baughman points out in the previous article, there are no organic markers for this behavioural disorder.

In the UK, most of these children receive no drug treatment, but all the same, 55,000 of them were being given the powerful stimulant medication methylphenidate (Ritalin, or Concerta) by 2007. This drug is thought to help inattentive and unruly children focus. Over the last decade or so it has been the first choice for doctors treating ADHD. In the UK, just 3,500 prescriptions were written for Ritalin in 1993. By 1998 this had risen to 26,500. And by 2006 the NHS gave out about 250,000 prescriptions. The great increase resulted from a widely publicised report in 1999 which highlighted ADHD and appeared to confirm the benefits of Ritalin. In the USA, doctors write two million prescriptions each month.

However, as Dr Baughman shows, this medical stimulant is not without its problems. Similar to amphetamine, it can cause insomnia and suppress the appetite, cause weight loss and stunt growth. There are reports of many medicated children becoming more unruly and aggressive, and some becoming suicidal. But most parents and officials are willing to weigh those risks against an ADHD child failing at school and having an increased risk of delinquency, substance misuse and criminal conviction.

During the 1990s, the US-based Multimodal Treatment Study of Children with ADHD (the MTA study) compared the treatment of 600 children with ADHD. In 1999 it reported that medication was superior to behavioural therapy. In the USA and in the UK this led to a steep rise in the numbers being medicated. However, by 2007 the continuing MTA study had discovered that in the long-term, after three years of drug use, Ritalin is no better than behavioural therapy or no therapy at all, and it can stunt children's growth. This was widely reported in the media at the time.

The co-author of the 2007 report, Professor William Pelham of the University of Buffalo, said:

> I think we exaggerated the beneficial impact of medication in the first study. We had thought that children medicated longer would have better outcomes. That didn't happen … The children had a substantial decrease in their rate of growth, so they weren't growing as much as other kids in terms of both their height and their weight. And … there were no beneficial effects – none. In the short run [medication] will help the child behave better [but] there's no indication that medication's better than [no therapy] in the long run. And that information should be made very clear to parents.

In fact, not only do the drugs often deliver no benefits, even initially, but many parents with children on Ritalin have horror stories about their children becoming very aggressive, suffering night terrors, self-harming and becoming socially isolated.

By 2007 the National Institute for Health and Clinical Excellence (NICE) was busy revising its treatment guidelines for ADHD. At the time Dr Tim Kendall, of NICE and the Royal College of Psychiatrists, said:

> I hope that we will be able to make recommendations that will give people, based on the best evidence we've got, a comprehensive approach to treatment which will advise about the use of parent training programmes, the use of behavioural interventions. The important thing is that we have an approach which doesn't focus just on one type of treatment.

Methylphenidate (Ritalin and Concerta) has the same effect as 'speed' and cocaine: like amphetamine, it stimulates the central nervous system. Doctors maintain that, 'paradoxically', this can have a calming and focusing effect. No one knows why it works this way, although there is some evidence that the effect is achieved by the slow release of the hormone dopamine, which controls behaviour, attention and learning.

Other recent findings suggest that Ritalin can stunt growth as well as cause heart problems, insomnia and weight problems. From 1999 until 2007 the authorities in the US acknowledged 51 deaths among children and adults taking Ritalin. And by then, according to the Medicines and Healthcare Products Regulatory Agency, 11 British children on Ritalin had died. The cause of two deaths was heart-related: one had a heart attack, the other an enlarged heart. One was recorded as 'sudden death'. One died of a brain haemorrhage; another of a swelling in the brain; two committed suicide, and one died of neo-natal respiratory distress syndrome.

A mother on the Panorama program about ADHD and Ritalin, in 2007, reported that her son was first medicated at the age of five. But there were no benefits, "… so the doctor kept upping the doses until he was on six times the normal dose, yet he was still hyperactive." Finally, when he was fourteen, the boy was put on Risperdal. This is an antipsychotic drug usually given for schizophrenia. (It was also used as a 'truth drug' on political prisoners in the Soviet Union.) "It was as if my son had been replaced by a doped-up zombie. I could hardly wake him in the morning. It was as if all his personality was disappearing, like a patient in a mental institution." After a month she took her son off the drug. Yet by 2007 about 8,000 British youngsters were being treated with this powerful tranquilliser, or a similar drug called Zyprexa – despite the fact of dangerous side effects ranging from diabetes to brain tumours.

There are a few experts who fear that not only are inappropriate drugs being used to control children's behaviour, but they are being massively over-prescribed to many children who are 'simply naughty'. They say that ADHD is nothing more than a symptom of Britain's 'time-poor' society, where children of parents working long hours are cracking-up under

the strain of family life. There are also criticisms that doctors tend to dole out pills when behavioural therapy would be a safer option.

And a growing body of experts questions whether ADHD really exists. "As a society, we are quick to reach for a pill," says David Healy, a leading expert in psycho-pharmacology, and Professor of Psychiatry at Cardiff University. He goes on:

> There's much less willingness on the part of the medical profession to say to parents: 'You have an awkward child. You must discipline them.' So we prescribe pills instead … The drugs used to treat ADHD are the same as speed and cocaine. We react with horror to the idea that our kids would use such drugs, but don't react about drugs such as Ritalin being given to them. There's a risk that your child won't grow as well. There are high risks that children will go on to use street drugs, too, because they will have grown used to their effects.

In 2007 Dr Kendall admitted:

> We have a situation where GPs prescribe antipsychotics inappropriately. There is no real excuse for prescribing drugs which are associated with such severe side effects … A generous understanding would be to say that doctors have reached the point where they don't know what else to offer and they haven't got the right support to help parents. I hope we will be able to make recommendations that will give people a comprehensive approach to treatment and that will advise about what teachers might be able to do within the classroom when they're trying to deal with kids who have difficult problems of this kind …

But even where Ritalin is used, which it is routinely (rather than less often, like the antipsychotic Risperdal), Dr Kendall says guidelines do not make it clear when doctors should diagnose ADHD and when they should prescribe drugs. "If you diagnose people loosely, you could end up with 16% of the child population with ADHD. Under tight criteria, only 1.6% would be diagnosed."

Of course, the ADHD debate inevitably arouses great passions. While some question the existence of the disorder and say that medicating has simply replaced good parenting, for others the idea that 'bad parenting' is behind their child's problems is almost too much to bear. One mother described Risperdal as "a life-saver". She maintained that without it her son was unmanageable. "It controls his ADHD and gives us both peace of mind. I know there are side effects, but for me it's a calculated risk. He's put on a lot of weight and is now obese because the drug makes him hungry all the time, but I think that's the lesser of two evils."

Perhaps most disturbing is the suggestion that ADHD is nothing more than the invention of pharmaceutical companies who have used clinical trials to create a disease that can be treated with their drugs. Professor Healy pointed out that "There is an active campaign by pharmaceutical companies to convince people that there's 'Adult ADHD'. Adults with problems are being told they have Adult ADHD, and are being offered drugs for it. Pharmaceutical companies market these drugs aggressively. How can GPs refuse to prescribe a drug 'clinically proven' to work?" It is hardly surprising, then, that parents who are encouraged to give drugs to their children, rather than face up to the causes of the behaviour, usually take the easy way out.

The current conventional wisdom is that if a child's behaviour worsens when he is on Ritalin then his medication should first of all be changed to the slow-release and weaker version of the drug, Concerta.

But some parents also look to improve the child's diet by seeing whether it helps to cut out gluten, wheat or dairy products and to add mineral supplements, natural produce and fish oils. Others combine this with removing their child from school and teaching them at home. There are claims of great successes within weeks.

No one suggests it, but perhaps these successes are somewhat a function of parents at last being appropriately attentive to the child's needs. Meanwhile, the Cactus Clinic at the University of Teesside's School of Social Sciences, which has a drug-free approach, is billed as "a groundbreaking centre". The clinic refuses to use the term ADHD, and according to manager Amanda Clarkson, "… helps children learn appropriate behaviour. Attention disorders are not diseases, but patterns of inappropriate behaviour." One parent who took his teenage son there said: "After three months, I knew I was getting my boy back. I think it's wicked how children are being doped when there are alternatives."

However, the treatment is not free: parents can pay up to £600. Money well spent, according to that parent, who asked why it wasn't available to everyone on the NHS.

The response from NICE

The NHS guidelines on ADHD were revised due to concerns that treatment was not consistent. The National Institute for Health and Clinical Excellence (NICE) spent two years investigating the disorder and its treatment. Led by Dr Tim Kendall, a bevy of experts looked at the criteria under which ADHD should be diagnosed and, if it exists at all, the best treatment. In 2007 Dr Kendall had hoped that the new guidelines would reduce the over-prescription of drugs, while recognising their usefulness in extreme cases. "We are looking at dietary interventions," he said. "There is some evidence that coal tar derivatives found in things such as diet colas increase hyperactivity. There is some evidence that fish oils improve things. And there is evidence that education can help teachers deal better with hyperactive children, and that parent training programmes are helpful."

The NICE review delivered its findings as Guidelines in September 2008. As we have seen, there is an argument – never answered, by the way – that ADHD is a subjective, motivated, political construct which conveniently serves a number of cynical or misguided interests (the drugs companies, of course; also doctors, teachers, other agents of the state, desperately worried or punitive parents…) The NICE Guidelines neither mention that idea nor breaches the consensus: it assumes that ADHD is a genuine, objective disorder. For diagnostic criteria, it used the *International Classification of Mental and Behavioural Disorders, 10th revision* (*ICD-10*) and the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*).

The NICE Guidelines state that:

> … moderate ADHD in children and young people is taken to be present when the symptoms of hyperactivity/impulsivity and/or inattention, or all three, occur together, and are associated with at least moderate impairment, which should be present in multiple settings (for example, home and school or a healthcare setting) and in multiple domains (domains refers to a type of social or personal functioning in which people ordinarily achieve competence, such as, achievement in schoolwork or homework; dealing with physical risks and avoiding common hazards; and forming positive relationships with family and peers), where the level appropriate to the child's chronological and mental age has not been reached. Determining the severity of the disorder should be a matter for clinical judgement, taking into account the severity of impairment, pervasiveness, individual factors and familial and social context.
>
> The level of impairment could also be estimated by using a predetermined level on a global adjustment scale (for example, a score of less than 60 on the Children's Global Assessment Scale [C-GAS]).
>
> …Using the criteria of DSM-IV, ADHD is thought to affect about 3–9% of school-age children and young people in the UK, and about 2% of adults worldwide.
>
> In general, ADHD is a persisting disorder. Of the young people with a sustained diagnosis, most will go on to have significant difficulties in adulthood, which may include continuing ADHD, personality disorders, emotional and social difficulties, substance misuse, unemployment and involvement in crime.
>
> Symptoms of ADHD can overlap with symptoms of other related disorders, and ADHD cannot be considered a categorical diagnosis. Therefore care in differential diagnosis is needed. Common coexisting conditions in children with ADHD are disorders of mood, conduct, learning, motor control and communication, and anxiety disorders; in adults they include personality disorders, bipolar disorder, obsessive-compulsive disorder and substance misuse.

The Guidelines recommend psychological and dietary interventions, better teacher awareness and help, and parent training.

> Drug treatment is not indicated as the first-line treatment for all school-age children and young people with ADHD. It should be reserved for those with severe symptoms and impairment or for those with moderate levels of impairment who have refused non-drug interventions, or whose symptoms have not responded sufficiently to parent training/education programmes or group psychological treatment. Following treatment with a parent-training/education programme, children and young people with ADHD and persisting significant impairment should be offered drug treatment.

However, NICE still recommends Ritalin, and it remains to be seen how far its non-drug recommendations are put into practice.

The Guidelines quote a recent UK survey of over 10,000 children (from age 5 to 15) which found that 3.62% of boys and 0.85% of girls had ADHD. It also cites twin studies which suggest that about 75% of the variation in ADHD symptoms in the population is due to genetic factors.

Big questions remain. It is important that the NICE Guidelines draw attention to the need for doctors to be careful about diagnosis: an ADHD diagnosis might well mask a more fundamental condition. It seems clear to sensitive psychiatric workers that many people go through childhood labelled as 'difficult' or 'learning disability' due to an unrecognised psychological trauma (often due to abuse) or to a constitutional condition, e.g., on the autistic spectrum (such as Asperger), or even simply dyslexia. Then, as teenagers or young adults, they go on to attract a mental health misdiagnosis such as personality disorder or OCD, and eventually perhaps schizophrenia or bi-polar disorder. And yet no authority seems to recognise the approximation of the ratios of boys-to-girls for both ADHD and autistic spectrum disorders, which is to say, the ratio of 4:1.

Finally, nobody in the mainstream seems willing to address the whole question of the social construction of the diagnostic category, and the social contexts of its use. Not only is it a fact that ADHD was invented by psychiatrists in the pay of drug companies, but there has never been a study of the social contexts within which ADDH-type behaviour arises. For example, perhaps those kinds of behaviour are the response of children who simply react in frustration (and in kind) to authoritarian parenting and teaching, which they experience as unremittingly boring, demeaning, bullying, and perhaps actually violent and abusive. In this regard, Professor Healy's reported response to the problem of 'troublesome' children seems particularly crass: 'You have an awkward child. You must discipline them.'

Sociological or social-psychological research might throw much needed light onto how and why the 'bad behaviour' arises, and why so many more boys than girls are diagnosed ADHD. (There does not ever seem to have been any such research.) For example, school is largely a feminine institution which, these days, seems increasingly unwilling to cater to energetic boys who might sometimes wish to contest their domestication. And how does the ADHD diagnosis spread across the social classes? I would guess that the diagnosis is applied quite disproportionately to those children who are already 'socially disadvantaged'. Perhaps a certain combination of unhappy social and individual constitutional or developmental factors is most likely to lead particular children towards the diagnosis of ADHD and their drugging with Ritalin or Risperdal.

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4: AT LAST - REAL MEDICAL SCIENCE

PSYCHOTROPIC MEDICATIONS: REMEDIES OR POISONS?

THE EVIDENCE FROM PHARMACOGENETICS

by Catherine Clarke

Few psychiatrists or GPs hesitate before prescribing a psychotropic 'remedy'. But do they have any idea at all about the individual patient's capacity to 'take up' that particular drug, or whether, on the contrary, the patient is simply unable to metabolise the medication and it will actually poison him and worsen his condition?

This most important issue concerns the rationale for almost the whole of mental health therapy. To understand it, we need an idea about that process within the body of every living thing which is known as 'metabolism'.

What is metabolism?[1]

This is the set of chemical reactions which occurs in a living organism so as to maintain its life. Metabolic processes allow organisms to grow and reproduce, maintain their structures and respond to their environments. Metabolism is usually divided into two categories. Catabolism breaks down organic matter, e.g., to harvest energy in the process of cellular respiration. Anabolism, on the other hand, uses energy to construct components of cells such as proteins and nucleic acids.

The chemical reactions of metabolism are organised into metabolic pathways in which one chemical is transformed into another by a sequence of enzymes. Enzymes are crucial to metabolism because they allow organisms to drive desirable but thermodynamically unfavorable reactions by coupling them to favorable ones, and because they act as catalysts to allow those reactions to proceed quickly and efficiently. Enzymes also allow the regulation of metabolic pathways in response to changes in the cell's environment or signals from other cells.

An organism's metabolic set-up determines which substances sustain and enhance the processes essential to its life and which it finds poisonous. For example, those elementary forms of life known as bacteria use hydrogen sulfide as a nutrient, and yet that gas is a deadly poison to animals. So when we take any medicine whatsoever, its effects depend absolutely upon how our particular body metabolises that input.

What is pharmacogenetics?

This is the study of the metabolisation of medications. 'Pharmacogenetics' denotes 'pharmaco' (the employment of a drug) and its good or bad relationship to the body's constitution (genetics): it is specifically concerned with the body's ability or inability to metabolise and excrete medication. Wikipedia defines pharmacogenetics as "the study or clinical testing of genetic variation that gives rise to differing response to drugs."

Any medication can only be therapeutic when it is metabolised efficiently, i.e., when it achieves what the medication is designed to do, and with minimal 'side effects'. On the other hand, if a medication is not metabolised efficiently, it cannot achieve the desired therapeutic response. More than this, it may well be harmful: the patient may suffer from increasingly severe 'side effects'.[2] This is due both to the high levels of medicated chemical toxicities in the blood stream and to their accumulation due to taking too long to clear from the body.

Research in this area has developed since the 1950s, when it was first observed that there were genetic variations in people's responses to drugs. The research is therefore mainly to improve drug safety and efficacy. And, "[d]riving this trend are the 106,000 deaths and 2.2 million serious events caused by adverse drug reactions (ADRs) in the US each year. As such ADRs are responsible for 5–7% of all hospital admissions in the US and Europe, lead to the withdrawal of 4% of new medicines, and cost society an amount equal to the costs of drug treatment."[3]

General medicine now benefits from technological developments consequent to research in this field. For example, various pharmacogenetic tests are routinely carried out prior to treatment with the medications prescribed for rheumatoid arthritis, HIV, breast cancer, Crohn's disease and warfarin therapy. This is precisely to assess the degree of efficacy or inefficacy of the proposed drug for each unique patient, and to reduce seriously adverse reactions. In those areas of medicine, the tests only take about 90 seconds and can be done at an out-patient clinic for just £10.

By comparison, research into the pharmacogenetics of psychotropic medications is neglected. But there is some research, and there are tests available – at a price, if you search hard to find them, and certainly not freely available from the NHS. In fact, when it comes to the day-to-day use of the array of psychiatric medicines on offer, the pharmacogenetics of psychotropic medications is almost completely unknown. Don't take my word for it – just ask your psychiatrist or GP to explain pharmacogenetics and how the medication that he prescribes will metabolise in your body!

I first heard about pharmacogenetics and the Genotyping Test in 2004. It was a revelation because ever since my son had experienced a manic psychosis, in 2000, I had suspected that it may well be linked with the Prozac he was then taking. His psychiatrist on the acute ward discontinued the Prozac, and instead prescribed Sulpiride. However, within five weeks my son experienced an acute psychosis, and throughout the years 2000 –2001 he went through six acute crises. We protested to 'the experts' that my son was sensitive to neuroleptics, and tried to show them research findings in support of our claims. Despite our protests, each psychiatrist we encountered insisted on prescribing yet another drug. In the end, my son was given a range of neuroleptics, both atypicals and typicals, at high and low doses, as well as benzodiazepines, anticholinergic medication and hypnotics. Within weeks of taking the prescribed neuroleptics he began to suffer from both physical and psychological 'side effects'. It was very clear to us that these ill

effects became more intense whenever a dose was raised or during times of polypharmacy (mixing drugs).

How the body metabolises psychiatric medication – or fails to do so and ends up poisoned

There are different systems in the body for metabolising medication. The CYP450 Cytochrome system is where most psychotropic medications are metabolised, and it is the most researched. These enzyme pathways are found primarily in the liver. They include CYP2D6, CYP219, CYP2C9, CYP1A2 and CYP3A4 pathways. 75% of all psychotropic drugs are metabolised through the CYP2D6. 15% of all prescription drugs including psychotropic medications are metabolised through the CYP2C19 pathway and similarly 16% are metabolised through the CYP2C9 pathway.

A major problem is that natural genetic variations in the CYP pathways determine whether a person metabolises his medication quickly or slowly. Four groups have been identified: Poor, Intermediate, Extensive and Ultra-Extensive Metabolisers. There is no genetic metabolising functional activity in a pathway if a patient is a Poor Metaboliser (PM) for that pathway. This means that medications which require that specific pathway cannot be therapeutic for the patient. Additionally, it is inevitable that he or she will suffer from 'side effects' and adverse reactions. This means that if a person is a PM for the CYP2D6 pathway, medications should not be prescribed if they require that CYP2D6 for metabolisation. If a person is given such a medication when he is constitutionally unable to metabolise it he experiences a reaction similar to taking an overdose. 10% of Caucasians, and 40–50% of Asians, Pacific Inlanders, African and African American are PM for the CYP2D6. PM for the CYP2C19 includes 10–20% of African, 15–20% of Japanese and 3–6% Caucasian. 1–3% of the general population is PM for the CYP2C9.

The Intermediate Metaboliser (IM) group has a pathway which is only 50% efficient. This indicates a lower-than-average dose for an optimal therapeutic response. It is recommended that patients should start with the lowest possible dose, and prescribing any other medications should be avoided, since that inhibits or induces the workings of the pathway. This group are prone to toxicity 'side effects'. 35% of Caucasians are IM.

Those in the group of Extensive Metabolisers (EM) require the optimal dose recommended (e.g., by the *British National Formulary*), since their EM enzyme metabolising activity functions at 100%. And Ultra-Extensive Metabolisers (UM) account for 7% of the population: this group consists of notably excessive metabolisers who eliminate medication from the body too rapidly. To get any therapeutic effect, a higher level of medication is required for a UM patient.

Pharmacogenetics is by now a well-established area of knowledge and has been utilised by the pharmaceutical companies for many years – but usually only cynically for their own purposes, rather than first of all in the interests of patients' welfare. Generally, drug trials proceed in four phases. The first phase includes a group which is representative of the population as a whole. Phases 2–4 exclude persons who are PM: primarily this eliminates all those who would report severe 'side effects'. And the later phases of the research are then conducted on people who are specifically selected for their efficiency in metabolising the drug in question. This enables pharmaceutical companies to show the best possible outcome for their new drugs. It also has the potential for excluding from the research report the most severe adverse reactions and side effects, which would have been experienced by those who turn out to be PM. In other words, testing is knowingly engineered so as to play up the beneficial workings of the drug and to hide adverse reactions.

The Genotyping Test

Some pharmaceutical companies market a Genotyping Test which determines a person's ability to metabolise medication. This consists of a blood test or a buccal swab test (taking cells from the inner lining of the mouth). These tests are available from Genelex, who charged $250 for a Single Pathway test, $600 for the Standard Panel pathways – CYP2D6, CYP2C19 and CYP2C9, and $1000 for their Extended Panel, comprising pathways CYP2D6, 2C19, 2C9, NAT2 and CYP1A2. Results take ten to fourteen days from their receiving the blood sample or buccal swab. The company provides a software program so as to interpret the results; it also offers a personal service for one month following the genotyping results so as to answer clients' questions. Their tests and procedures also allow clients to check for potential drug–drug and drug–gene interactions.

In this way, information may be derived which profiles the kind of medications which pose possibly dangerous combinations for the genetic profile in question. If the data is intended as legal evidence, a witness is needed to confirm that the person who collected the blood sample or buccal swab can confirm the identity of the person providing the sample. Genelex is unusual since they do not require referral from a physician. This makes it much more accessible to the public. Genelex will only deal with the client requesting the test: confidentiality is guaranteed so that this information is not shared with a medical practitioner unless the client agrees. Their website is: www.healthanddna.com

LGC normally provide their services only to pharmaceutical companies. However, I was quoted £1000 for the test for pathways CYP2D6, CYPC219 and CYP2C9. I was also told that they require a referral from the GP or psychiatrist for the genotyping test to proceed. The company insists on discussing the implications of the genotyping test with the responsible physician; they say that this is to ensure that the client is fully informed. More information may be found at: www.lgc.co.uk

DXS also offers its services primarily to pharmaceutical companies. DXS also requires referral from a physician if a member of the public requests a genotyping test. Members of the public do not routinely contact either LGS or DXS. In 2006, the latter charged £500 for its test for CYP2D6, CYP2C19 and CYP2C9. Further information may be found at: www.dxs-genotyping.com.

My experience of the Genotyping Test

In the event, I decided to have my son's genotyping test done by DXS. I approached my son's psychiatrist to request a referral for testing. I produced the appropriate literature and paperwork. This psychiatrist seemed to know nothing about genotyping and the attendant problems with medication. In my experience this is not unusual. (Although some pharmacists are aware

of pharmacogenetics, others are obviously unaware.) And yet, when in a multidisciplinary setting, many pharmacists seem to suppress this information from colleagues. And they especially do not speak about it to service users and carers.

Our psychiatrist did send a referral letter to DXS. This letter included a list of all the psychotropic drugs my son had been prescribed. DXS decided to test the CYP450 Cytochrome system: CYP2D6, CYP2C19 and CYP2C9. In order to maintain strictly professional procedures, the blood test was taken by a nurse at the GP surgery and posted to DXS along with the fee of £500. And although I had paid privately, the company insisted on the results being sent directly to the psychiatrist. He copied-on the results to me.

At last the cause of my son's interminable suffering since he had been prescribed psychotropic medication was made crystal clear. His genotyping results showed that he was a PM for CYP2D6 and IM for CYP2C19.

Prozac is metabolised primarily through pathways CYP2D6 and CYP2C9, and to a lesser extent through 2C19 and 3A4. If Prozac is to be metabolised efficiently all of those pathways need to be functioning efficiently. Imagine a water system: if all the pipes are clear there is a free flow of water; however if just one pipe is blocked up there is an ever-increasing backlog of water pressure. Similarly, if just one metabolic pathway is deficient due to its genetic basis, the body cannot help but accumulate an ever-increasing backlog of toxic medication (i.e., poison). Now we could see what had happened to my son. When the Prozac dose was doubled his metabolic system was overwhelmed by the toxin, and it is not surprising that a manic psychosis ensued. Due to the non-functioning of his metabolic pathway CYP2D6, it was inevitable that he would respond badly. My theory is that his acute psychosis (which followed five weeks later) was the result of the abrupt withdrawal from Prozac and the sudden switch to an atypical antipsychotic.

Over the years my son had been prescribed Acuphase, diazepam, haloperidol, risperidone, olanzapine and clozapine. Each is metabolised through CYP2D6. Anyway, by definition, a neuroleptic is always to some degree neurotoxic. However, because my son was unable to metabolise and thereby rid himself of them efficiently, he had been poisoned by the prescribed psychotropic drugs: this was signalled by the many 'side effects' he experienced.

If doctors ever recognise this kind of poisoning at all, they prefer to see it as inadvertent, and call it 'iatrogenic toxicity'. In my son's case, the 'side effects' included extrapyramidal symptoms (e.g., shaking), the symptoms of neuroleptic malignant syndrome, tardive dyskinesia, excessive weight gain, drooling, difficulty in breathing, and excessive sedation. He also suffered psychologically. He experienced the physical and emotional restlessness associated with suicidal and violent feelings (known as akathesia); within minutes his mood alternated between crying and giggling (dysphoria); he experienced more extreme psychosis when the neuroleptic dose was raised (called Super-Sensitivity Psychosis); and he went 'cold turkey' during drug withdrawal (called Tardive or Rebound Psychosis).

The general experience of neuroleptics

Currently about 250,000 people in the UK are prescribed neuroleptics. It is well known that roughly one-third of service users respond well: they are able to integrate into the community, resume work and have a decent enough quality of life, with only infrequent admissions into the acute wards. Since neuroleptics appear to be therapeutic in their cases, it is my hypothesis that it is most likely that those particular service users are EM's. My theory is that probably they are also not dependent on neuroleptics.

Then there is another one-third who experience the 'revolving door' syndrome; and then there is the last one-third, who populate the secure units, ad infinitum. My hypothesis is that a high proportion of all patients are Poor or Intermediate Metabolisers. They are the service users whose quality of life is always unpredictable and poor: 'side effects' constantly hinder their integration into the community and deny them any prospects for work. I think the main reason why this type of service user experiences great difficulty in withdrawing from neuroleptics is their physiological dependency.

Using knowledge of pharmacogenetics

My son has managed to reduce the dose of clozapine. Because he lives at our family home, I discovered another link related with pharmacogenetics and the process of 'coming off' a drug. We noticed that he became uptight and irritable at a lower dose of Clozapine. It appeared that these emotions were triggered by eating certain foods containing high levels of tyramine, an essential amino acid found in many foods. Tyramine is metabolised by the Monoamine Oxidase enzymes and also by CYP2D6. It is known that the neuroleptic psychiatric drugs inhibit MAO.[4] This, in turn, increases tyramine levels in the body. Since my son is PM for CYP2D6, this situation would be enhanced. And high tyramine levels interfere with serotonin production. This makes for a low level of serotonin which, in turn, can trigger aggression; noradrenaline and adrenaline levels increase, causing headaches, enlarged pupils, high blood pressure and occasionally heart dysarrthmia, failure and strokes.

My son's irritation ceased by excluding foods rich in tyramine – such as those containing yeast (e.g., extracts like Marmite), mature cheese, processed meat, peanut butter, chocolate and yoghurt. Other foods to avoid include red wines, bananas, broad beans, protein extracts, sausages, salami, red plums, soy sauce and spinach. Food which is spoiled or too old also increases tyramine levels. Hence the importance of eating fresh food so as to avoid feelings of hostility and aggression – let alone to maintain the body's physical health as much as possible when a neuroleptic is prescribed.

Access to my son's genetic profile also made evident probable drug–drug interactions. Lanzoprazole was recommended by the psychiatrist to treat gastric reflux (burning throat), and it was prescribed by the GP. Initially this worked well. However, within two weeks my son's psychological functioning started to slip. When I searched the Internet I discovered that lansoprazole is metabolised through the CYPC19, and for my son that pathway only works at 50%. The medication also induces the CYP1A2, which is the major pathway for clozapine metabolism. This meant that clozapine went through my son's body at a faster rate[5] and was likely to precipitate an unwanted 'cold turkey' reaction. I informed the GP. Lansoprazole

was discontinued and my son's re-admission for psychosis was avoided. Other standard medications for physical illnesses also inhibit CYP1A2, thereby affecting the metabolism of clozapine. These include ciprofloxacin and erythromycin antibiotics: they cause an increase of clozapine levels to the extent of causing the symptoms of toxicity.

Certain foods which are metabolised through that CYP450 system also affect the rate of clozapine metabolism. Broccoli and brussels sprouts were taken from my son's diet since their chemistry induces CYP1A2. On the other hand, by inhibiting that pathway, caffeine in food and liquids has the opposite effect on the CYP1A2: ingesting caffeinated products raises the plasma clozapine levels. This is potentially dangerous since high levels of clozapine can cause a seizure. Decaffeinated tea and coffee are important dietary factors keeping my son safe from detrimental physical and psychological conditions which would otherwise lead to a crisis and hospital admission. Smoking tobacco induces CYP1A2, and for this reason some service users are prescribed high doses of clozapine. This is serious if the service user stops smoking (or wishes to do so): the clozapine level in the body rises, tending to cause a seizure.

Knowledge of my son's genetic metabolising status has helped me as a carer. The information that I have been able to discover and offer has been placed on the advance directive. There is no doubt that my son has been poisoned due to psychiatrists' ignorance of his genetic metabolising status. In the event of a potential future hospital admission, I doubt any psychiatrist would knowingly want to take the clinical responsibility of increasing the neuroleptic poison in his body. I have Power of Attorney for him, and the advance directive is a document which would be viewed with high regard in a Court of Law in the event of my son's death.

I have helped to keep my son out of the mental health system by paying meticulous attention to his diet within the neuroleptic withdrawal process, and also by being aware of potential drug–drug interactions (when the GP may prescribe a drug and not know about the possible interactions). With the knowledge of my son's genetic metabolising status, I feel empowered by having an informed choice.

Prospects for routine genotyping testing in the UK

In 2008 there was a conference entitled 'Adverse psychiatric side effects of medicines: What's your responsibility?' This was organised by the Adverse Psychiatric Reactions Information Link. One speaker referred to research for the suitability of the genotyping test prior to prescribing SSRI antidepressants undertaken in the USA. Apparently the results showed that genotyping was inappropriate. But pharmaceutical companies have been caught out before, distorting research findings, and I wonder which organisation funded that particular piece of research.[6]

Currently, research to determine the suitability of the genotyping test for patients prescribed neuroleptics is being carried out at Liverpool University and funded by the Department of Health. This has covered the first stage and second stages: analytical validity and clinical validity. The research results were published on the National Institute for Health Research Evaluation Trials and Studies Co-ordinating Centre (NCCHTA) website, October 2009. Again, the results are disappointing. They conclude that there is not enough evidence to support routine genetic testing in all individuals prior to prescribing neuroleptics; also that there is not sufficient evidence to show routine identification of patients CYP profiles, so as to provide psychiatrists with the information they need to adjust an initial dose of a neuroleptic.

That study was a review of the research, and I wonder if the authors had been selective. In fact, the psychopharmacologist I saw at the national meeting had carried out a genotyping survey on patients, and found that none were PM or IM metabolisers. But his sample had only included out-patients, and all were Caucasians. To guard against bias, research really has to include the full range of patients with a 'long and enduring mental illness'.

According to NCCHTA, the next stage is for 'clinical utility'. Such research uses the knowledge from previous stages and would involve genotyping patients to tailor the neuroleptic dose to the patient. Apparently patients are being recruited for trials but I am not able to locate that research on the NCCHTA website. Finally, the last stage involves the ethical, social and/or legal consequences of pharmacogenetic testing. I maintain there is a requirement for all sectioned patients in secure units to be genetically tested, as opposed to the one-third of patients on neuroleptics who do relatively well. This would make the research more honest.

We already know that a very significant proportion of the population would classify as Poor Metabolisers for psychotropic medicines. Particular attention to the 2D6 and the 2C19 variants is needed to ascertain drug dosage and likely effects.[7] However there are other factors that influence medication metabolism. These include variations in P-glycoproteins and Uridino-glucuronisil transferases (UGTs)[8] and variations in the Serotonin Transporter Gene which can impede the action of serotonin neurotransmission.[9] Pharmaceutical companies are also aware of these variations. It is important for all mental health employees to be educated about pharmacogenetics. This would enable doctors and psychiatrists to be mindful that severe adverse reactions such as hallucinations, psychosis, suicidal ideation and mania may be antidepressant-induced, resulting from the status of the patient's CYP450 system.

I think it is imperative to use the knowledge about pharmacogenetics that we already have so as to immediately implement the genotyping test before any more psychotropic medication is prescribed. It is not only irresponsible but also unethical to continue prescribing psychotropic medication to service users 'on a section' without knowing the genetic status of their ability to metabolise the drugs they are forced to take.

Even though genotyping is only part of the picture for safe prescription, it is a good start. Genotyping is actually performed as a matter of routine for mental health patients in both Sweden and the USA: it is considered a priority for patient safety and to reduce neuroleptic 'side effects'.[10] The UK's mental health service urgently needs to emulate this much more responsible clinical practice.

While we in the UK await this necessary reform with bated breath, our doctors continue to prescribe, and acute and chronic psychiatric patients who are Poor or Intermediate Metabolisers continue to be medicated. And everyone – doctor and patient, nurse and carer – remains without any informed

understanding of how each individual patient really can or cannot metabolise his or her medication, and why patients so often suffer such terrible consequences. Until the authorities get their act together, it is only informed individuals who are able to buy themselves that genotype testing which is absolutely necessary for the mental health patient's well-being.

In the next issue of *Asylum* magazine Catherine Clarke writes about the politics of psychopharmacogenetics in the UK.

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5: THE SOCIAL CONSEQUENCES?

MORE DRUGGING, LESS RIOTS ?

SURVEILLANCE AND TRANQUILLISATION VS PROTEST

GUY HOLMES

Black man gotta lotta problems
But they don't mind throwing brick
White people go to school
Where they teach you how to be thick …
('White Riot', Strummer/Jones)

In 1977 I struggled to make out Joe Strummer's roughly barked lyrics to the Clash's song, 'White Riot'. But once deciphered the lyrics were not difficult to understand. To a teenager, the Notting Hill Carnival riots of 1976 had seemed astounding, and in subsequent years riots always seemed to be breaking out. St Paul's, Toxteth, Handsworth, Brixton, Broadwater Farm – virtually every major English city had at least one riot, and many had several in the 1980s. Buildings which were symbols of the State or oppressive corporations were attacked and set on fire; police fought battles with the locals which lasted several days and nights. If riots did not happen in your neighbourhood then you got to see them on TV. I remember reading an interview with Duran Duran in the New Musical Express. One of the band looked out of the window, yawned and – as if commenting on the weather – said: "Oh look … it's rioting." At the end of the 1980s we had the Poll Tax riots and the Strangeways Prison riot.

The causes of these riots were obvious, even to the politicians: a racist and oppressive State personified by the police who had legitimised means of harassment, for example the hated 'sus' laws; poverty, unemployment and social deprivation; profoundly unfair public policies; and, in the case of Strangeways, what Lord Woolf called "intolerable" prison conditions. Basically, the poor and disadvantaged were hitting out after years of being treated very badly. Since then, apart from the 1995 Brixton riot (triggered by the death of Wayne Douglas whilst in police custody) and the 2001 'race riots' in Oldham and Bradford, there have been few riots. Moreover, the civil disturbances which have occurred have tended to be characterised by violence between different groups rather than protest, destruction and violence against the representatives and symbols of the State.

Brixton Riot, 1981

Why have there been relatively few riots in 21st century Britain? There are likely to be many interacting factors. I will concentrate on three that relate closely to my work as a clinical psychologist who has an interest both in the social causes of distress and in the history of psychiatry.

1) Tranquillising protest

Histories of psychiatry reveal recurrent themes in its practice, e.g. harm inflicted in the name of help; a clampdown on protest and a refusal to listen to the people supposedly being helped; denigrating and disempowering labels applied to people viewed as deviant; and always the obsessive monitoring, surveillance

and tranquillisation.

Rush's original Tranquillizer, where every movement of the patient was restricted, reveals the true purpose of those psychiatric drugs which initially shared its name and subsequently have been given to so many millions. The British psychiatrist, David Healy, showed that ever since their manufacture in the 1950s 'the Major Tranquillisers' were known to have little effect on psychotic symptoms (e.g. hearing voices and delusions) but were well known to produce indifference – a feeling of 'who cares?' Other types of psychiatric drugs, e.g. 'the Mood Stabilisers' and 'the Antidepressants' have a similar effect.

The Tranquillizer: designed by Benjamin Rush

It can be argued that for some individuals this effect may be 'therapeutic': the person is less concerned by those ideas, feelings or experiences which previously troubled or haunted him. Certainly the medications were viewed as enormously helpful on the understaffed hospital wards, where controlling people's behaviour was the major challenge. And they still are seen in that way.

However it should be disturbing that there is a long history of protesting psychiatric patients being medicinally sedated until they conform or are 'zombified'. For decades this has been known as 'the chemical cosh'. Originally such powerful mind- and mood-altering medications only tended to be used on psychiatric in-patients but during the last 20 years there has been a great increase in their use in prisons, schools and out-patient settings, on people who have never been admitted to a psychiatric unit.

Pharmaceutical companies would like us to believe that needy and previously undiagnosed people are now benefiting from having their mental illnesses treated without requiring hospitalisation. For years we mocked the Russians for medicating their dissidents so brazenly. Yet are we so different? Doesn't it suit the elite to have the bulk of us working ourselves to exhaustion whilst people not willing or able to do this are, by means of tranquillisation, kept quiet and made indifferent to their toxic social and environmental conditions?

The 'Roundhouse', Brynmawr

The rich and powerful are at best disinterested and at worst prejudiced and oppressive to the poor. This attitude, when accompanied by spirit-crushing policies, will induce learned helplessness (a.k.a. depression) in some, and anger and protest in others. The elite have always been concerned about possible protests. In the 19th century, in my Welsh grandmother's town of Brynmawr, the owners of the ironworks quite expected the local population to protest, riot and try to lynch them, as a result of being treated so unfairly and oppressively. So the owners built their own private mini-castle, a bolt-hole to escape to. With 21st century technology, there is no need for a private castle like that: perhaps drugs that induce detachment, indifference and a sense of 'who cares?' do the job just as well.

2) Surveillance and the confinement of all

In 1785, Jeremy Bentham designed the Panopticon, a prison where a small group of people could keep continual watch over all the inmates.

Bentham's Panopticon

The design was to allow an observer to observe (-opticon) all (pan-) the prisoners without their being able to tell whether they were being watched, thereby conveying what one architect called the "sentiment of an invisible omniscience". Bentham himself described the Panopticon as "a new mode of obtaining power of mind over mind, in a quantity hitherto without example".

In the 21st century, whilst the rich and powerful choose from a dizzying array of psychological therapies, the poor and disadvantaged tend to have a different experience. Psychiatric in-patients are used to nurses keeping watch on them from a centralised nurses' station, or if they are 'in the community' having home visits from someone from the Assertive Outreach Team, aimed at 'checking how they are doing'. Survey after survey of both the patients' and the professionals' experience reveals encounters that centre around 'risk assessments', note-keeping and the compulsory sharing of information between different agencies of the State: in short, overt and covert surveillance and monitoring. The similarities between prisons and psychiatric institutions was noted by Goffman, in 1959. Now institutional practices which used to envelop the lives of a small number of people seem to engulf the majority.

Strangeways Prisoners, 1990

A few years ago I heard a radio interview with a man imprisoned for 20 years for a crime he did not commit. Clearly moved by the injustice of the man's story, the interviewer tried to end the interview on a positive note. He asked the man how much he was enjoying his freedom. The ex-prisoner's reply went something like this: "When I go into a shop I notice I am on CCTV. A security guard stands at the exit and monitors me. When I open a bank account, in seconds the clerk gets 'my details' on her computer. My emails are undoubtedly screened, my phone calls give the traces of my movements. Walking down the street I am constantly filmed. Some houses and streets are gated – presumably I cannot enter them without some kind of security clearance. You call it freedom, but to me it doesn't seem very different to the open prisons I lived in during most of my sentence."

All the power's in the hands
Of people rich enough to buy it
While we walk the street
Too chicken to even try it
Everybody's doing, Just what they're told to
Nobody wants, To go to jail!
('White Riot', Strummer/Jones)

3) Public Policy

> *Disobedience, in the eyes of anyone who has read history, is man's original virtue. It is through disobedience that progress has been made, through disobedience and through rebellion.*
> (Oscar Wilde)

The succession of riots in the period 1976–1990 led to significant changes in public policy, e.g. substantial public and private investment in inner city areas; abolition of the SUS laws and greater protection of people's rights in the Police and Criminal Evidence Act; scrapping of the Poll Tax; prison reform and significant investment in the fabric of prison buildings. Whilst people who wish to live in a more equal, liberal, democratic Britain might describe such changes as meagre (and even Gordon Brown described the number of children currently living in poverty in Britain as a "scar that demeans our nation") there may have been public policy changes following these riots that subsequently defused the type of protest that takes the form of a riot.

But the conditions that sparked the riots of twenty years ago appear to be returning: a Government that only pretends to listen to the people whilst ignoring legitimate protest (e.g. 2 million demonstrating against the war in Iraq); an oncoming recession at a time when (even according to the government's own figures) millions already live in poverty; a widening gap between rich and poor; overcrowded prisons described by the Prison Reform Trust as "officially full" and "appalling"; anti-terror legislation that allows more stop-and-search and long-term detention without charge (predominantly of Blacks and Asians); a rise in stereotyping, oppression and violence towards minority groups. It remains to be seen whether this is enough to spark the current generation, more sedated and imprisoned than their predecessors, to have, in Joe Strummer's words, "a riot of my own".

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6: PRACTICAL ADVICE FOR SICKENED PATIENTS

HOW TO WITHDRAW FROM PSYCHIATRIC DRUGS

Peter Lehmann

Peter Lehmann's *Coming off Psychiatric Drugs: Successful Withdrawal from Neuroleptics, Antidepressants, Lithium, Carbamazepine and Tranquilizers* was published in Germany in 1998. Since then several editions have been published, there are English and Greek translations, and more are being prepared. Others have also published books on this topic. Mental health organisations have started to address the problems that patients face when they decide by themselves to come off psychotropic drugs. But often their assigned workers simply let them get on with their sorrows and problems on their own.

Guides for withdrawal

It is probably possible to live a more fulfilling life if you do it without psychotropic drugs which act on your personality. This is why many users and survivors of psychiatry eventually decide to withdraw. However, this often brings them into conflict with those prescribing the drugs. In most cases, those who prescribe the drugs will dismiss patients' decisions to come off as 'unsound'. Consequently they are not willing to provide information on the effects of withdrawal, nor on how to minimise those effects.

Those who have gone through the process of withdrawal and who have contact with others who have done so are aware of many factors that can ease the process. Publications that deal with the subject of self-determined withdrawal from psychiatric drugs are rare, but in the last few years several publications of (ex-)users and survivors of psychiatry, and their supporters, have been published to give advice about lowering the risks involved. Many of their recommendations accord with the experiences reported in Peter Lehmann's book.

As in every area of life, one should be careful of people who offer support, because one can meet charlatans, dogmatists and wannabe-therapists along the way. The decision to seek support for withdrawal does not automatically lead someone out of the psychiatric swamp. It is important to be cautious – about both professionals and the self-help sector.

In order to avoid the animosity of his colleagues, David Richman, a physician from Berkeley, California, published the first guide in 1984. Under the pseudonym 'Dr. Caligari', his booklet, *Dr. Caligari's Psychiatric Drugs*, gave a lot of valuable and responsible tips.

A series of published statements were also available after the conference 'Alternatives to Psychiatry', in 1990 in East Berlin, where Richman's colleague Marc Rufer (from Switzerland) spoke about the options available to doctors and therapists when they support patients who wish to withdraw. Rufer warned listeners about how difficult it is to withdraw despite one's own convictions, due to the doubts and fears of others, and because of the hierarchical relationships in medicine and psychotherapy. He recommended:

> As soon as an expert or a professional (or perhaps just a 'reasonable person') is sitting across from another person who needs and is looking for help, a differential of power and powerlessness automatically develops. One of them makes the decision; the other must listen, accept and follow it, and must also be thankful. The only one who can really help is someone who refuses to accept such a position of power. Because out of this unequal distribution of power, and out of a position of dependence within it, the one seeking help begins to inhabit the role of the patient who is ill. Out of gratitude, respect, fear – or whatever else – he forgets that he can make his own decisions and live independently of this expert.

At the same conference, Anna Ochsenknecht, a Berlin healer, described the natural healing effects of plants, and the possibilities for combining their active substances in order to ward off undesired psychological states and to remain free of harmful psychoactive drugs. In particular, she addressed the effects of valerian, fenugreek seeds, fennel, oats, hops, jasmine blossoms, St. John's wort, kava-kava, lavender blossoms, marjoram, balm mint, orange blossoms, passion flowers, peppermint leaves, yarrow and whitethorn blossoms. She reported:

> I do a lot of work with medicinal herbs. They regulate not only physical but also inner balance. This distinguishes them from chemical drugs which only eliminate or suppress a specific

> symptom without activating the body's self-regulating forces. Thus, they also help to relieve or intercept severe withdrawal symptoms when psychiatric drugs are stopped. It is often the fear of withdrawal symptoms (such as sleep disorder, a racing heart, nausea, sweats, or inner restlessness, among others) that serves as a reason to continue taking the drug that causes illness. It is a fear that is further spurred by many psychiatrists.
>
> It is important to undertake a comprehensive search for possible ways of offering support. Not only to ease symptoms but also to activate regulatory forces and thereby re-establish inner balance. The medicinal power of plants can be utilized in the form of teas, extracts (alcoholic/liquid or ether oils) or appropriate coated tablets. The prescriptions and tea mixtures I propose are meant as an inspiration to try them out, not as a long-term treatment for everyone and not according to the motto 'a lot helps a lot'.

Amongst users, ex-users and survivors of psychiatry, Sylvia Caras from Santa Cruz, California, also wrote about the topic. In 1991 she published a brochure: *Doing without Drugs*, in which she recorded recommendations from people who reported positive experiences with withdrawal.

Two years after the release of *Coming Off Psychiatric Drugs*, the American psychiatrist Peter Breggin and the psychologist David Cohen published their book: *Your Drug May be Your Problem*. This included more good tips. From Canada, *My Self-Management Guide to Psychiatric Medication* was financed by the Quebec Health and Social Ministry and published in 2003. In that book, the valuable and reasonable recommendation to withdraw gradually was preceded by a warning that it would be dangerous to come off without counselling and supervision by experienced medical practitioners.

Financed by the UK's Department of Health, and commissioned by the national organisation MIND, a team of service user/survivor researchers was recruited to investigate coming off psychiatric drugs in England and Wales. The team carried out 204 short telephone interviews and interviewed 46 people in depth, using a topic guide. It was found that doctors could not predict which patients would be able to come off successfully. Two-thirds of those who came off neuroleptics or mood stabilisers did so against their doctor's advice or without telling their doctor. Those who stopped taking psychiatric drugs against their doctor's advice were just as likely to succeed as those who came off with physician agreement (Read, 2005). Following this study, MIND changed its standard advice to patients. Historically, their advice was not to come off psychiatric drugs without first of all consulting a doctor. MIND now advises people to seek information and support from a wide variety of sources (Darton, 2005).

User- or survivor-led research is especially valuable because people can be more open about their experiences of support (Wallcraft, 2007). In this research, the forms of support found most helpful were: from a counsellor, a support group or a complementary therapist, peer support, information from the Internet or from books, and activities such as relaxation, meditation and exercise. Doctors were reported as the least helpful category to those who wanted to reduce or come off psychiatric drugs.

Between the advice to seek competent professional advice or to keep way from doctors and other 'helpers' – who may be misinformed and dependent on (mis-)information from Big Pharma – a balanced view is given in *Harm Reduction Guide: Coming off Psychiatric Drugs* (2007). This is available for free download on the Internet.

Standard advice

People with personal experience of 'coming off' psychiatric drugs, or have supported others in the withdrawal process, have highlighted many factors which alleviate withdrawal problems. These can help to replace psychopharmacological suppression of the so-called illness with more personal control and self-determination.

• Do not rush it

Richman wrote:

> The best way to minimize drug-withdrawal problems is to reduce drug intake gradually. This is especially important if the drug has been taken for more than one or two months. If you have been taking small doses of psychiatric drugs, or have been taking such drugs for a brief time (i.e., a few days or weeks), then you may wish to try discontinuing 'cold turkey,' that is, just stop taking the drug. (Dr. Caligari's, 1984, p. 55)

• Inform yourself about the risks and undesired effects of psychiatric drugs as well as alternative ways of coping with emotional distress. Anticipate the withdrawal effects that may set in, even after weeks

> Withdrawal from psychiatric drugs can be very trying. You should know that withdrawal can cause moderate to severe discomfort and outright misery at times. Being mentally prepared for this decreases the chance that you will become scared or discouraged. Patience and determination are needed. (Dr. Caligari's, pp. 56–57)

• Plan ahead

It may be wise to begin changing your situation or your lifestyle (living arrangements, work, or social contacts) before withdrawing. Consider changing your doctor or psychiatrist if you anticipate that yours may refuse to help support your withdrawal. Switch from injections to tablets or drops that you can dose yourself. Before withdrawing, inform yourself as to the risks of losing your apartment, welfare or other benefits, if any of these are dependent upon your willingness to take psychiatric drugs. Look for the right season for change. Think about how long the process might take. Inform those close to you (and who you trust) about your undertaking.

In 1985 Josef Schöpf from the University Clinic in Lucerne published an article about dependence on benzodiazepines in which he advised that withdrawal should be planned such that disruptive symptoms do not bring unpleasant social consequences. His advice can be applied to withdrawal from other drugs as well: 'The choice of when to withdraw should be made to insure that a temporary lower level of productivity is compatible with the patient's responsibilities' (Schöpf, 1985, p. 591).

• Get advice

Speak with those who have experienced withdrawal. Join a self-help group in which the individuality of each member is respected. Don't heed any sure-fire cures.

• Seek out support

Have healing substances on hand to ease withdrawal. Take preparations that strengthen the organs and promote detoxification. Seek the company of people who understand what withdrawal entails. You may want to seek out doctors or therapists who are willing to forget their psychiatric prejudices and instead have understanding, sympathy and discretion.

• Get legal protection

Contact independent patient spokespersons before you run the risk of being forced back into the psychiatric system. Or protect yourself with a Psychiatric Will or Advanced Statement (Krücke, 2007, and Ziegler, 2007) before you are committed to a hospital (again). (There are some countries where the human right of a psychiatric patient to physical inviolability is respected.)

You should ask yourself: What do I need if I become anxious, depressive, suicidal, manic, or crazy? What will help me in that situation? What should I refuse? What will I accept? What am I risking? Who are the people who will support me?

• Create a quiet environment
Keep away from relatives who cannot be burdened. Avoid stress and aggressive places. Don't exhaust yourself with difficult social relationships. Don't answer the phone if telephoning is associated with stress. Go somewhere peaceful, for example to the seaside or the countryside, a meditation centre, a church or a library.

• Get enough exercise

> Go walking, hiking, jogging, dancing, swimming or cycling, or do gymnastics or aerobics. But, Moderation is a key principle: as you increase your activities, do so gradually. (Dr. Caligari's, 1984, p. 56)

• Get good nutrition
Eat well: regularly, but not excessively. Roughage, wholewheat foods, salad, fresh vegetables, fresh fruits, lots of liquids. Avoid drinks that make you nervous such as black tea and black coffee. Avoid drugs such as alcohol, marijuana, cocaine, and other stimulants.

• Do something good for yourself
Listen to relaxing music, read pleasant literature. Keep in touch with people. Telephone friends or visit them.

• Live with awareness
Keep a diary, write things down.

• Be sure to get enough sleep!
There are many guides on how to combat sleeping problems with naturopath and low-risk measures. Sleep problems often bother users, ex-users and survivors of psychiatry. Psychiatric drugs can actually induce sleeping problems, but drug withdrawal can also affect sleep. When losing the chemical-tampering effect of the drugs, rebound phenomena can occur, including the re-occurrence of sleeping problems. Sometimes these problems can be reduced when you reduce or eliminate troublesome environmental burdens, for example everyday poisons such as dioxin, benzene, formaldehyde, biocides, furan, heavy metals, amalgam, lead or mildew: all these can induce sleeping problems. Also problematic may be electromagnetic fields, malnutrition, day-and-night rhythm disorders, noise, stress, etc.

• Beware of know-it-alls and patent recipes!
No matter how many tips are on your list, remember: there is no patent recipe for excluding problems when coming-off or withdrawing from psychiatric drugs. The uniqueness of each individual, their problems and their possibilities, mitigates against any hope of a generalised approach. The wide variety of factors described by the authors in *Coming off Psychiatric Drugs* as essential for successful withdrawal illustrates the diversity of strategies and needs.

Without a doubt, it is important to keep an eye not only on therapists, doctors, and in particular psychiatrists, but also on all those who are involved in the recent psycho-boom – and particularly those who charge too much for their false claims to cure psychological and social problems.

Psychiatrists have already started to give misleading advice on how to come off their drugs. They like to promote so-called 'atypical neuroleptics' as a less harmful substitute. But they often do not address the dependency effects of psychiatric drugs, such as receptor changes and tolerance in neuroleptics and antidepressants, nor the lowered life expectancy due to drug damage. They concentrate on their own bad experiences and disregard the positive experiences of coming off a psychiatric drug. In his chapter in *Coming Off Psychiatric Drugs*, 'Creating Fear/Removing Fear: When You Wish to Withdraw, the Opinion of Your Doctor is Dangerous', Rufer maintains that doctors and psychiatrists together create a climate of fear and simply do not listen. Psychiatrist Loren Mosher from Soteria Associates addressed this in his preface to the book:

> Do the psychiatrists and other physicians prescribing psychotropic drugs listen carefully to each patient's personal experience with a particular one? The answer to the question varies of course but if you speak a different language, are a member of a minority, are poor, seen as 'very ill' or forcibly incarcerated in a mental hospital, the likelihood of being really listened to falls dramatically – although it is not very high for anyone. (p. 16)

Unfortunately, the self-help sector is not free of people wishing to profit at the cost of those earnestly seeking help. In his contribution in the German edition of *Coming off Psychiatric Drugs*, David Webb from Melbourne, Australia, took a critical look at the dark side of self-help groups, which is, in general, ignored by those involved – often with fatal consequences: "During times of struggle, one of the most annoying things was all those people who believe that what had worked for them could also work for me. The path to peace and freedom is unique for each individual and very personal."

Beyond health, nothing is more valuable than freedom and independence.

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Beside this literature, mailing lists provide advice for people who want to share information about the withdrawal risks and possibilities to do with every kind of psychiatric drug. See: www.peter-lehmann-publishing.com/info/mailinglists.

To contact the author: www.peter-lehmann.de/inter

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