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Responding to the Frightening Reduction of Psychiatric Patients' Life Expectancy

Topics:

1. Mental disorders due to psychotropic substances, behavioural addictions (No. 2)
2. Pharmacotherapy (No. 18)
3. Social discrimination against people with mental illness (No. 39)

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The life expectancy of psychiatric patients with serious psychiatric diagnoses is reduced by two to three decades, on average. Psychiatrists discuss whether this catastrophe is due to the toxic effects of psychiatric drugs or to the "bad life style" of their patients. Why are psychiatric drugs the third leading cause of death after heart disease and cancer? Psychiatrists learn how to administer psychiatric drugs, but not to withdraw them. The needs of psychiatric patients to overcome problems in withdrawal from psychiatric drugs are immense. Mainstream psychiatry often does treat with informed consent and also does not inform patients about early warning signs of drug-related problems that can lead to serious or even deadly conditions, nor about useful physical health monitoring or the meaning of the symptoms which give a hint about serious problems ahead. Critical patients can help develop information sheets about risks and alternatives, as the innovative example in the German Bundesland Rhineland-Palatinate shows. If you assume that people are extremely vulnerable even before treatment, doesn't it then make it even worse to also administer toxic drugs? There is a worldwide need for a user-orientated ethical agreement on the administration of psychiatric drugs and for the full implementation of the United Nation's *Convention on the Rights of Persons with Disabilities* to ensure the existential needs of psychiatric patients.

Speakers (in the order of presentation): Peter Gøtzsche, Salam Gómez, Darby Penney, Peter Lehmann

Contributions

Peter C. Gøtzsche: Why are psychiatric drugs the third leading cause of death after heart disease and cancer?

It is difficult to know how much of the drastically shortened life-span of patients with schizophrenia that is caused by antipsychotics and other psychiatric drugs. Almost all trials are flawed by design because patients in the placebo group are exposed to withdrawal effects, which increase suicides. Trials in dementia might be more reliable, as fewer would be expected to be on antipsychotics beforehand, and a meta-analysis of such trials showed that for every 100 people treated for a few weeks, there was one additional death. More than half of the deaths in psychiatric drug trials are omitted from published trial reports, which make an assessment of the lethality of these drugs very difficult. Based on the most reliable trials and cohort studies I could find, and on data on drug usage, I have estimated that psychiatric drugs are the third major cause of death, after heart disease and cancer. By far most of these deaths are caused by antidepressants, which are immensely overprescribed and which, like virtually all psychiatric drugs, increase the risk of falls and deaths by hip fracture. Many people are in long-term treatment with psychiatric drugs, although this cause more harm than good and increase the risk of

permanent brain damage and drug dependence. There is an urgent need of research into methods of safe withdrawal of psychiatric drugs and of courses for both doctors and patients and helplines for patients who want to come off their drugs. We need to reduce our consumption of psychiatric drugs drastically and focus much more on psychotherapy. This would improve both survival, the chance of recovery, and quality of life for the patients.

Peter C. Gøtzsche, Prof. Dr. Med. Sci., Copenhagen, Denmark, pcg@cochrane.dk

Salam Gómez: Ethical and legal problems in forced administration of toxic drugs world-wide especially to a highly vulnerable group of people

Forced administration of psychiatric medications and electroshock without consent or adequate information is standard practice used on millions of psychiatric patients worldwide, under the guise of protection and care. This is often the only option presented to relatives, caregivers or companions for the care and management of complex situations. These interventions have been disseminated globally, ignoring the humanity of psychiatric patients by positioning them as objects of care and not as people deserving of rights.

Substituted decision-making and the lack of support systems for persons with psychosocial disabilities and their families contribute to the violation of human rights, ranging from isolation to forced medication, to death.

Over the last 20 years, the World Network of Users and Survivors of Psychiatry (WNUSP), a global organization and member of the United Nations Economic and Social Council, has developed important positions regarding forced treatment and other forms of human rights violations affecting users of mental health services / persons with psychosocial disabilities, demonstrating its impact on the social, economic and cultural development of a historically marginalized and excluded population.

Recognition of the rights of persons with psychosocial disabilities requires changing the way psychiatric patients are viewed and understood. It is the ethical and moral responsibility of mental health professionals to prevent and mitigate human rights violations and to ensure a respectful treatment.

This presentation will discuss regional realities, including evidence of the loss of humanity of users of mental health services / persons with psychosocial disabilities. This will include the current conditions and degrading, inhumane and torturous treatments practiced in Latin America, Africa, Europe, Asia Pacific and the USA.

Salam Gómez, Bogotá, Colombia, fundamentalcolombia@gmail.com

Darby Penney: Lack of information about risks and options: Innovative ways to overcome this world-wide ethical problem in psychiatry

While the potentially harmful effects of psychiatric drugs – including a 25-year reduction in life-expectancy – are well-documented, most patients do not receive complete, unbiased information on the risks and benefits of these drugs from prescribers or about non-psychopharmacological approaches, and thus cannot give fully informed consent. Prescribers seem to fear that people may refuse to take the drugs if they know the risks or believe that people will not take them unless forced to do so.

In order to fill this information gap, ex-patient activists – sometimes with the help of critical psychiatrists and other professionals – have compiled resources on the effects of psychiatric drugs and about how to withdraw, since professionals generally do not make this information accessible and often refuse to assist patients in dosage reduction or withdrawal. These resources include a guide by the US-based Icarus Project & The Freedom Center, *Harm Reduction Guide to Coming Off Psychiatric Drugs;* a UK-based website *Coming Off Psychiatric Medications;* a U.S. web-based decision aid offering unbiased information about the risks and

benefits of drugs, as well as non-drug alternatives; and an innovative project in the German federal state Rhineland-Palatinate, in which patient activists and critical psychiatrists worked together to develop fact sheets in plain language about the risks of antidepressants and neuroleptics as well as inpatient alternatives to psychiatric drugs. Members of this panel have published on this topic, included Peter Lehmann's *Coming off Psychiatric Drugs: Successful withdrawal from neuroleptics, antidepressants, lithium, carbamazepine and tranquilizers* (2004), Peter Gøtzsche's *Deadly Psychiatry and Organised Denial* (2015) and Salam Gómez' *Dejando los medicamentos psiquiátricos* (2016, together with Peter Lehmann). While these resources are helpful, it will be important to share them more widely and make them available to patients in all parts of the world.

Darby Penney, MLS, Albany, USA, darby@capital.net

Peter Lehmann: Psychiatric patients' needs to overcome problems withdrawing from psychiatric drugs

Psychotropics, especially neuroleptics and combinations of psychiatric drugs, can have many life-threatening effects (f.e., metabolic syndrome, liver cirrhosis, renal failure, agranulocytosis, asphyxia, suicidality). When there is a decision to withdraw, patients can face serious physical or mental withdrawal syndromes.

In general, patients are not informed about low-risk ways to come off psychiatric drugs. If one does not withdraw slowly enough, one often suffers unpleasant symptoms, which can include heart and circulatory problems, dizziness and deadly circulatory collapse. When serious withdrawal problems arise, the doctor, the patient, and their relatives might believe (and may even be told) that the drugs will need to be taken forever. The cycle of long-term treatment often leads to worsening physical health, worsening economical situation, enhancing stigmatisation and enhancing demoralisation.

With the exceptions of benzodiazepines and illegal substances, institutions helping patients with withdrawal do not exist. Lack of competent support in withdrawal from psychotropics is a risk factor for reduced life expectancy in patients with serious psychiatric diagnoses. Because basic knowledge about risk-lowering ways to withdraw from psychotropics has been developed mostly by patients, it should be required to include their experience when designing facilities to support withdrawal (including inpatient withdrawal). And because drug companies know that dependence is real, but to not warn about this, they and prescribers should be to sued for reckless bodily harm with possible fatal consequences.

Beside the need for facilities to support withdrawal, there is also a need for criminal and civil legal consequences for professionals who treat their patients recklessly. These would be appropriate and powerful measures in response to the frightening reduction of psychiatric patients' life expectancy.

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Peter Lehmann. Born in Calw in the Black Forest. Certified pedagogue. Living in Berlin. Author and editor since 1986, then foundation of Peter Lehmann Publishing and Mail-Order Bookstore. 1989 co-founder of the Association for Protection against Psychiatric Violence (running the Runaway-House Berlin). In 1991, co-founder of the European Network of (ex-) Users and Survivors of Psychiatry, from 1997 to 1999 their Chair, afterwards for years, until 2010, board member for the North-East European region (Estonia, Germany, Latvia, Lithuania, Poland, Russia). From 1997 to 2000, member of the Executive Committee of Mental Health Europe, the European section of the World Federation for Mental Health. In 2010, awarded with an Honorary Doctorate in acknowledgement of "exceptional scientific and humanitarian contribution to the rights of the people with psychiatric experience" by the Aristotle University of Thessaloniki. In 2011, awarded the Order of Merit of the

Federal Republic of Germany by the President of Germany. Since 2013, Patron for the Berlin Organisation of Users and Survivors of Psychiatry and blogger at Robert Whitaker's *Mad in America*.

Publications include, *Coming off Psychiatric Drugs: Successful Withdrawal from Neuroleptics, Antidepressants, Lithium, Carbamazepine and Tranquilizers* (ed. 2004) and *Alternatives beyond Psychiatry* (ed. 2007 together with Peter Stastny). Both books are available also in German and Greek, the latter one as ebook in Spanish. In German: *Neue Antidepressiva, atypische Neuroleptika – Risiken, Placebo-Effekte, Niedrigdosierung und Alternativen. Mit einem Exkurs zur Wiederkehr des Elektroschocks* (2017, together with Volkmar Aderhold, Marc Rufer and Josef Zehentbauer). More at peter-lehmann.de