A SUBMISSION PAPER TO THE SENATE SELECT COMMITTEE ON MENTAL HEALTH RELEASED OCTOBER 2005

FROM:
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ABOUT THE CITIZENS COMMISSION ON HUMAN RIGHTS (CCHR)

The Citizens Commission on Human Rights (CCHR) is the world's leading watchdog dedicated to **investigating and exposing psychiatric violations of human rights**. It is completely **non-profit** in nature and exists **for the public benefit.** It also ensures that criminal acts within the psychiatric industry are reported to the proper authorities and acted upon.

Co-founded in 1969 by the Church of Scientology and **Dr. Thomas Szasz**, Professor Emeritus of Psychiatry at the State University of New York, Syracuse, CCHR now has **134 chapters** in **33 countries** around the world.

CCHR's members include prominent doctors, lawyers, artists, educators, civil and human rights representatives and professionals who see it as their duty to "expose and help abolish any and all physically damaging practices in the field of mental healing." They work to accomplish these clearly stated aims with many like-minded individuals and groups, including politicians, teachers, health professionals, government and law enforcement

At that time of CCHR's founding, the victims of psychiatry were a forgotten minority group, warehoused under sub-standard conditions in institutions around the world. Because of this, CCHR penned a **Mental Health Declaration of Human Rights** that has served as its guide for mental health reform.

Acknowledged by the Special Rapporteur to the United Nations Human Rights Commission as responsible for "many great reforms" that protect people from psychiatric abuse, CCHR has documented thousands of individual cases that demonstrate the failings of many psychiatric practices. Not least of these failings is the use of dangerous and mind-altering drugs on persons of all ages… some as young as one year old.

Since 1969, CCHR's work has helped to save the lives of millions and prevented needless suffering for millions more. Many countries have now mandated informed consent for psychiatric treatment and the right to legal representation, advocacy, recourse and compensation for patients.

This submission is submitted to further the above aims.

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1. FOCUS OF THE SUBMISSION

Whilst the work of CCHR and the scope of this submission covers almost every aspect of the Terms of Reference of the Committee, and bearing in mind every single one has a direct bearing on the most important people in the process, namely those suffering mental health issues and their rights, we will narrow our focus to the four most important being:

a. the extent to which the National Mental Health Strategy, the resources committed to it and the division of responsibility for policy and funding between all levels of government have achieved its aims and objectives, and the barriers to progress;

b. the adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care;

k. the practice of detention and seclusion within mental health facilities and the extent to which it is compatible with human rights instruments, humane treatment and care standards, and proven practice in promoting engagement and minimising treatment refusal and coercion.

f. the special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and co-morbid conditions and drug and alcohol dependence

We have chosen these as our submission will contend that the National Mental Health Strategy has failed and is failing to achieve its aims of “improving the lives of people with a mental illness”, the sheer number of submissions to this committee being evidence of that.

CCHR, along with a growing number of medical experts, also contends that the current model for treating those with mental health issues in Australia is inadequate owing to a reliance on unproven methods which increasingly rely too heavily on the use of powerful and dangerous drugs.

We also contend that anyone detained within a mental health facility in this country may inevitably suffer human rights abuses and inadequate care because of the above model of treatment.

We are very concerned that an over reliance on a model which focuses heavily on the use of drugs in treating those suffering mental health issues is failing to resolve those mental health issues. It is also increasingly evident that the treatments themselves are leading to an increase in the very problems the industry is meant to be tackling, including mental health problems caused by psychotropic drug use and drug abuse.

We are also extremely concerned at the growing rate at which children are being given powerful, toxic and addictive drugs for so called “learning disorders” in this country and that strategies for “early intervention” seem to be leading to an increase in the drugging of children.

More broadly we will demonstrate that the mental health system in Australia is not only failing the very people it is supposed to help and protect but is in fact doing them increasing harm.

2. CLARIFICATION OF TERMS

It is important to recognise whilst reading this submission that it is not our contention that people don't have problems in life or suffer emotional problems and need care. They do. Many people do suffer from severe problems in life, often deeply affecting their lives and crippling them in many ways, causing them and their loved ones great anguish and suffering.

We believe however that it is the care they are receiving whilst undergoing these problems which needs closer examination of methods, principles and outcomes, due to the high number of documented cases of mental, physical and emotional damage caused to people in the mental health system by the treatment they received.

A growing number of medical experts now agree that many of these so called "mental disorders" are simply labels for other conditions affecting the human psyche, including undiagnosed physical and emotional ailments.

We are saying that people suffering from problems in life do need to be helped with their actual problems using proven and workable solutions that do not cause them further harm.

We also contend:

- that far too many people with so called "mental health disorders" are in fact not suffering from mental illness at all but are suffering problems related to or caused by other problems, ranging from undiagnosed underlying medical conditions, severe vitamin/mineral deficiencies, short term traumatic life experiences and drug and alcohol abuse, all of which do not require psychiatric treatment but rather handling of the underlying causes of their problems
- that in many cases the current forms of treatment for many people within the mental health system are not helping them, but making them worse, causing an exacerbation of their symptoms

3. The failure of the National Mental Health Strategy

We contend that the National Mental Health Strategy has clearly failed to achieve its aims and objectives.

The number of submissions to this Committee alone attest to this fact. Most speak of a system in complete crisis.

What they don't recognise is why the system is in crisis.

Our submission goes straight to the core of this problem.

The NMH strategy has not failed because of the lack of intent on the part of governments and government agencies.

It has not failed because of lack of funding. It has not failed because of the lack of goodwill exhibited by many people who work within the system.

And it has not failed because of the enormous efforts of a large number of small, community support and aid groups who struggle to shoulder the burden of a system that has drastically failed the very people who should be able to rely on it.

The strategy has failed because of the ideology which drives the practices and behaviour of the people at the very core of the mental health system.

4. The cause of our failing mental health system

One cannot address any aspect of the mental health system without first directly addressing the very nature of that which is at its core – namely psychiatry.

It is psychiatry and its principles which are used to:
• provide the diagnosis of “mental illness”
• recommend the treatments
• supervise the system
• make recommendations to government on funding and strategies for mental health.

We contend that currently Australia’s mental health system is characterised by:
• inadequate or harmful “care” caused by
• incorrect diagnoses based on psychiatry
• leading to improper treatment, in particular a dramatic over-reliance/emphasis on the use of powerful & dangerous drugs
• which itself is causing a growing incidence of suicide, mental health problems, violence, crime and drug & alcohol abuse
• with resultant growing abuses of fundamental human rights.

Of greatest concern is the growing number of innocent children who are being misdiagnosed with “learning disorders” and then placed on powerful drugs which in some cases are causing psychotic behaviour and even suicide.

“I am sure it would be sensible to restrict as much as possible the work of these gentlemen [psychiatrists], who are capable of doing an immense amount of harm with what may easily degenerate into charlantry.”

Winston Churchill, 1942

5. Inadequacy of care

It is CCHR's contention that any and all problems relating to "the **in**adequacy of various modes of care for people with a mental illness" that can be found in the mental health system are directly attributable to several key aspects of the nature of psychiatry namely:

- the fact that psychiatry itself is a pseudoscience founded on less than scientific principles,

- that psychiatry's system of diagnosis and classification of "mental disorders" is deeply flawed and unscientific
-
- that even psychiatrists themselves freely admit that psychiatry is flawed

- that psychiatry itself admits to being unable to cure anyone of any mental disorder

- that psychiatry has been engaged in a long term strategy of manufacturing "mental illnesses" and promoting an epidemic of depression in order to obtain greater government funding and support which, with the wholehearted support of the pharmaceutical industry, has produced alarming high usage rates of powerful and dangerous drugs.

6. Psychiatry – a pseudoscience at work in Australia's mental health industry.

One of CCHR's primary concerns with psychiatry is its unscientific diagnostic methods.

In conventional medical testing one can state categorically that if tests prove a person has the influenza virus in their body and has the accompanying symptoms of headache, sore throat, runny nose, cough, muscle aches and pains then there is no doubt that person has a widely recognised medical condition called "the flu". A psychiatric "diagnosis" however actually involves no diagnostic tests at all. There are no blood tests, no x-rays, no tests of glandular or any other function of the body, no test for deficiencies of any kind, not even MRI scans nor even any "brain function" tests. A person is simply classified according to their symptoms and then labeled as suffering from a "disease".

John Read, senior lecturer in psychology at Auckland University, New Zealand summarises it perfectly when he states:

"Making lists of behaviours, applying medical-sounding labels to people who engage in them, then using the presence of those behaviours to prove they have the illness in question is scientifically meaningless. It tells us nothing about causes or solutions."

When you understand what causes something, you can cure it or at the very least treat if successfully. However the psychiatric industry itself admits it cannot do that.

As Dr Norman Sartoris, former President of the World Psychiatric Association stated in 1994, "The time when psychiatrists considered that they could cure the mentally ill is gone. In the future, the mentally ill will have to learn to live with their illness."

7. Psychiatry's "bible" – the source of its incorrect diagnoses

When one hears of a person being described as a "schizophrenic" or suffering a "bipolar disorder" one can be deluded into thinking these people have been subjected to independent testing to unequivocally establish they actually have this so called "disease". In fact nothing could be further from the truth.

In fact, take the same patient to several different psychiatrists and you are highly likely to get several different "diagnoses".

In psychiatry diagnosis is done from their own "bible" -– the Diagnostic and Statistical Manual or DSM for short. (Although US in origin, the DSM is used worldwide, including in Australia.)

No document more emphasises and underscores the erratic and unscientific nature of psychiatry than this publication.

Unlike conventional medical reference books which are the culmination of many years of extensive, independent and scientifically proven analysis of diseases, classifications of diseases, the "disorders" listed in the DSM are simply voted into existence by a committee of psychiatrists. A group of symptoms are chosen, they are grouped together and given a label as a "disorder" and then voted on to be included in the book. Once they are in the book, according to psychiatry, they now officially exist.

The list grows longer with each edition of the DSM, leading psychiatry to conclude that an ever increasing number of people are becoming "mentally ill". Its real purpose however is to classify more and more aspects of human behaviour as "mental disorders" in order to get more and more people to fall under their treatment regimes, thereby increasing the demand for more funding to allegedly "help" these people.

The original 1952 edition of the DSM listed only 112 “mental disorders” including “homosexuality”. But in 1968 the manual was revised and the number of “disorders” listed jumped to 163. By 1980 the list had grown to 224 “disorders”, while 3 years later it had leapt again to 253.

In 1994, DSM-IV was released. The number of “disorders” had now jumped to 374. In just seven short years psychiatry had created *more new mental disorders than had existed in the entire first volume of the DSM!*

Occasionally however, disorders are actually taken out of the DSM, but not because new scientific research has brought new insight into them. They are simply voted out for various political or other reasons.

In the 1980s for example “homosexuality” was voted out of existence as a mental disorder by the American Psychiatric Association (APA) membership after the APA was actively picketed by gay activists. The scientific method chosen was 5,854 votes to 3,810.

In 1987 a contentious new disorder called “Paraphilic Rapism” was assigned to anyone who had attempted rape or fantasized about it, and could therefore be excused for committing this horrible act because the person was suffering a “mental disorder”. After considerable public furor, the APA also voted to drop this alleged disorder.

Many women quite rightly objected to the original inclusion of PMS (Pre Menstrual Stress) as a “mental disorder”. However instead of voting it out, the committee simply changed the title of the “disorder” to “Late Luteal Phase Dysphoric Disorder”.

A psychologist attending the hearings for one issue of the DSM was quoted in Time magazine as saying *“The low level of intellectual effort was shocking.*

Diagnoses were developed by majority vote on the level we would use to choose a restaurant. You feel like Italian, I feel like Chinese, so let's go to a cafeteria."

Even well known "disorders" such a schizophrenia were subject to an enormous amount of discussion before originally being listed. But not about the nature of the "disorder" just the name of it. For example the manual said *"Even if it had tried, the Committee could not establish agreement about what this disorder is; it could only agree on what to call it."*

It is no wonder that more and more people in the medical profession are questioning the validity of this book.

"The Diagnostic and Statistical Manual of Mental Disorders is a farce. What it is, is a book that contains thousands of symptoms that have a number to it. When you bill the insurance company, you can't say the word—you've got to say the number. And they have numbers for the most ridiculous things, like arguing with your mother, or peeing in the bed or arguing with your sister."

"I take it as an insult to the field of medicine to allow a manual like that to be shown to anybody who has any respect for the field of medicine."

Lawrence B. Hooper, M.D.

While others question the motives behind the ever-growing list of new "disorders".

"If you stop drinking coffee, you get irritable, get a headache. That doesn't mean you're mentally ill," she said. "Anytime anybody ever suggests a new category should go into this three-pound DSM [Diagnostic and Statistical Manual of Mental Disorders], we should ask if there's a drug company connection."

Paula Caplan, Ph.D

Still others question not only its value but its title.

"The so-called Diagnostic and Statistical Manual of Mental Disorders is really anything but diagnostic or statistical for that matter."

"…[T]here is no objective scientifically valid test which actually documents any physical, biochemical or anatomic abnormality in any mental illness."

Moira Dolan, M.D., medical consultant

As Jeffrey A. Schaler, Ph.D., says, *"The notion of scientific validity, though not an act, is related to fraud. Validity refers to the extent to which something represents or measures what it purports to represent or measure. When diagnostic measures do not represent what they purport to represent, we say that the measures lack validity.... The Diagnostic and Statistical Manual (DSM-IV) published by the American Psychiatric Association…is notorious for low scientific validity."*

Professor Stuart A Kirk is a professor of social welfare at UCLA and the co-author the book, "The selling of DSM". In a recent article he wrote.
"The current psychiatric bible published by the American Psychiatric Assn (APA)., "The Diagnostic and Statistical Manual of Mental Disorders," or the DSM, continues [a] tradition of making us all crazy.

Because there are no biological tests, markers or known causes for most mental illnesses, who is counted as ill depends almost entirely on frequently changing checklists of behaviors that the DSM considers as symptoms of mental disorder. In the recent research, lay interviewers asked a sample of people to respond to lengthy questionnaires based on the DSM lists. Computer programs then counted the responses to determine if those interviewed had ever had the required number of behaviors for any mental disorder at some time in their life.

We keep getting higher estimates of mental disorders in part because the APA keeps adding new disorders and more behaviors to the manual.

Since 1979 some of the new disorders and categories that have been added include panic disorder, generalized anxiety disorder, post-traumatic stress disorder, social phobia, borderline personality disorder, gender identity disorder, tobacco dependence disorder, eating disorders, conduct disorder, oppositional defiant disorder, identity disorder, acute stress disorder, sleep disorders, nightmare disorder, rumination disorder, inhibited sexual desire disorders, premature ejaculation disorder, male erectile disorder and female sexual arousal disorder. If you don't see yourself on that list, don't fret, more are in the works for the next edition of the DSM.

Because so little is known about the causes of most mental disorders, just about any behavior can look like a symptom. Here is a selection from hundreds of behaviors listed in the DSM, behaviors that signify one disorder or another: restlessness, irritability, sleeping too much or too little, eating too much or too little, difficulty concentrating, fear of social situations, feeling morose, indecisiveness, impulsivity, self-dramatization, being inappropriately sexually seductive or provocative, requiring excessive admiration, having a sense of entitlement, lacking empathy, fear of being criticized in public, feeling personally inept, fear of rejection or disapproval, difficulty expressing disagreement, being excessively devoted to work and productivity, and being preoccupied with details, rules and lists.

For children, signs of disorder occur when they are deceitful, break rules, can't sit still or wait in lines, have trouble with math, don't pay attention to details, don't listen, don't like to do homework or lose their school assignments or pencils, or speak out of turn."

8. The myth of “chemical imbalance” in the brain.

The most recent demonstration of questionable science being used by psychiatry is the “chemical imbalance” of the brain theory which has gained considerable currency of late. This theory has been the key factor in the dramatic **342% rise** in the use of antidepressants in Australia between 1990 and 2000. (Good Weekend, June 25, 2005).

Despite the “chemical imbalance of the brain” theory being constantly referred to by the media, government agencies and mental health lobby groups as if it were unarguable scientific fact, renowned medical experts around the world debunk it as little more than “drug company propaganda” created solely to sell powerful drugs to an unsuspecting public.

Probably the most dramatic indictment of this theory comes from none other than the president of the American Psychiatric Association, Steven Sharfstein who admitted in a 2005 PEOPLE magazine interview that there is no way to test for a "chemical imbalance" as the cause for mental disorders. The magazine quoted Dr. Sharfstein as conceding, "*We do not have a clean-cut lab test...”*

Later on CBS TV Dr. Mark Graff, Chair of the Committee of Public Affairs for the American Psychiatric Association (APA), was asked why the APA's president did a 180 degree turn on the existence of a "chemical imbalance" stating that, actually, there are no tests to substantiate this.

Dr. Graff was even more inarticulate and blunt, stating: *“Chemical imbalance…it’s a shorthand term really, it’s probably drug industry derived...We don’t have tests because to do it, you’d probably have to take a chunk of brain out of someone – not a good idea,”* but *“I agree. There aren’t any blood tests”* to determine any mental disorder.

Elliot Valenstein, Ph.D. also says it very compellingly when he states, *"[T]here are no tests available for assessing the chemical status of a living person's brain."*

Ron Leifer, MD agrees. *"There's no biological imbalance. When people come to me and they say, 'I have a biochemical imbalance,' I say, 'Show me your lab tests.' There are no lab tests. So what's the biochemical imbalance?"*

Joseph Glenmullen of Harvard Medical School explains the deficiency of the "brain imbalance" theory by comparing it to a known disease such as diabetes, of which he says *"the definitive test and biochemical imbalance is a high blood sugar balance level. Treatment in severe cases is insulin injections, which restore sugar balance. The symptoms clear and the retest shows the blood sugar level is normal. Nothing like a sodium imbalance or blood sugar imbalance exists for depression or any other psychiatric disorder."*

Edward Drummond, M.D. Associate Medical Director at Seacoast Mental Health Center in Portsmouth, New Hampshire further reinforces this view by saying *"First, no biological etiology [cause] has been proven for any psychiatric disorder... in spite of decades of research. So don't accept the myth that we can make an accurate diagnosis... Neither should you believe that your problems are due solely to a "chemical imbalance."*

While Beverly Eakman, the author of Cloning of the American Mind says *"No one knows, for example, how much serotonin (the chemical associated with depression) is normal, or how much is too much or not enough."*

Ty C. Colbert, Ph.D sums it up by saying: *"We know that the chemical imbalance model for mental illness has never been scientifically proven. We also know that all reasonable evidence points instead to the disabling model of psychiatric drug action. Furthermore, we also know that the research on drug*

effectiveness/efficacy are unreliable because drug tests only measure efficacy based on symptom reduction, not cure."

"Diagnosing someone as schizophrenic may appear scientific on the surface, especially when biopsychiatry keeps claiming that a genetic brain disease is involved. But when you step back and observe from a distance what these researchers are really doing, you wonder how they can justify their work….This is not science. This is simply the mathematical manipulation of meaningless data."

The “chemical imbalance in the brain” theory is unfortunately the result of a rampant drug industry, all too willing to exploit the commercial opportunities provided by the misdiagnoses offered up by psychiatry.

9. Psychiatrists and doctors are speaking out against psychiatry

The growing clamour of concern over the psychiatric profession does not only come from groups like CCHR. The clamour also comes from within its own ranks.

"In recent decades we have had no shortage of alleged biochemical imbalances for psychiatric conditions. Diligent [hardworking] though these attempts have been, not one has been proven. Quite the contrary. In every instance where such an imbalance was thought to have been found, it was later proven false."

Joseph Glenmullen, M.D., Harvard psychiatrist

"And if you read about the history of psychiatric treatment what becomes very apparent is that unlike most of the rest of medicine where there was at least some scientific rationale…in psychiatry, even to this very day whatever you decide you want to do to somebody, if you call it a treatment, you can do just about anything you want to."

"Whatever was done to make this person more manageable would be simply called a treatment. And then it would all get defined within the medical framework. And the sad reality is that many of these so-called treatments were in essence torture…."

"Now people who promote the medical model in psychiatry, which is the vast majority of the field, love to proclaim that they are medical but it's basically a fond hope of psychiatry. Something they'd love to have turn out to be true but despite they're best efforts, it's not turning out to be true."

Lee Coleman, psychiatrist

"If we just stop here and we step outside the biological brain disease model and we look at the actual facts and the actual data, there are no facts and data supporting the brain disease model and there's no facts and data supporting many treatments and many things that psychiatrists claim."

Colin Andrew Ross, M.D., psychiatrist and author

"There is no blood or other biological test to ascertain the presence or absence of a mental illness, as there is for most bodily diseases."

Thomas Szasz, M.D., Professor of Psychiatry Emeritus
SUNY Health Science Center in Syracuse

10. Who's really ill in the mental health system?

One could be forgiven for assuming that the only people with problems in Australia's mental health system are the patients.

However the real problem in the mental health system is with psychiatry itself.

In 1993, The Daily Telegraph Mirror reported in a story "Doctors bill Medicare for Sex" that an alarming *"10% of patients who undergo psychotherapy are sexually exploited".*

In the US, the American Journal of Psychiatry reported "Of 1,423 psychiatrists responding to a national survey, 65% reported treating patients who had been sexually involved with previous therapists. Respondents saw these prior involvements as harmful in 87% of cases, but reported the sexual abuse in only 8% of cases." This raises some serious question marks over the professional ethics of psychiatrists.

In 1997, Psychology Today Magazine reported that psychiatrists commit suicide at twice the rate of those expected of physicians. Another report in the same year said psychiatrists also top the list of medical doctors most likely to get a divorce.

Other studies show that psychiatrists have drug addiction rates significantly higher than the general population or other equally stressed out medical professionals.

One might be forgiven for wondering why this is so. The answer lies in another survey of 531 psychiatrists which revealed that 1 in 4 had chosen the field of psychiatry *because of their own psychiatric problems or treatments.*

Another insight is to be found in a 1986 report in the *New England Journal of Medicine* which shows that psychiatrists are so obsessed with using mind-

altering drugs that “nearly half the psychiatrists were currently taking self-prescribed psychotropic medication themselves” and that “psychiatrist had much higher rates for all types of [psychoactive drugs] use at any time (83 percent)... than did other groups of physicians.”

11. The manufacture of madness

One of the most overlooked aspects of psychiatry is the fact that despite the increased funding for mental health in this country, by all reports, the incidence of "mental illness" is growing.

This would seem to indicate that the more money the government puts into mental health funding, the more "mental illness" you get.

Which is exactly true.

If any other government funding programs showed such an appalling return on investment there would be a national public outcry. Yet the lobbiers in the mental health industry cry for even more.

Why this factor works is simple.

Once upon a time, if a person experienced a short term trauma in their life, such as the death of loved one, the loss of their job, a marriage break up or so forth, generally it would be agreed they would be feeling down, depressed, sad or angry. The "treatment" would be for friends and family to rally around them in support and let time take its healing effect. They would recover without any treatment.

Now, with a growing awareness of "depression", people who are feeling down are being funneled into psychiatric treatments.

Instead of person just feeling depressed, they are labeled as having "depression". They now believe they have a disease. It all sounds so scientific because psychiatry told them to believe it. They get some falsities about their "brain chemical imbalance" and next thing they are told they need to take an anti-depressant. They start taking the drug and the feelings don't improve. (This is

because many of the symptoms of “mental illness” are in fact the known and published side effects of the drugs they are taking – nervousness, anxiety, even thoughts of suicide.)

Months later they tell their psychiatrist they still feel depressed. The treatment is recommended to be continued.

Years later, a person who simply had something bad happen to them in life, is now a long term patient of the mental health industry. They have been labeled as suffering from a “mental illness” when in fact what they were suffering from was a traumatic life event. A very real event, but not something that needs classifying as a “mental illness”.

"Unhappiness is a problem; it is not a disease. Low self-esteem also is not a disease. Eating too much is not a disease, and neither is eating too little. And, despite a huge lobby to the contrary, drinking too much alcohol is not a disease either...the psychological establishment has defined virtually all less-than-desirable behaviors, from hatred of first grade to serial rape, as psychological diseases, and represents itself as uniquely able to provide the necessary 'therapies' for them."

"There are a great many ways to do science badly, and the junk science that makes up the bulk of the body of 'knowledge' of clinical psychology manages to exemplify every one of them….Our legal system has been told that clinical psychology is a scientific discipline, that its theories and methodology are those of a mature science, and our legal system has believed it. Given the deplorable state of the 'science' of clinical psychology, that is truly unbelievable."

Margaret Hagen, Ph.D.

"It is well established that the drugs used to treat a mental disorder, for example, may induce long-lasting biochemical and even structural changes [including in the brain], which in the past were claimed to be the cause of the disorder, but may actually be an effect of the treatment."

Elliot S. Valenstein, Ph.D., author of *Blaming the Brain: The Truth About Drugs and Mental Health*

12. The dangers of psychiatric drugs

In institutions, psychiatry has long relied on various forms of restraint and sedation to keep patients quiet and manageable. “Chemical straitjackets” are what psychiatry used to called them.

Since then, drugs have been at the forefront as psychiatry’s main tool of choice in “treating” their patients.

Never have the effects of these drugs on people been more frightening.

One study from the US National Health Survey tracked this trend saying that of patients visits to psychiatrists offices “one or more medications were ordered or provided in only on quarter of visits in 1975 –76” but by 1985 this figure had risen to “almost half.”

These days, send a person to a psychiatrist and they are more than likely to be given drugs as part of their “treatment”. If the person mentions feeling down and the discussion may turn to anti-depressants before you know it. This is why the “depression” lobby groups may publicly state they don’t only promote drug treatment, but when the patient presents at the psychiatrist’s office, often drugs are what they’re going to be given, particularly if they tell the psychiatrist that they may be suffering from “depression.”

So concerned are governments in the Western World that the UK Government and European Union recently warned against the use of all anti-depressant medication on children under 18, with only one exception.

In the US, the FDA has ordered a "black box" label be added to antidepressant packaging, warning doctors and parents that the drugs could cause suicide in under 18 year olds.

A new study by Norwegian scientists on the antidepressant Paxil has found that it increases the risk of suicide in adults *7 times greater* than if the patient had taken a placebo (sugar pill). The new statistics reported in the British Medical Journal are based on 16 clinical trials presented to the world's leading drug regulatory agencies since 1989.

"…the thing that we find most often, is that these (antidepressants) are not discussed with the patient. And the patient is out there in a quandary, not knowing what to do. Therefore, they keep taking the drug. Some of these drugs, of course, cause suicide. And that's a big issue. And I don't think that that's stamped enough on the minds of the individuals who start taking these so-called SSRIs [Selective Serotonin Reuptake Inhibitors]."

Lawrence B. Hooper, M.D.

13. The drugging of children – psychiatry's greatest crime

Of all the victims who are falling under the ever widening net of increased psychiatric labeling and drugging, the most innocent of all are the children.

They are being increasingly labeled with disorders like ADD and ADHD and given drugs so powerful and addictive they are listed as Schedule 8 drugs in State government regulations, putting them on the same level as cocaine.

These children are being labeled and drugged because some "experts" consider the following behaviours in children to be signs of a "mental disorder":

• deceitful
• breaks rules
• can't sit still or wait in lines
• has trouble doing maths
• don't pay attention to details
• don't like to do homework
or speaks out of turn.

To any average person these would be the common behaviours of any normal child at various times. But to these "experts" they are all signs of a far more sinister condition.

Psychiatry is turning normal childhood behaviour into a disease.

Whether or not the child may be having some behavioural problems or need some help with their maths or their homework, the solution is most definitely not to be drugging them with powerful highly addictive drugs.

"How can millions of children be taking a drug that is pharmacologically very similar to another drug, cocaine, that is not only considered dangerous and

addictive, but whose buying, selling, and using are also considered a criminal act?"

Richard DeGrandpre, Ph.D., author

"It's a crime to drug children when there's no true reason for it. They have nothing wrong with them. They don't have to be drugged. And the drugging, of course, leads to a drugged society. We are supposed to be saying, 'No—Just say no.' And yet, in the schools these kids must say, 'yes.'"

"There must be something wrong with an education system that requires so many children to be drugged just to attend school. You cannot reform education without first divorcing it from behavioral psychology."

Samuel Blumenfeld, Ph.D., educator and author

A recent report in the Herald Sun, quoted the Statistics of Drug Use in Australia showed that an alarming 10.2% of children aged 12-15 took illicit drugs in 2004.

We already know that drug and alcohol abuse can lead to people developing “mental illnesses”.

How can we be telling our kids not to be taking drugs on one hand, then on the other giving them drugs to control their behaviour?

14. ADD/ADHD – another psychiatric misdiagnosis

What is most frightening about ADD/ADHD is that in fact the "disorder" exists only in the minds of those practising psychiatry.

As Dr. Joe Kosterich, Federal Chairman of the General Practitioners' branch of the Australian Medical Association, said, *"The diagnosis of ADD is entirely subjective....There is no test. It is just down to interpretation. Maybe a child blurts out in class or doesn't sit still. The lines between an ADD sufferer and a healthy exuberant kid can be very blurred."*

In March 1998, James Swanson of the U.S. National Institute for Mental Health, and one of the foremost proponents of ADHD as a disease, addressed a meeting of the American Society of Adolescent Psychiatry, admitting: *"I would like to have an objective diagnosis for the disorder [ADHD]. Right now psychiatric diagnosis is completely subjective....We would like to have biological tests—a dream of psychiatry for many years."* Simply put, a child is mentally ill with ADHD if a psychiatrist *thinks* he/she is, or is of that opinion.

For all of the publicity surrounding ADD/ADHD one would think this "disorder" was discovered through a long, comprehensive and independent research project in which thousands of children were tested and assessed by rigorous scientific methods.

Nothing could be further from the truth. Like other "mental disorders", ADHD came into existence through literally a vote by a show of hands at an American Psychiatric Association (APA) Committee meeting in 1987. Inserted into the American Psychiatric Association's billing bible, the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), within one year, 500,000 American children were diagnosed as ADHD sufferers. Despite the total lack of objective proof of its existence, millions of children have been needlessly drugged because of the use of this "diagnosis".

Even if some of the behaviours described in the ADD/ADHD propaganda were true, the real cause of them may not have anything to do with a “mental disorder” at all.

"A wide variety of complaints, including over-activity, fatigue, bed-wetting, inappropriate behavior, and even epilepsy, in some children, may be due to allergies. Allergic infants can be so hyperactive that they rock their cribs about the room or bounce them off the walls and begin to walk earlier than normal. By isolating and correcting this, the child can be helped so that there are no symptoms and no need for drugs."

Doris J. Rapp, M.D., environmental medical specialist and pediatric allergist

"Psychiatry has yet to validate a single psychiatric condition/diagnosis as an abnormality/disease, or as anything 'neurological,' 'biological,' 'chemically-imbalanced' or 'genetic.'"

"The fundamental flaw...is that Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) have never been proven to be a disease, or anything physical or biological."

"The invention of diseases satisfied medical-economic needs. Additional income for growing numbers of psychologists and psychiatrists is generated.... Presently, child psychiatrists, psychologists, counselors and special educators in and around the U.S. public schools nearly outnumber teachers...."

Fred Baughman, M.D., pediatric neurologist, Fellow of the American Academy of Neurology, and author of the upcoming book *The ADHD Fraud—How Psychiatry Makes "Patients" of Normal Children*

"If there is no valid test for ADHD, no data proving ADHD is a brain dysfunction, no long-term studies of the drugs' effects, and if the drugs do not improve academic performance or social skills and [they] can cause compulsive and mood disorders and can lead to illicit drug use, why in the world are millions of children, teenagers and adults…being labeled with ADHD and prescribed these drugs?"

Mary Ann Block, D.O., osteopathic physician and top-selling author of books including *No More ADHD*

According to Beverly Eakman, author of *Cloning of the American Mind*, *"These drugs make children more manageable, not necessarily better. ADHD is a phenomenon, not a 'brain disease.' Because the diagnosis of ADHD is fraudulent, it doesn't matter whether a drug 'works.' Children are being forced to take a drug that is stronger than cocaine for a disease that is yet to be proven."*

Even more remarkable is the fact that in his book, *Ritalin Nation*, Richard DeGrandpre, Ph.D., states, *"One study, reported in the journal Pediatrics, found that 80% of the children thought to be hyperactive, according to home and school reports, showed 'exemplary behavior and no sign of hyperactivity in the office.' This finding is consistent with numerous studies showing, and dozens of newspaper articles reporting, considerable disagreement among parents, teachers, and clinicians about who qualifies for a diagnosis. This can only raise questions about the existence of ADD as a real medical phenomenon since it is these symptoms alone that are the basis of the diagnosis."*

In other words, when examined in a physician's office, the children showed no actual symptoms of the "disorder" despite others claiming they had it.

"When psychiatrists label a child or [adult], they're labeling people because of symptoms. They do not have any pathological diagnosis; they do not have any laboratory diagnosis; they cannot show any differentiation that would back up the diagnosis of these psychiatric 'diseases.' Whereas if you have a heart attack, you

can find the lesion; if you have diabetes, your blood sugar is very high; if you have arthritis it will show on the X-ray. In psychiatry, it's just crystal-balling, fortune-telling; it's totally unscientific."

Julian Whitaker, M.D.

"... children should not be medicated by expensive, ineffective, and dangerous medications based on vague and dubious diagnoses."

"Mental health diagnoses are 'subjective' and 'social constructions' as admitted by the authors of the diagnostic manuals themselves."

Karen Effrem, M.D., pediatrician,

15. Growing voices against the drugging of children

What is most disturbing for Australian children is that we are following the American model, where in the 1990s US federal government incentives helped increase the number of children diagnosed with “ADHD": Low-income parents whose children were diagnosed with “ADHD” were given more than $450 a month. In 1991, U.S. federal education grants also provided schools with $400 in annual grant money for each child diagnosed with “ADHD.” The number of children diagnosed with this “disorder” soared again. By 1997, the number of children labeled as having “ADHD” had risen alarmingly to 4.4 million. Today, the figure is closer to six million.

It’s a similar story with the growing use of anti-depressants on children. A growth that some governments are starting to take action against.

In the UK, health authorities, alarmed at the growing rate of suicide among children recently took the step of recommending against the use of all anti-depressants, except for one, on children under 18.

In the US, the FDA has issued strong warnings against all anti-depressants, including those for children.

And just recently in Europe, The European Commission confirmed the recommendation of the Europe’s Committee for Medicinal Products for Human Use (CHMP) has just issued the strongest warnings against child antidepressant use to date following a review of clinical trials that showed the drugs cause “suicidal behavior, including suicide attempts and suicidal ideation and/or related behavior like self-harm, hostility (predominantly aggression, oppositional behavior and anger) and mood lability [instability] in children and adolescents.” Due to the drugs dangerous side effects, the agency said they should not be prescribed to any under 18-year-old.

And in a landmark report just released, the United Nations Committee on the Rights of the Child, the world's premier children's rights body, has issued a strong warning against falsely labeling youth with the psychiatric diagnosis of "Attention Deficit Hyperactivity Disorder (ADHD)" and administering powerful ADHD-drugs.

In its Concluding Observations on reports by Australia, Finland and Denmark regarding their compliance to the U.N. Convention on the Rights of the Child, the Committee expressed concern that "[ADHD] and Attention Deficit Disorder (ADD) are being misdiagnosed and therefore psycho-stimulant drugs are being overprescribed, despite growing evidence of the harmful effects of these drugs."

The Committee urges that "other forms of management and treatment" be used to address difficult behavior in children.

With an estimated 17 million children being prescribed mind-altering drugs, the United Nations is the latest organisation to join governments to alert the public to the damage they can do to young people. Prompted by reports of harm -- including deaths -- attributed to the drugs, agencies have been reviewing clinical reports that confirm the side effects to include hallucinations, hostility, agitation, aggression, suicidal tendencies and violent behavior.

On September 29, the U.S. Food and Drug Administration ordered that "black box" warnings be placed on a commonly prescribed ADHD drug, after clinical trials linked the drug to suicidal thoughts and behavior. The FDA indicated that the new warning stems from an ongoing review of <u>all</u> ADHD drugs and their possible association with suicide.

A day before the FDA's ruling, the British National Health Service's Institute for Health and Clinical Excellence (NICE) issued guidelines for doctors on non-psychiatric remedies for children, including regular sleep, exercise and

nutrition. NICE issued the guidelines following a June 2003 British Medical advisory warning doctors that anti-depressants can pose suicidal risks for young people.

16. Conclusion and Recommendations.

Our conclusion is simple.

The National Mental Healthy Strategy will continue to fail as long as it is controlled by the psychiatry lobby, whose self serving aims intend only to increasingly label more and more people as suffering “depression” and other “mental disorders”, in order to obtain more government funding to support their flawed theories and harmful practices which in turn lead only to more mental health problems, especially with such a heavy reliance of drug based treatments.

We respectfully urge the Committee to implement the following recommendations immediately.

1. To follow the lead of other governments in protecting innocent children, by immediately banning the use of all anti-depressants on children under the age of 18 and to also prohibit the use of any other psychiatric medications on children.

2. To immediately increase the warnings on all anti-depressant medication to a size and style in conformity with the “black box” warnings instituted by the FDA in America for adults.

3. To put an immediate freeze on any increase in funding to the mental health industry until it agrees to independent testing to clearly demonstrate that any of its treatments or methods are a solution to mental health problems and actually cause the number of mentally ill to fall.

4. To immediately implement procedures to ensure that any patient presenting to a medical or psychiatric facility with any symptoms of any alleged mental illness be first subject to a thorough and complete non-psychiatric medical examination including tests for any underlying medical condition, illness, injury or defect which could be producing the symptoms described.

5. To ensure that all psychiatric institutions or centres provide patients with a safe and caring environment in which they can rest and recover whilst obtaining proper nutrition and being treated for any underlying medical or dietary disorders.

6. To immediately implement the following charter of human rights to protect the rights of all those who may fall within the treatment of the mental health industry in Australia

The Mental Health Declaration of Human Rights

All great organizations set forth codes by which they align their purposes and activities. The Mental Health Declaration of Human Rights articulates the guiding principles of CCHR and the standards against which human rights violations by psychiatry are relentlessly investigated and exposed.

A. No person shall be given psychiatric or psychological treatment against his or her will.

B. No person, man, woman or child, may be denied his or her personal liberty by reason of mental illness, so-called, without a fair jury trial by laymen and with proper legal representation.

C. No person shall be admitted to or held in a psychiatric institution, hospital or facility because of their religious, political or cultural beliefs and practices.

D. Any patient has:

1. The right to be treated with dignity as a human being;

2. The right to hospital amenities without distinction as to race, color, sex, language, religion, political opinion, social origin or status by right of birth or property.

3. The right to have a thorough, physical and clinical examination by a competent registered general practitioner of one's choice, to ensure that one's mental condition is not caused by any undetected and untreated physical illness, injury or defect, and the right to seek a second medical opinion of one's choice.

4. The right to fully equipped medical facilities and appropriately trained medical staff in hospitals, so that competent physical, clinical examinations can be performed.

5. The right to choose the kind or type of therapy to be employed, and the right to discuss this with a general practitioner, healer or minister of one's choice.

6. The right to have all the side effects of any offered treatment made clear and understandable to the patient, in written form and in the patient's native language.

7. The right to accept or refuse treatment but in particular, the right to refuse sterilization, electroshock treatment, insulin shock, lobotomy (or any other psychosurgical brain operation), aversion therapy, narcotherapy, deep sleep therapy and any drugs producing unwanted side effects.

8. The right to make official complaints, without reprisal, to an independent board which is composed of non-psychiatric personnel, lawyers and lay people. Complaints may encompass any torturous, cruel, inhuman or degrading treatment or punishment received while under psychiatric care.

9. The right to have private counsel with a legal advisor and to take legal action.

10. The right to discharge oneself at any time and to be discharged without restriction, having committed no offense.

11. The right to manage one's own property and affairs with a legal advisor, if necessary, or if deemed incompetent by a court of law, to have a State appointed executor to manage such until one is adjudicated competent. Such executor is accountable to the patient's next of kin, or legal advisor or guardian.

12. The right to see and possess one's hospital records and to take legal action with regard to any false information contained therein which may be damaging to one's reputation.

13. The right to take criminal action, with the full assistance of law enforcement agents, against any psychiatrist, psychologist or hospital staff for any abuse, false imprisonment, assault from treatment, sexual abuse or rape, or any violation of mental health or other law. And the right to a mental health law that does not indemnify or modify the penalties for criminal, abusive or negligent treatment of patients committed by any psychiatrist, psychologist or hospital staff.

14. The right to sue psychiatrists, their associations and colleges, the institution, or staff for unlawful detention, false reports, or damaging treatment.
15. The right to work or to refuse to work, and the right to receive just compensation on a pay-scale comparable to union or state/national wages for similar work, for any work performed while hospitalized.
16. The right to education or training so as to enable one to better earn a living when discharged, the right of choice over what kind of education or training is received.
17. The right to receive visitors and a minister of one's own faith.
18. The right to make and receive telephone calls and the right to privacy with regard to all personal correspondence to and from anyone.
19. The right to freely associate or not with any group or person in a psychiatric institution, hospital or facility.
20. The right to a safe environment without having in the environment, persons placed there for criminal reasons.
21. The right to be with others of one's own age group.
22. The right to wear personal clothing, to have personal effects and to have a secure place in which to keep them.
23. The right to daily physical exercise in the open.
24. The right to a proper diet and nutrition and to three meals a day.
25. The right to hygienic conditions and non-overcrowded facilities, and to sufficient, undisturbed leisure and rest.

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