

Treatment Alternatives to Psychiatric Drugs for Patients, with Particular Reference to Lower and Middle Income Countries¹

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Psychiatric drugs (also known as psychotropic medications) are prescribed by psychiatrists and general practitioners to almost everyone with a psychiatric diagnosis. The effects of such drugs are associated with significantly reduced quality of life and life expectancy. Drug lists—such as the *British National Formulary*, the Latin American *Vademecum*, the US-American *Physicians' Desk Reference*, the German *Rote Liste*, the French *Vidal*, and the African *Dictionnaire Therapeutique*—cite more or less identical risks and adverse effects for all doses of psychiatric drugs, including antidepressants, mood stabilisers, psychostimulants, and tranquilizers. The United Nations' Sustainable Development Goal 3 (SDG3) of the 2030 Agenda for Sustainable Development² requires states to improve citizens' well-being. However, the perpetuation of discrimination against psychiatric patients and persons in severe emotional distress through the compulsory administration of psychotropic drugs will inhibit attempts to meet it. Accordingly, this chapter will suggest alternatives to psycho-pharmacological psychiatry, and will argue that education about the risks of psychiatric drugs and problems associated with withdrawal, as well as physical health monitoring, can reduce mortality in psychiatric patients, and enhance well-being. Supporting the self-help efforts of people in severe emotional distress and collaborating with dedicated family members, community members, and professionals in the development of humanistically-oriented support systems should be strategies of first choice for all countries in their approaches to SDG3, including lower and middle income countries (LMICs). Such strategies will safeguard psychiatric patients' civil rights simultaneously.

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² United Nations (2016), *Sustainable Development Goals. Goal 3: Ensure healthy lives and promote well-being for all at all ages*. [online] Available at: <http://www.un.org/sustainabledevelopment/health/> [Accessed 15 Aug. 2016].

Reduced life expectancy and life quality in psychiatric patients

Following the adoption of the SDGs in 2015, countries all over the world have been asked to mobilise efforts to ensure healthy lives and promote well-being for all people at all ages, in accordance with SDG3. SDG target 3.4 requires states, “[by] 2030, [to] reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.” It is a pity that psychiatric problems are not specifically mentioned, as many studies in recent years have shown that psychiatric patients’ life expectancy is reduced by, on average, two to three decades, compared to the general population. Since the 1980s, that mortality rate has continued to grow.³

Reduced life expectancy

The reduced life expectancy of persons with serious psychiatric diagnoses (such as schizophrenia, bipolar disorder, major depression, and personality disorder) is a vital issue to address. In particular, people diagnosed with (and treated) for schizophrenia die in Europe on average twenty-two years earlier than others, and in the USA, on average, thirty years earlier. SDG3 applies to “all at all ages”, and naturally that includes psychiatric patients in all countries, and people of all income levels.

Some psychiatrists and major pharmaceutical companies deny that the effects of psychotropic drugs are a significant factor in reduced life expectancy.⁴ They point to patients’ often precarious economic situations and the health effects associated with poor diet, lack of physical exercise, use of street drugs, alcohol and increased smoking habits.

Yet the unwanted effects of potentially toxic psychiatric drugs are one of the main reasons for patients’ reduced life expectancy, and further, the effects of psychiatric drugs may exacerbate already poor health conditions. Medical researchers have reached different conclusions with regard to the high mortality rate of psychiatric patients. Some studies identify the vulnerability of patients as a factor, and some research has focused on the negative effects of neuroleptics, antidepressants and mood stabilisers on pre-existing cardiovascular disease, combined with inadequate medical attention and access to it. In 2006, the Chair of the Medical Directors Council of the American National Association of State Mental Health Program, Joe Parks, warned:

“It has been known for several years that persons with serious mental illness die younger than the general population. However, recent evidence reveals that the rate of serious morbidity

³ See, e.g., Saha, S., Chant, D. & McGrath, J. (2007), A systematic review of mortality in schizophrenia: Is the differential mortality gap worsening over time?, *Archives of General Psychiatry*, 64, pp.1123-1131.

⁴ For example, in its newsletter, *Choices in Recovery*, Janssen Pharmaceuticals, Inc. commented in 2012 upon the increased mortality rate in psychiatric patients, acknowledging that “[r]esearch has shown that the life expectancy for people living with a serious mental health condition is, on average, 25 years shorter than the general population. Heart disease, diabetes, respiratory diseases, and infectious diseases (such as HIV/AIDS) are the most common causes of death among this population” (Janssen Pharmaceuticals, Inc. (2012), The importance of total wellness, *Choices in Recovery – Support and Information for Schizophrenia, Schizoaffective, and Bipolar Disorder* [online], 9(2), p.12. However, perhaps understandably, the company failed to accept a connection with the drugs it produces and sells.

(illness) and mortality (death) in this population has accelerated. In fact, persons with serious mental illness (SMI) are now dying 25 years earlier than the general population”.⁵

He and his colleagues further identified modern neuroleptics’ toxic effects:

“However, with time and experience the second generation antipsychotic medications have become more highly associated with weight gain, diabetes, dislipidemia [fat metabolism disorder], insulin resistance and the metabolic syndrome and the superiority of clinical response (except for clozapine) has been questioned. Other psychotropic medications that are associated with weight gain may also be of concern”.⁶

Adverse effects and withdrawal problems associated with psychiatric drugs

The Danish physician Peter Gøtzsche, leader of the Nordic Cochrane Center at Rigshospitalet in Copenhagen, Denmark, considers psychiatric drugs to be a leading cause of death from heart disease and cancer.⁷ He (and others) identified an extensive list of risks accompanying the administration of psychiatric drugs, including the following: cardiovascular disease (especially in elderly people, children and adolescents), cardiac arrhythmia, Takotsubo cardiomyopathy (often caused by physical restraint), syncope, strokes, allergic reactions (like anaphylactic shock, Lyell-syndrome, DRESS-syndrome or Quincke’s disease), glaucoma, hormonal changes combined with sexual disorders, neoplasm in the mammary glands (which can develop into cancer), hyponatremia, serotonin-syndrome, diabetes, obesity, thromboembolisms, liver fibrosis, icterus, ileus, renal failure, high blood pressure and vascular disorders (e.g. priapism), metabolic syndrome, malignant neuroleptic syndrome, malignant hyperthermia, agranulocytosis, asphyxia, tardive dyskinesia, foetal malformations and life-threatening withdrawal symptoms in newborn whose mothers received neuroleptics and antidepressants during pregnancy.

Many psychiatric drugs cause unwanted effects in the central and autonomous nervous system, the muscle system, and the psyche (mind). Common problems include somnolence, sedation, apathy, irritability, delirium, fear, pain, restlessness, and sleep and dream disorders.⁸ Additionally, psychoses may become more pronounced and may be accompanied by the reduction of grey matter volume and changes in the frontal lobe of the brain,⁹ which further

⁵ Parks, J. (2006), Foreword. In: J. Parks, D. Svendsen, P. Singer & M. E. Foti (eds.), *Morbidity and mortality in people with serious mental illness* (1st ed.), [online] Alexandria: National Association of State Mental Health Program Directors, Medical Directors Council, p.4. Available at:

<http://www.nasmhpd.org/sites/default/files/Mortality%20and%20Morbidity%20Final%20Report%2008.18.08.pdf> [Accessed 15 Aug. 2016].

⁶ Parks, *et al* (2006), *ibid*, p.6.

⁷ See Gøtzsche, P. C. (2015), *Deadly Psychiatry and Organised Denial* (Copenhagen: People’s Press).

⁸ See Lehmann, P., Aderhold, V., Rufer, M. & Zehentbauer, J. (2017), *Neue Antidepressiva, atypische Neuroleptika – Risiken, Placebo-Effekte, Niedrigdosierung und Alternativen. Mit einem Exkurs zur Wiederkehr des Elektroschocks* (1st ed.) (Berlin and Shrewsbury: Peter Lehmann Publishing).

⁹ See Bonelli, R. M., Hofmann, P., Aschoff, A., *et al* (2005), The influence of psychotropic drugs on cerebral cell death: Female neurovulnerability to antipsychotics, *International Clinical Psychopharmacology*, 20, pp.145-149; Andreasen, N. C., Nopoulos, P., Magnotta, V., *et al* (2011), Progressive brain change in schizophrenia: a prospective longitudinal study of first-episode schizophrenia, *Biological Psychiatry*, 70, pp.672-679; Aderhold, V., Weinmann, S., Hägele, C. & Heinz, A. (2015), Frontale Hirnvolumenminderung durch Antipsychotika?, *Nervenarzt*, 86, pp.302-323.

contributes to the deterioration of cognitive skills, concentration, executive functions, verbal learning, memory and problem-solving abilities. In addition, antidepressants can have paradoxical suicidal effects, and antipsychotics (neuroleptics), intrinsic suicidal effects.¹⁰ Clearly, there remains an urgent need for involvement of psychiatric patients' organisations in all aspects of psychiatric drug issues—especially licensing processes and monitoring.

Patients in countries with poor infrastructure face additional difficulties. Poorly developed primary care community-based service infrastructure for psychiatric patients deter recovery and in some cases, increase mortality.¹¹ Access to emergency departments in a timely manner, especially in rural areas, can be very challenging, even when a condition is recognised as an emergency. This is particularly the case in relation to life-threatening adverse effects of psychiatric drugs, such as heart attack, dystonic attack (asphyxia), neuroleptic malignant syndrome, febrile hyperthermia, agranulocytosis, deep vein thrombosis, pneumonia, anaphylactic shock, and states of raptus (a sudden state of excitation) or delirium. Those effects can lead quickly to death; emergency treatment often cannot stop the deadly processes which have begun.

Further, it should not be overlooked that all kinds of psychiatric drugs can produce physical dependence, or at least strong withdrawal-syndromes. Monitoring, including admission into intensive care units, may be medically necessary to help patients cope with withdrawal. Withdrawal may even cause death through severe brain cramping and cardiac arrest. The symptoms can include heart and circulatory problems, such as racing heartbeat, dizziness and physical collapse. This has been explained in an animal study by Helma Sommer and Jochen Quandt at the Psychiatric Clinic in Bernburg in former GDR. Their observations were based on metabolic changes induced by chlorpromazine, the neuroleptic prototype, that caused a circulatory collapse after withdrawal. For six months, Sommer and Quandt had administered neuroleptics to 20 rabbits. The four animals that had received the highest dosage (16.7 mg/kg) died after a brief fit of cramping, and the psychiatrists reported:

“At a dosage of 13.3 mg/kg of chlorpromazine, abrupt withdrawal led to a sudden death within 14 days, probably due to irreversibly blocked metabolic processes that stopped functioning (similar observations in human beings have been published in which death followed a brief stage of cramping)”.¹²

Available at: http://www.dgsp-ev.de/fileadmin/dgsp/pdfs/Wissenschaftliche_Artikel/Frontale_Hirnvolumenminderung_durch_Antipsychotika_-1.pdf [Accessed 15 Aug. 2016].

¹⁰ For more information, see Lehmann, P. (2012), About the intrinsic suicidal effects of neuroleptics: Towards breaking the taboo and fighting therapeutical recklessness, *International Journal of Psychotherapy*, 16, pp.30-49. Available at: <http://www.peter-lehmann-publishing.com/articles/lehmann/pdf/neuroleptics-suicide.pdf> [Accessed 15 Aug. 2016].

¹¹ See, e.g., Makgoba, M. W. (2017), *The report into the 'Circumstances Surrounding the Deaths of Mentally Ill Patients: Gauteng Province' – No guns: 94+ silent deaths and still counting*. Pretoria: Office of Health Standards Compliance, p.1. [online] Available at: <https://www.sahrc.org.za/home/21/files/Esidimeni%20full%20report.pdf> (Access 1 Febr 2017).

¹² Sommer, H., Quandt, J. (1970), Langzeitbehandlung mit Chlorpromazin im Tierexperiment, *Fortschritte der Neurologie-Psychiatrie und ihrer Grenzgebiete*, 38, pp.466-491, at p.487.

The Swiss pharmaceutical company Janssen-Cilag has also warned of withdrawal problems for newborns, when their mothers have received antipsychotic medication during pregnancy. In 2016, its product information stated as follows:

“In the neonates of mothers who took antipsychotics (including haloperidol) during the third trimester of pregnancy, there is risk of extrapyramidal symptoms and/or withdrawal symptoms. These symptoms in newborns may include agitation, abnormally increased or decreased muscle tone, tremors, sleepiness, difficulty breathing or feeding problems.

These complications may vary in their severity. In some cases, the symptoms were self-limiting, in other cases, the newborns required monitoring in the intensive care unit or a longer hospitalisation”.¹³

Numerous other research has shown a clear link between psychiatric drugs (especially antipsychotics) and reduced life expectancy.¹⁴ Some researchers with links to the pharmaceutical industry, however, have tended to deny such links.¹⁵

¹³ Janssen-Cilag, A. G. (Switzerland) (2016), Haldol (Product information). In: *Arzneimittel-Kompendium Online*. [online] Basel: Documed AG. Available at: <https://compendium.ch/mpro/mnr/3404/html/de?start=1#7450> [Accessed 15 Aug. 2016].

¹⁴ See, for example, Newman, S. C. & Bland, R. C. (1991), Mortality in a cohort of patients with schizophrenia: A record linkage study, *Canadian Journal of Psychiatry*, 36, pp. 239-245; Ösby, U., Correia, N., Brandt, L., *et al* (2000), Mortality and causes of death in schizophrenia in Stockholm county, Sweden, *Schizophrenia Research*, 45, pp.21-28; Colton, C. W. U., & Manderscheid, R. W. (2006), 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*, 3(2), pp.1-14; Manderscheid, R. W. (2006), The quiet tragedy of premature death among mental health consumers, *National Council News*, (September), p.1, p.10. Available at: http://www.public-health.uiowa.edu/icmha/outreach/documents/TheQuietTragedyofPrematureDeathAmongMentalHealthConsumers_000.pdf [Accessed 15 Aug. 2016]; Manderscheid, R. W. (2009), Premature death among state mental health agency consumers: Assessing progress in addressing a quiet tragedy, *International Journal of Public Health*, 54 (Suppl.1), pp.7-8; Aderhold, V. (2010), *Neuroleptika zwischen Nutzen und Schaden: Minimale Anwendung von Neuroleptika – ein Update*. [online] Available at: http://www.bgt-ev.de/fileadmin/Mediendatenbank/Themen/Psychopharmakadebatte/Aderhold_Neuroleptika_update.pdf [Accessed 15 Aug. 2016]; Weinmann, S., Read, J. & Aderhold, V. (2009), Influence of antipsychotics on mortality in schizophrenia: Systematic review, *Schizophrenia Research*, 113, pp.1-11; Chang, C. K., Hayes, R. D., Perera, G., *et al* (2011), Life expectancy at birth for people with serious mental illness and other major disorders from a secondary mental health care case register in London, *PLoS One* [online], 6, e19590. Available at: <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0019590> [Accessed 15 Aug. 2016]; Laursen, T. M., Munk-Olsen, T. and Vestergaard, M. (2012), Life expectancy and cardiovascular mortality in persons with schizophrenia, *Current Opinion in Psychiatry*, 25, pp.83-88; Tenback, D., Pijl, B., Smeets, H., *et al* (2012), All-cause mortality and medication risk factors in schizophrenia: a prospective cohort study. *Journal of Clinical Psychopharmacology*, 32, pp.31-35; Ringen, P. A., Engh, J. A., Birkenaes, A. B., *et al* (2014), Increased mortality in schizophrenia due to cardiovascular disease—A non-systematic review of epidemiology, possible causes, and interventions, *Frontiers in Psychiatry*, 5, Article 137; Walker, E. R., McGee, R. E. & Druss, B. G. (2015), Mortality in mental disorders and global disease burden implications: A systematic review and meta-analysis, *Journal of the American Medical Association*, 72, pp.334-341.

¹⁵ See, for example, Tiihonen *et al.*, who state that “[i]n patients with one or more filled prescription for an antipsychotic drug, an inverse relation between mortality and duration of cumulative use was noted” (Tiihonen, J., Lonnqvist, J., Wahlbeck, K., *et al* (2009), 11-year follow-up of mortality in patients with schizophrenia: a population-based cohort study (FIN11 study), *The Lancet*, 374, pp.620-627). In a declaration on conflicts of interest two years later, Tiihonen had to state: “Dr. Tiihonen has served as a consultant to Lundbeck, Organon, Janssen-Cilag, Eli Lilly, AstraZeneca, Hoffmann-La Roche, and Bristol-Myers Squibb and has received fees for giving expert opinions to Bristol-Myers Squibb and GlaxoSmithKline and lecture fees from Janssen-Cilag, Bristol-Myers Squibb,

Often patients, who may not withdraw slowly enough to minimise risks, suffer from unpleasant and/or life-threatening withdrawal problems that can contribute to a relapse into severe emotional distress and/or result in their return to the doctor's surgery or a psychiatric ward. This can create a spiral effect where the symptoms caused by withdrawal from psychiatric drugs may cause patients to continue taking them indefinitely when they are no longer necessary.¹⁶

Interestingly, in LMICs like India, Nigeria and Colombia, where until recently there has been a lack of availability of expensive second generation psychiatric drugs, recovery rates from severe emotional distress are higher, which compares similarly to results in high income countries, where some research has found that recovery rates are better if psychiatric drugs are either not given so readily,¹⁷ not prescribed,¹⁸ or are under the control of patients themselves.¹⁹ Nevertheless, psychiatric patients are at increased risk of death in all countries where psychiatric drugs are administered. It is likely that the negative effects of many psychiatric drugs on the psyche, the central nervous system, the autonomic system and the internal organs may also unintentionally intensify the burden of patients' severe emotional distress. On the other hand, sometimes drug-caused diseases overlap with the original emotional problems, or suppress them. Klaus Dörner, a prototypical leader of reform psychiatry in Germany, has described the common modern treatment aim of reducing emotional distress:

“We temporarily turn the mentally suffering patient into a person with an organic brain disease; with ECT it happens in a more global way, but for a substantially shorter period of time than with pharmacological therapy”.²⁰

Education about risks, alternatives, and withdrawal support

It is regrettable that the medical profession learns to prescribe psychotropic drugs, but not how to help patients withdraw from them.²¹ Patients too often do not receive information about

Eli Lilly, Pfizer, Lundbeck, GlaxoSmithKline, and AstraZeneca” (Tiihonen, J., Haukka, J., Taylor, M., *et al* (2011), A nationwide cohort study of oral and depot antipsychotics after first hospitalization, *American Journal of Psychiatry*, 168, pp.603-609, at p.608. Available at <http://ajp.psychiatryonline.org/doi/pdf/10.1176/appi.ajp.2011.10081224> [Accessed 15 Aug. 2016].

¹⁶ See Lehmann, P. (ed.) (2004), *Coming off psychiatric drugs: Successful withdrawal from neuroleptics, antidepressants, lithium, carbamazepine and tranquilizers* (1st ed.) (Berlin, Eugene and Shrewsbury: Peter Lehmann Publishing); Lehmann, P. (ed.) (2013), *Coming off psychiatric drugs: Successful withdrawal from neuroleptics, antidepressants, mood stabilizers, Ritalin and tranquilizers* (1st ed.), (Berlin, Eugene and Shrewsbury: Peter Lehmann Publishing), ebook.

¹⁷ See Leff, J., Sartorius, N., Jablensky, A., *et al* (1992), The international pilot study of schizophrenia: Five-year follow-up findings, *Psychological Medicine*, 22, pp.131-145.

¹⁸ See Jablensky, A., Sartorius, N., Ernberg, G., *et al* (1992), Schizophrenia: manifestations, incidence and course in different cultures. A World Health Organization ten-country study, *Psychological Medicine Monograph Supplement*, 20, pp.1-97.

¹⁹ See, for example, Dumont, J. & Jones, K. (2007), The Crisis Hostel: Findings from a consumer/survivor-defined alternative to psychiatric hospitalisation. In: P. Stastny & P. Lehmann (eds.), *Alternatives beyond psychiatry* (1st ed.) (Berlin, Eugene and Shrewsbury: Peter Lehmann Publishing), pp.179-187, ebook; Seikkula, J. & Alakare, B. (2007), Open dialogues. In: P. Stastny & P. Lehmann (eds.), *op cit.*, pp.223-239.

²⁰ Dörner, K., & Plog, U. (1992), *Irren ist menschlich* (7th ed.), Bonn: Psychiatrie-Verlag, p.545.

²¹ Asmus Finzen, former psychiatrist at the University of Basel, confessed publicly: “It is the psychiatrist’s role to prescribe drugs. Physicians learn this role well. They do not learn how to help a patient successfully withdraw from

withdrawal risks and are unaware of the strategies to help minimise withdrawal symptoms. When psychiatric drugs cause health problems, withdrawal is the likely result. However, if a patient—for whatever reason—independently decides to come off their psychiatric drugs, psychosocial professionals often judge the patient adversely.²² Strategies to respect the human rights of patients ought to be introduced in higher income countries and LMICs alike in order to overcome the problems arising from a lack of support in withdrawal from dependence upon psychotropic medication.²³ If such innovations can be embraced, there is the potential to lower the mortality rate for those suffering from serious mental health problems, and to improve their quality of life and enhance their well-being in accordance with SDG3.

This is a global phenomenon, criticised by the UN Special Rapporteur on health, Dainius Pūras, in his recent 2017 report.²⁴ The dominance of the biomedical model, together with its attempt to reduce psychological problems to metabolic disorder thereby placing them in the purview of medicine, has resulted in additional diagnostic categories that increasingly endanger the diversity of human life. Information on adverse treatment is tardy, leading to delay in policy change, and therefore leads neither to the development of recovery-oriented treatment approaches, nor to alternatives which make compulsory treatment superfluous. According to the Special Rapporteur, a global change of consciousness is necessary:

“...[T]he field of mental health continues to be over-medicalized and the reductionist biomedical model, with support from psychiatry and the pharmaceutical industry, dominates clinical practice, policy, research agendas, medical education and investment in mental health around the world. The majority of mental health investments in low-, middle- and high-income countries disproportionately fund services based on the biomedical model of psychiatry. There is also a bias towards first-line treatment with psychotropic medications, in spite of accumulating evidence that they are not as effective as previously thought, that they produce harmful side effects and, in the case of antidepressants, specifically for mild and moderate depression, the benefit experienced can be attributed to a placebo effect. Despite those risks,

drugs” (Finzen, A. (2015), *Wie man Medikamente absetzen, lernen Ärzte nicht*. In: Finzen, A., Lehmann, P, Osterfeld, M., *et al* (2015), *Psychopharmaka absetzen: Warum, wann und wie* (p.16), *Soziale Psychiatrie*, 39(2), pp.16-19. Available at: <http://www.antipsychiatrieverlag.de/artikel/gesundheit/pdf/absetzen-bremen.pdf> [Accessed 15 Aug. 2016].

²² See Lahti, P. (2004), Preface. In: P. Lehmann (ed.), *op cit.*, nt.15, pp.13-15.

²³ Many users and survivors of psychiatry have experienced withdrawal problems. As currently occurs in Germany, physicians, pharmacologists, therapists, lawyers, carers and naturopathic healers should distribute knowledge about competent support for withdrawal, collaborating to find answers to currently unsolved questions such as: Which withdrawal symptoms in psychiatric drugs are most likely to be experienced during the transition from mini doses to zero? Which naturopathic methods relieve withdrawal symptoms and help stabilise people in the vulnerable period immediately after withdrawal? How do you best reduce dosages with capsules and pellets? Which kinds of environments, lifestyles, diets and physical activities support successful withdrawal? How do you cope with sleeping problems caused by withdrawal? For more information, see Lehmann, P. (2017), *(Einige) offene Fragen Psychiatriebetroffener zum Absetzen von Psychopharmaka*. In: Berliner Organisation Psychiatrie-Erfahrener und Psychiatrie-Betroffener (eds.), *PSYCHEXIT – Auf dem Weg zum Curriculum “Kompetente Hilfe beim Absetzen von Antidepressiva und Neuroleptika”* (2nd ed.) (Berlin: self publication), pp.15-24. Available at: http://www.antipsychiatrieverlag.de/artikel/gesundheit/pdf/lehmann_absetzen-offene-fragen-2016.pdf [Accessed 3 Jan. 2017].

²⁴ The UN Special Rapporteur on health has co-authored a chapter of this book; see chapter by Dainius Puras and Julie Hannah.

psychotropic medications are increasingly being used in high-, middle- and low-income countries across the world. We have been sold a myth that the best solutions for addressing mental health challenges are medications and other biomedical interventions”.²⁵

Dealing with reduced quality and expectancy of life

As a result of the use of psychiatric drugs, some concomitant western psychiatric approaches to treatment are liable to compound higher mortality rates and decrease well-being. These approaches are considered below.

Treatment without informed consent

In general, psychiatric patients do not receive complete information about the risks, unwanted effects, and alternatives to the proposed administration of psychiatric drugs. Therefore, the treatment takes place without genuine informed consent. Further, psychiatric patients seldom receive necessary medical examinations before or after they begin treatment with psychiatric drugs. For example, following a literature evaluation undertaken by the Psychosis Clinic at the University of California to develop a physical health monitoring system for people diagnosed with schizophrenia,²⁶ the research team recommended regular monitoring of body mass index, plasma glucose levels, lipid profiles, and signs of prolactin elevation or sexual dysfunction. They also proposed cardiac monitoring of patients who receive medications associated with QT interval prolongation, monitoring of myocarditis in patients treated with clozapine, checks for extrapyramidal symptoms and tardive dyskinesia, as well as regular visual examinations in patients who receive neuroleptics. Clozapine is the only psychiatric drug on the World Health Organization (WHO) *Complementary List* “for which specialized diagnostic or monitoring facilities, and/or specialist medical care, and/or specialist training are needed”²⁷, within the *WHO Model List of Essential Medicines*. Such testing may never take place, particularly in LMICs due to a lack of resources; one more reason to avoid psychiatric drugs in such countries. However, even the best monitoring facilities do not protect patients from unwanted fatal effects. For example, clozapine is an antipsychotic drug usually prescribed to patients diagnosed with schizophrenia who are considered treatment-resistant. The drug has a somewhat higher death rate attributable to agranulocytosis than alternatives. Therefore, leukocyte and differential blood counts must be carried out before the first administration of clozapine, and monitor counts must

²⁵ United Nations (2017, March 3), *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, report A/HRC/35/21 to the Human Rights Council, 35th session 6-23 June 2017, agenda item 3 [online], pp.5-6. Available at: <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G17/076/04/pdf/G1707604.pdf?OpenElement>

[Accessed 7 Jul. 2017].

²⁶ See Marder, S. R., Essock, S. M., Miller, *et al* (2004), Physical health monitoring of patients with schizophrenia. *American Journal of Psychiatry*, 161, pp.1334-1349. Available at: http://www.researchgate.net/publication/8424008_Physical_health_monitoring_of_patients_with_schizophrenia/links/0912f509c21467fb26000000 [Accessed 15 Aug. 2016].

²⁷ World Health Organization (2015), *WHO model list of essential medicines* (19th ed.), p.3 [online]. Available at: http://www.who.int/medicines/publications/essentialmedicines/EML_2015_FINAL_amended_NOV2015.pdf?ua=1 [Accessed 15 Aug. 2016].

be carried out every week for eighteen weeks. The monitoring must continue at least every two weeks, and, after one year, at least every four weeks. Nevertheless, the onset of agranulocytoses is often sudden and severe; hence, such blood monitoring has “only a relative prophylactic value”.²⁸ As Wahlländer has stated, “[e]ven the best medical treatment cannot reduce the risk of a fatal process to zero”.²⁹

Patients ought to be alerted to the early warning signs of chronic or lethal diseases due to the administration of psychiatric drugs as a matter of course.³⁰ Before patients decide to take such drugs, they should also be informed about the danger of the development of physical dependence, and about low-risk ways to withdraw from them. With the exception of benzodiazepines and illegal substances, institutions helping patients in withdrawal generally do not exist.

Low dose, zero problems?

For some patients, there is no effective alternative to psychotropic drugs. So what can be done to reduce the risk of early mortality, and to minimise adverse effects such as brain shrinkage via the decrease of grey and white matter volume in the frontal brain, and the development of various metabolic and organ disorders? Some psychiatrists advocate finding the ‘lowest effective dose’ and the reduction of polypharmacy. Whilst the lowest effective dose should be provided as a matter of course in medicine, many guidelines suggest comparatively high initial doses.

Further, often psychiatric patients receive a number of drug combinations, as each drug’s adverse effects are treated with an additional drug. Minimising the number of potentially toxic drugs and reducing the dose of any useful drug ought to be something for which modern psychiatry strives. Focus on the lowest effective dose (even if the effect is the alleviation of emotional suffering and nothing else) would be a more humane approach for most patients. Furthermore, it would lower drug administration costs for hospitals—which is a particular difficulty in LMICs where universal health insurance coverage is unlikely, and health budgets are stretched. The total cost of the medical treatment of acute and chronic diseases arising from drug effects, would also decrease. Clearly, this would assist states in meeting SDG3.

However, unwanted effects can occur independently of a drug dosage; they also occur in lower therapeutic doses, and after short-term administration, including, on occasion, after only one dose.³¹ Some of these unwanted effects can be permanent. Neuroleptics, for example, can produce

²⁸ Kähler, H.-J. (1967), *Störwirkungen von Psychopharmaka und Analgetika*, Stuttgart: Wissenschaftliche Verlagsgesellschaft, p.127.

²⁹ Wahlländer, B. (1992), Leukopenie und Agranulozytose. In: D. Naber, & F. Müller-Spahn (eds.), *Clozapin – Pharmakologie und Klinik eines atypischen Neuroleptikums* (1st ed.), Stuttgart & New York: Springer, pp.147-153, at p.149.

³⁰ See Lehmann, P. (2013), Early warning signs of chronic or lethal diseases due to the administration of neuroleptics. *Journal of Critical Psychology, Counselling and Psychotherapy*, 13, pp.23-29. Available at: <http://www.peter-lehmann-publishing.com/articles/lehmann/pdf/warningsigns-jcpcp.pdf> [Accessed 15 Aug. 2016].

³¹ For further information on this topic see, e.g., Lehmann, P. (2017), *Schöne neue Psychiatrie*, Vol.1: [Wie Chemie und Strom auf Geist und Psyche wirken](#) (worked-over ed.), ebook, Berlin and Shrewsbury: Antipsychiatrieverlag, pp.115-118, 172-174, Vol.2: [Wie Psychopharmaka den Körper verändern](#) (worked-over ed.), ebook, Berlin and Shrewsbury: Antipsychiatrieverlag, pp.158-162, 264-270.

changes in the brain structure and liver mitochondria, even in low doses.³² Somnolence, dysarthria, hyperthermia, and tachycardia were observed after a once-only application of a low dose of the neuroleptic chlorprothixene.³³ Depressive mood with suicidality can also occur at low doses.³⁴ Other risks caused also by low dose neuroleptics are disorders of the pancreas hormone system combined with weight gain,³⁵ circulatory insufficiency,³⁶ or agranulocytosis.³⁷ Serious Parkinsonian symptoms can occur after short-term administration.³⁸ Serious neurological reactions, accompanied by dystonic disorders and comatose states, can be triggered by low dosages of neuroleptics.³⁹ Psychiatrists have reported tardive dyskinesia caused by low dosages of neuroleptics,⁴⁰ which has also been reported in young people.⁴¹ This chronic disease, which is connected with shortened life expectancy, develops independently of the duration of administration of the neuroleptic and its dosage,⁴² even at very low dosages.⁴³ Dystonic disorders are reported after single doses of neuroleptics,⁴⁴ even if they are low.⁴⁵ In 1983 Helmchen (the

³² See Christensen, E., Møller, J. E. & Faurbye, A. (1970), Neuropathological investigation of 28 brains from patients with dyskinesia, *Acta Psychiatrica Scandinavica*, 46, pp.14-23.

³³ See Von Brauchitsch, H. & Bukowczyk, A. (1962), Zur Frage der Verwendung des Chlorprothixen ("Taractan") im psychiatrischen Hospital, *Schweizer Archiv für Neurologie, Neurochirurgie und Psychiatrie*, 90, pp.104-117.

³⁴ See Benkert, O. & Hippus, H. (1980), *Psychiatrische Pharmakotherapie* (3rd ed.), Berlin, Heidelberg and New York: Springer, p.257.

³⁵ See Heinrich, K. (1976), *Psychopharmaka in Klinik und Praxis*, Stuttgart: Thieme, p.55.

³⁶ See Kähler, H.-J. (1967), *op cit.*, nt.25, pp.107-108; Degkwitz, R. (1967), *Leitfaden der Psychopharmakologie*, Stuttgart: Wissenschaftliche Verlagsgesellschaft, p.139.

³⁷ See Hippus, H. (1960), Therapeutisch unerwünschte Wirkungen der modernen Psychopharmaka, I. Mitteilung: Phenothiazin-Derivate und verwandte Verbindungen. *Internist* (Berlin), 1, pp.453-460; Winslow, R. S., Stillner, V., Coons, D. J. & Robison, M. W. (1986), Prevention of acute dystonic reactions in patients beginning high-potency neuroleptics, *American Journal of Psychiatry*, 143, pp.706-710.

³⁸ See Häfner, H. & Kutscher, I. (1964), Komplikationen der klinischen Behandlung mit Psychopharmaka, *Ärztliche Forschung*, 18, pp.18-36.

³⁹ See Swaiman, K. F. (1960), Acute neurologic reaction to promethazine—Report of a case, *New England Journal of Medicine*, 263, p.747.

⁴⁰ See Jus, A., Pineau, R., Lachance, R. *et al.* (1976), Epidemiology of tardive dyskinesia. Part 2. *Diseases of the Nervous System*, 37, pp.257-261.

⁴¹ See Kane, J., Struve, F. A., Weinhold, P. *et al.* (1980), Strategy for the study of patients at high risks for tardive dyskinesia, *American Journal of Psychiatry*, 137, pp.1265-1267.

⁴² See Casey, D. E. (1987), Tardive dyskinesia. In: H. Y. Meltzer (ed.), *Psychopharmacology* (1st ed.) (New York: Raven Press), pp.1411-1419.

⁴³ See Crane, G. E. (1968), Tardive dyskinesia in patients treated with major neuroleptic, *American Journal of Psychiatry*, 124(8), Suppl., pp.40-48; Thornton, W. E. & Thornton, B. P. (1973), Tardive dyskinesia and low dosage, *American Journal of Psychiatry*, 130, p.1401; Thornton, W. E. & Thornton, B. P. (1973), Tardive dyskinesia from the major tranquilizers, *Journal of the Florida Medical Association*, 60 (September), pp.24-26.

⁴⁴ See Benkert, O. & Hippus, H. (1980), *op cit.*, nt.31, p.100; Bellabarba, U., Hippus, H. & Kanowski, S. (1967), Zur Differentialdiagnose hyperkinetisch-dystoner Begleitwirkungen von Psychopharmaka, *Medizinische Welt*, 10, pp.559-563.

⁴⁵ See Pietzcker, A. (1987), *Neuroleptische Langzeitmedikation in der ambulanten Behandlung schizophrener Kranker*, Hamburg: Promonta, p.53.

then President of the German Psychiatric Association), described the danger of life-threatening dystonia thus:⁴⁶

“In the Berlin clinic a candidate of the state examination developed a laryngeal pharyngeal syndrome during the exam period. After detailed questioning, it became clear that he had taken one tablet [of] Tonoquil [a combination compound containing the neuroleptic ingredient thiopropazate]; here seems the thesis disproved that minimal doses are completely non-hazardous.”⁴⁷

Elevated prolactin levels which are associated with sexual disorders and neoplasm in the mammary glands, are associated with very low drug doses, even if they would not produce a plasma level which could be measured.⁴⁸ One single dose of an antipsychotic frequently leads to a significant stimulation of prolactin.⁴⁹ Unsurprisingly, therefore, researchers of the Gynaecological Department of the State University of New York in Buffalo found that the risk of breast cancer in female psychiatric patients was three and a half times higher than in general patients, and nine and a half times higher than the average person.⁵⁰

To complicate the matter, it is still not possible to predict how a psychiatric drug might work in an individual patient. Over fifty years ago, Heinrich Kranz, a former President of the German Society for Psychiatry and Neurology, made the following observation:

“We have...learned that, at therapeutically flawless and even low doses, harmful concomitant effects and potentially lethal outcomes can occur—due to still largely unknown individual dispositions or other complicating factors that we hardly survey”.⁵¹

Twenty years later, Kranz’s colleague, Wolfgang Seeler of the Psychiatric Clinic Hamburg-Ochsenzoll, acknowledged that such challenges remained inherent in his profession:

“To put it bluntly, when treating a patient with an acute condition, it is as if the doctor were always conducting an uncontrolled individual experiment”.⁵²

⁴⁶ Neuroleptic-caused mouth-tongue-throat dystonia can trigger aspiration (suctioning of blood or vomit in the trachea or bronchial tubes) with subsequent asphyxia, resulting in a life-threatening state of suffocation—see Zugibe, F. T. (1980), Sudden death related to the use of psychotropic drugs, *Legal Medicine*, pp.75-80. For more information about its general occurrence in psychiatric institutions, see Spitz, W. U. (1980), Asphyxia. In: W. U. Spitz & R. S. Fisher (eds.), *Medicolegal investigation of death* (2nd ed.), Springfield: Thomas, pp.338-350. The risk of this condition is severe during heat waves (Gupte, P. [1978, July 17], Tranquilizers held an agent in deaths of mental patients. *New York Times*, pp.1 & D8). See also Lehmann, P. (2017), *Schöne neue Psychiatrie*, Vol.2: [Wie Psychopharmaka den Körper verändern](#) (worked-over ed.), ebook, Berlin and Shrewsbury: Antipsychiatrieverlag, pp.248-251.

⁴⁷ Helmchen, H. (1983), Contribution to the discussion. In: H. Hippus & H. Klein (eds.), *Therapie mit Neuroleptika* (1st ed.), Erlangen: perimed Fachbuch-Verlagsgesellschaft, pp.186-187, at p.187.

⁴⁸ See Langer, G. (1983), Contribution to the discussion. In: Hippus, H., & Klein, H. E. (eds.), *ibid*, pp.113-114.

⁴⁹ See Laakmann, G. & Benkert, O. (1978), Neuroendokrinologie und Psychopharmaka, *Arzneimittel-Forschung/Drug Research*, 28 (II, 8), pp.1277-1280.

⁵⁰ See Halbreich, U., Shen, J. & Panaro, V. (1996), Are chronic psychiatric patients at increased risk for developing breast cancer? *American Journal of Psychiatry*, 153, pp.559-560.

⁵¹ Kranz, H. (1964), Schlusswort. In: H. Kranz & K. Heinrich (eds.), *Begleitwirkungen und Misserfolge der psychiatrischen Pharmakotherapie* (1st ed.), Stuttgart: Thieme, pp.201-202, at p.201.

⁵² Seeler, W. (1983), Contribution to the discussion. In: H. Hippus & H. E. Klein (eds.), *op cit.*, nt.44, p.140.

It is important to note that newer neuroleptics do not have fewer unwanted effects. Regarding the new ‘atypical’ antipsychotics, the President of the Swiss Association of Psychiatric Medical Directors, Gerhard Ebner, admitted in 2003:

“It is not a case of fewer side-effects, but of different ones which can be just as debilitating even if the patient isn’t immediately aware of them. Therefore, patients can be more easily motivated to take these drugs because they no longer suffer instantly and as much from the excruciating dyskinesias/extrapyramidal side-effects”.⁵³

The necessary approach to SDG3

How might states reduce the mortality rate of those who suffer from psychiatric problems, thereby helping to fulfil their obligation under SDG3? Weinmann *et al.* believe that early mortality can be reduced through the implementation of effective psychosocial treatments, which can minimise distress levels and relapse rates, and improve recovery.⁵⁴ In their view, effective humanistic alternatives (such as have been seen in Soteria, Crisis Hostel, and in the Open Dialogue/Need-adapted Treatment, which are discussed below) result in better outcomes for patients. These alternatives include less violations of human rights (including compulsory treatment), the use of fewer psychiatric drugs, fewer relapses, less loss of employment, the continuation of social contact, and lower cost. In the opinion of psychiatrists who developed humanistic alternatives, psychosocial ‘emergency states’ should not be seen as symptomatic of metabolic disorders, but as coping mechanisms, and, in the case of psychotic symptoms, as responses to various traumatic events causative of a retreat from conventional reality. Consequently, psychiatric drugs should not be prescribed automatically, particularly given their incalculable risks to health, and the negative impact they are liable to have on a patient’s recovery and rehabilitation. The providers of humanistic alternatives, such as Loren Mosher from Soteria, recommend that these drugs should be prescribed only in extreme and life-threatening states for a short time when no other solution appears appropriate. Further, best practice requires that they remain under the control of the patient.⁵⁵

Such humanistic alternatives are—or at least, should be—well-known in high income countries,⁵⁶ and yet they are rarely used. Hence, they are probably not the first choice for LMICs, despite being cost-effective. They ought to be introduced as likely improvements on conventional psychosocial approaches. However, other models of support in LMICs may also offer possibilities for achieving SDG3. One approach might be for patients to return to their communities and be provided with support which combines self-help and evidence-based practice of adequate and effective assistance of solving mental health problems that are largely of a social nature, in

⁵³ Ebner, G. (2003), Aktuelles aus der Psychopharmakologie. Das Wichtigste vom ECNP-Kongress in Barcelona 05.-09.10.2002. *Psychiatrie*, (1), pp.29-32, at p.30.

⁵⁴ See Weinmann, S., Read, J. & Aderhold, V. (2009), Influence of antipsychotics on mortality in schizophrenia: Systematic review, *Schizophrenia Research*, 113, pp.1-11.

⁵⁵ See Aderhold, V., Stastny, P. and Lehmann, P. (2007), Soteria: An alternative mental health reform movement. In: P. Stastny & P. Lehmann (eds.), *op cit.*, nt.18, pp.146-160.

⁵⁶ For an overview on these humanistic approaches see Stastny, P. & Lehmann, P. (eds.) (2007), *op cit.*, nt.18.

addition to social acceptance. This would also require the political will to address the problems of people in severe emotional distress.⁵⁷

Key principles considered central to the improvement of psychiatry by present or former patients⁵⁸ were discussed by the European Network of (ex-) Users and Survivors of Psychiatry and set out in a Consensus Paper which was adopted at the Joint World Health Organization and European Commission Meeting in Brussels 1999.⁵⁹ All those present agreed that there was a need for the development of innovative mental health policies and practices in consultation with psychiatric (ex-) patients, as well as non-stigmatising and self-help approaches. Furthermore, it was agreed that mental health legislation based on human rights, and emphasising freedom of choice, was essential.⁶⁰ Best practice demands that relevant stake-holders are consulted prior to devising policy and legislation, and LMICs should include psychiatric (ex-) patients in such development. If organised groups do not exist for these advocacy processes, individuals who can speak as ‘experts by experience’⁶¹ should be invited and integrated into decision-making processes. The former Chair of the European Network of (ex-) Users and Survivors of Psychiatry, Karl Bach Jensen from Denmark, recommends the development of methods, systems, services and institutions for acute, short-term and long-term support that is not contingent upon the use of synthetic psychiatric drugs at all:

“In this field ex-users/survivors can play an important role as staff-members and consultants, having the knowledge about what helped us to recover. Such services linked with a positive subcultural identity and dignity can be provided by the public or with public financial support by the user/survivor movement itself giving people the space to meet and create their own lives...

Alternative systems and decentralised services to meet the needs of people experiencing mental health problems would minimise and in the long run make the use of synthetic and toxic psychiatric drugs needless. Until the final abolition of these drugs, a lot of people need help and support to withdraw from the drugs.”⁶²

⁵⁷ See Hopper, K., Harrison, G., Janca, A., *et al* (2007), Conclusion. In: K. Hopper, G. Harrison, A. Janca & N. Sartorius (eds.), *Recovery from Schizophrenia—An International Perspective. A Report from the WHO Collaborative Project, The International Study of Schizophrenia*. Oxford: University Press 2007, pp.277-282. Available at: http://dliia.ir/Scientific/e_book/Medicine/Internal_Medicine/RC_512_528_Psychoses_/017519.pdf [Accessed 15 Aug. 2016].

⁵⁸ Many of them use the term ‘users and survivors of psychiatry’, claiming the right to self-identification. In general, the psychiatric profession dislikes this term and the connotation that psychiatric treatment has potentially damaging and even life threatening effects, either mentally or physically.

⁵⁹ World Health Organization and European Commission (1999), *Balancing mental health promotion and mental health care: A joint World Health Organization/European Commission meeting*, Brussels: World Health Organization. Available at: <http://www.peter-lehmann-publishing.com/articles/others/consensus.htm> [Accessed 15 Aug. 2016].

⁶⁰ On the importance of mental health legislation, see further the chapter by Laura Davidson in this book. For an alternative view with regard to the utility of mental health legislation, see chapter of this book by Dainiūs Puras & Julie Hannah.

⁶¹ ‘Experts by experience’ are former psychiatric patients who now care for current psychiatric patients in psychosocial services that are regulated by organisations like the British Care Quality Commission. For more information see, e.g., <http://www.cqc.org.uk/content/become-expert-experience> [Accessed 15 Aug. 2016].

⁶² Bach Jensen, K. (2004), Detoxification—in the large and in the small: Towards a culture of respect. In: Lehmann, P. (ed.), *op cit.*, nt.15, pp.303-309, at p.308.

In Europe, promoting self-help and self-organisation, as well as supporting the international exchange of ideas amongst psychiatric (ex-) patients have been proposed as meaningful measures to combat discrimination.⁶³ Such methods, which enable patients to participate in user/survivor-led conferences or to research international self-help approaches, are surely as applicable in LMICs, and will be discussed further below.

Individual and organised self-help

The approaches available for dealing with severe emotional distress without using pharmacological treatment are extremely varied. According to some reports by patients themselves, acute psychiatric problems may be dealt with by retreating to quiet and safe places, through calming remedies, massage therapy, contact with animals, or through expressive artistic activity.⁶⁴ Others deal with crises through reflection in a self-help group, therapy or writing, political activism *vis-à-vis* psychiatry, or self-critical observation.⁶⁵

Traditional holistic interventions, as practised in Asian cultures like India, Pakistan and Sri Lanka, address severe emotional distress not as a metabolic problem, but rather, as unity of body and mind. Through a range of bodily techniques, they are able to build a sense of being centred in their bodies, heighten body awareness, and build the necessary motivation for overall body discipline to achieve a satisfying human experience. These approaches include relaxation, biofeedback (a method used consciously to perceive and influence unconscious bodily processes), guided imagery (a relaxation method to make positive changes by visualising healing or accomplishments), mindfulness training, breathing rhythms, trance, meditations, and physical exercise such as tai chi and yoga. These interventions address nutritional deficiencies, strengthen the cardiovascular system, and regulate breathing, sleep, appetite, desire and other body responses that are manifestations of severe emotional distress.⁶⁶

Being in the company of others and experiencing mutual support in self-help groups offers individuals the opportunity to communicate about overwhelming experiences, and discover that they are not necessarily unique. It can also help to create distance from the experiences, allow the person affected to reflect upon them, and develop a unique personal narrative free from diagnostic psychiatric stigmatisation.⁶⁷ A more hopeful understanding of their own alienating experiences may then be developed. When no organic basis for psychosis or other severe emotional crises is verified, people may recognise these states as natural (though haphazard)

⁶³ See Action Project against “Harassment and Discrimination Faced by People with Mental Health Problems in the Field of Health Services” (2005), *Recommendations*. [online] Available at: <http://www.peter-lehmann-publishing.com/articles/enusp/recommendations.htm> [Accessed 15 Aug. 2016].

⁶⁴ For more information about this topic, see Mitchell-Brody, M. (2007), *The Icarus Project: Dangerous gifts, iridescent visions and mad community*. In: Stastny, P. & Lehmann, P. (eds.), *op cit.*, nt.18, pp.137-145.

⁶⁵ See Stastny, P. & Lehmann, P. (2007), *What Helps Me if I Go Mad?* In: Stastny, P. & Lehmann, P. (eds.), *op cit.*, nt.18, pp.44-75.

⁶⁶ For more information about this topic, see Davar, B. (2007), *Depression and the use of natural healing methods*. In: Stastny, P. & Lehmann, P. (eds.), *op cit.*, nt.18, pp.83-90.

⁶⁷ See Boevink, W. (2007), *Survival, the art of living and knowledge to pass on: Recovery, empowerment and experiential expertise of persons with severe mental health problems*. In: P. Stastny, P. & Lehmann, P. (eds.), *op cit.*, nt.18, pp.105-116.

processes initiated by their own psyche in an attempt to cope with being in the world in a way that was simply no longer sustainable for them.⁶⁸

‘Accepting and Making Sense of Hearing Voices’ is the motto of the International Network, Training, Education and Research on Voices (Intervoice), which was founded by the Dutch psychiatrist Marius Romme in 1996. The organisation advocates a mixture of self-help and psychotherapy for those who have auditory hallucinations. By accepting the voices (seen by mainstream psychiatry as a sign of psychosis) which are often triggered by trauma, rather than suppressing them chemically, it becomes possible to make sense of the narrative and relate the voices to past or present life problems. Some research would suggest that this approach to auditory hallucinations is preferable to the use of antipsychotics, which risks alienating voice-hearers from their experiences, which then might cause chronicity.⁶⁹

Meanwhile, Intervoice, which gathers together people who hear voices in addition to professionals (mostly psychotherapists) who follow Romme’s approach, is spreading all over the world, including in LMICs such as Bosnia and Herzegovina, Palestine, and Uganda. Whilst Uganda does not yet have a national network, a Hearing Voices Group was started in Kampala in 2012. Daniel Sentamu, a voice-hearer and co-facilitator of the group, has reported as follows:

“The voice hearing voice group has not only been a place for voice hearers to talk about their voice hearing experiences but a place also to talk about other mental health concerns: in a session we find ourselves talking about medication, life in a mental hospital and stigmatisation.”⁷⁰

The beauty of such an approach to what mainstream psychiatry would categorise as schizophrenia is that there is no need to pay a therapist to facilitate groups. For this reason, the approach seems a good fit for LMICs with low resources. If those hearing voices are without any income, then transportation costs and a meeting place are the only organisational problems to be solved.

However, often severe mental health problems cannot be solved with self-help alone. Self-help and professional support are not mutually exclusive; psychotherapy, if available and affordable, may help to re-engage people in communication when self-help on its own does not work. Admittedly, this may be difficult in LMICs due to budgetary constraints and a lack of human resources. Nonetheless, it is important to recognise that the development of resilience is essential for those with psychiatric problems to avoid relapse once their condition improves. Without self-help resources, there is unlikely to be significant progress in recovery, or a sustained ability for a recoverer to live a self-determined life. Supporting the development of a self-help system at national, regional and local levels is an imperative, particularly in LMICs.

⁶⁸ See Williams, P. (2011), *A multiple-case study exploring personal paradigm shifts throughout the psychotic process from onset to full recovery*, Ph.D, Saybrook Graduate School and Research Center, San Francisco. Available at: <http://gradworks.umi.com/34/54/3454336.html> [Accessed 15 Aug. 2016].

⁶⁹ See Romme, M. & Escher, S. (2007), Intervoice: Accepting and making sense of hearing voices. In: P. Stastny & P. Lehmann (eds.), *op cit.*, nt.18, pp.131-137.

⁷⁰ Cited in Intervoice (undated), *Uganda*. [online] Available at: <http://www.intervoiceonline.org/about-intervoice/national-networks-2/uganda> [Accessed 15 Aug. 2016].

Global self-help examples

In the Anglo-American and North-West European regions, self-help aligns with the culturally dominant philosophy of individualism; the idea that people should take full responsibility for themselves and not rely upon their families or others. In other areas of the world, a self-help approach may be the exception to the norm, and emotional distress may be experienced differently. Three alternative models of treatment which have achieved good results are discussed below.

(1) MindFreedom Ghana

Support of those suffering from psychiatric problems is offered in Ghana by MindFreedom Ghana, an NGO founded in 2004 by ex-users and survivors of psychiatry and others with backgrounds in (*inter alia*) law, psychology, marketing, teaching, and agriculture. In general, the organisation is directed towards improving mental health and the lives of sufferers in Ghana, and aims to safeguard their human rights.⁷¹ Co-founder Dan Taylor has reported that in Ghana people with severe emotional distress are commonly mocked and sometimes physically assaulted, including by stoning. Sometimes relatives chain patients for so long that tetanus infections and gangrene result, resulting in amputation or even the death of the patient. In any event, most hospitals in Ghana are unable to provide either insecticide or mosquito nets, and there is a serious risk of an already weak patient dying from malaria. Those suffering from psychosocial disability may also be sent by their relatives to fetish shrines, or to spiritual camps for ‘treatment’ (generally for a fee). There are many reports of such patients being chained in the scorching sun, resulting in an aggressive attempt to escape, and/or hallucinations caused by dehydration.⁷²

MindFreedom Ghana aims to develop and facilitate the re-integration of psychiatric patients into society and to assure them of dignified, sustainable livelihoods. The organisation works to support and assist people with severe mental distress to receive the treatment they want, or to refuse a treatment with which they do not agree. The NGO also supports and assists with rehabilitative schemes for those in recovery from severe mental distress and psychiatric treatment. For example, it provides start-up capital for trading businesses in food stuffs such as yams, plantain, cassava, and maize to ensure that those in recovery can earn a livelihood and have sufficient money to provide for their own basic needs.

(2) Seher

The Seher Urban Community Mental Health and Inclusion Program in Pune, India, is designed to provide care to people in severe emotional distress directly in their communities.⁷³ The NGO provides ‘non-formal care’ via caregivers; some are paid staff, but most are unpaid volunteers. The volunteers come from low income communities who have completed primary or high school education. They organise meetings in the slums at the household level, and discuss a wide range

⁷¹ See MindFreedom Ghana (undated). *About us*. [online] Available at: <http://www.idealists.org/view/nonprofit/g24cjKCGb4w4/> [Accessed 15 Aug. 2016].

⁷² See Taylor, D. (2007), MindFreedom Ghana: Fighting for basic human conditions of psychiatric patients. In: P, Stastny & P. Lehmann (eds.), *op cit.*, nt.18, pp.336-342.

⁷³ Seher means ‘dawn’ in Urdu.

of mental health topics. The caregivers offer emotional support to those in severe emotional distress, and assist their families to support them. This inclusive approach would seem a useful model for the promotion of well-being, as required by SDG3. Having listened to the person's problems, they try to understand their issues and find out what psychic needs (such as controlling overwhelming emotions, or coping with trauma-caused stress) and social needs (such as economic problems, unemployment, domestic violence, or alcoholism) the individual and/or family might have. According to the spirit of Seher, peer support and supportive counselling is provided to the person with psychosocial disabilities as equal partners. This support includes basic counselling and body-based therapies including drumming, rhythmic movements, a variety of breath practices, body movements, certain dance movements, and mindfulness-based meditations, as well as the teaching of relaxation techniques such as chanting, dancing, muscle relaxation and deep breathing. It addresses malnutrition and hunger, and provides advice on nutrition, mediating and negotiating in the patient's interest, and establishing neighbour and foster-care support where necessary. Seher also helps to set up social support systems for individuals (food, housing, employment, education, loans, pensions, allowances, and certificates that will help people access a range of development-linked services), helping the person to identify problems, and enabling decision-making. The NGO aims to encourage hope, helping the person to move forward in a step by step process.⁷⁴

When those basic interventions are insufficiently healing, clients are referred to free 'formal care', by which is meant western medicine. If people wish, they may receive more structured therapeutic measures, including talking therapies, arts-based therapies, and referrals to more structured therapeutic support groups.⁷⁵ Those with physical health problems can be referred to a variety of health institutions. Seher also cooperates with one or two psychiatrists in a local open general hospital. Only when absolutely necessary, such as when someone's serious mental health problems are chronic and they are unable to maintain their current living situation, does the psychiatrist prescribe psychotropic medication. Such drugs are usually taken for a much shorter time than in a western setting because either the person is unable to pay for them, they are discontinued due to adverse effects, or the patient recovers. Thus, the risk of the development of chronic physical conditions like tardive dyskinesia, or physical dependency, is low. Seher is funded by a combination of local government, different agencies, grants, and individual donors. This multi-pronged approach is a realistic way in which states might replicate the approach and help to meet SDG3.

(3) La Cura and Associazione Penelope

La Cura is a social network in Sicily, which is in the southern part of Italy and has a lower socio-economic demographic than the rest of the country. La Cura offers acceptance and shelter twenty-four hours a day, seven days a week, to the socially marginalised who do not wish to accept traditional psychiatric treatment—namely, psychotropic drugs. One of La Cura's

⁷⁴ See Davar, B. (2014), *Non-formal care*. [video] Available at: <http://youtu.be/22blQzYFoMg> [Accessed 15 Aug. 2016]; Davar, B. (2014), *Peer support and support counselling*. [video] Available at: <http://youtu.be/U73aE3fhe6I> [Accessed 15 Aug. 2016].

⁷⁵ See Davar B. (2014), *Formal care*. [video] Available at: <http://youtu.be/uDTRjfgMHLE> [Accessed 15 Aug. 2016]; Pillai, K. & Davar, B. (2014), *Asha case study using arts based therapy*. [video] Available at: <http://youtu.be/xLxsXLIZMVs> [Accessed 15 Aug. 2016].

initiatives is the Telefono Viola (Purple Telephone); a phone line that provides useful legal strategies to help someone avoid coercive hospitalisation. Another such innovation is the *Associative Syndrome*, which promotes the sharing and exchange of practical knowledge by people who have had unusual emotional experiences and states of spiritual emergency (identity crises where individuals experiences dramatic changes to their normal meaning-system because of a spontaneous spiritual experience). Similar to the previously mentioned Ghanaian approach, Associazione Penelope—founded in 1996 and part of La Cura—supports people who would be labelled mentally ill by psychiatrists. It provides free meals, showers, a laundry service and fresh clothes to those with psychosocial disabilities in need. It runs an office for social services that helps to source jobs for those who wish to become more independent and earn their own livelihood. The administration of its centre is self-funded and supported by private structures and awards from public services. It is ‘de-psychiatrised’, which means that mental health workers are not allowed in the centre, and guests are free to choose whether or not they want to accept pharmacological treatment.⁷⁶

Legal measures to assist with SDG3

To meet SDG3, there are many challenges ahead for all states; social, economic, medical and, legal steps need to be taken. One possibility to assist states in meeting SDG3 is the introduction of and adherence to patient advance directives. People who want to decide about possible future treatment before a possible future psychiatric crisis have had a legal remedy in Germany since 2009, when German guardianship law was amended. The law now includes a provision that an adult considered capable of consent has the right to affirm in writing “independently of the type and stage of an illness” whether he or she “assents or disagrees with treatments, diagnostic procedures or medical interventions that are not immediately at hand at the time of this declaration”.⁷⁷ Such advance directives may include statements about personal experience and values. They offer the possibility of listing all personal and family history in relation to physical diseases. This will inform physicians, including psychiatrists, about the person’s unique vulnerabilities, including allergies to particular drugs or drug-groups. In addition, mental health workers must avoid the administration of any particular medication which the patient refused whilst they had the mental capacity to make the decision. This is a good example of how the law and a human rights approach can improve the situation of psychiatric patients dramatically, respecting their autonomy and enhancing their right to self-determination. All governments should introduce such laws. They and/or insurance companies could encourage the public to write advance psychosocial directives, as they did in Germany when the government requested clients of health insurance companies to express their readiness to donate their organs upon death. If people have difficulties in expressing their options or are illiterate, then technical support should be provided to explain the legal possibilities and to record their wishes in writing.

⁷⁶ See: Bucalo, G. (2007), A Sicilian way to antipsychiatry: La Cura. In: Stastny P. & Lehmann, P. (eds.), *op cit.*, nt.18, pp.217-223.

⁷⁷ See *Bürgerliches Gesetzbuch* (undated): para 1901a Patientenverfügung. [online] Available at: https://www.gesetze-im-internet.de/bgb/_1901a.html [Accessed 15 Aug. 2016]. For more information, see Lehmann, P. (2015), Securing human rights in the psychiatric field by advance directives, *Journal of Critical Psychology, Counselling and Psychotherapy*, 15, pp.1-10. Available at: http://www.peter-lehmann-publishing.com/articles/lehmann/pdf/lehmann_advance-directives-2014.pdf [Accessed 15 Aug. 2016].

States have a duty to respect the wishes of a patient who is undergoing treatment for physical health. The same ought to apply to the forced administration of psychiatric drugs; states must respect equality before the law, regardless of diagnosis. If ratified in individual countries, the UN Convention on the Rights of Persons with Disabilities (CRPD)⁷⁸ could establish equality before the law for persons with severe psychiatric diagnoses, safeguarding their human right to bodily integrity. Monitoring bodies that control the implementation of the CRPD,⁷⁹ as well as many users and survivors of psychiatry, consider the abolition of laws allowing forced administration of psychiatric drugs an important step to build equality before the law.⁸⁰ The same applies to particular laws strengthening people's right to have advance directives respected. Civil and criminal law already permit the emergency restraint and compulsory detention of persons in the case of serious danger to the health and the life of the patient or others. These regulations should be sufficient for psychiatry and make psychiatric privileges (like the violation under domestic law of the human right on bodily integrity) superfluous.⁸¹ Furthermore, fewer administrations of potentially toxic psychiatric drugs will protect the dignity and human rights of those diagnosed as mentally ill, and is likely to ensure a better quality of life with a decrease in mortality for psychiatric patients.

Conclusion

The world must act to reduce the excessively high mortality rate amongst psychiatric patients globally. An overwhelming majority of psychiatric patients worldwide live precariously in conditions which make them vulnerable to poor health. Psychiatric drugs, with their potentially toxic effects, contribute significantly to the excessive mortality of people who are considered to

⁷⁸ The Convention on the Rights of Persons with Disabilities (CRPD) is a treaty of the United Nations intended to improve the rights and dignity of persons with international human rights by means of proactive measures. Persons diagnosed as mentally ill belong per definition to the group of disabled people. The Convention was adopted by the United Nations General Assembly on December 13, 2006, and came into force on May 3, 2008. The convention became necessary because, in spite of human rights declarations, the human rights of psychiatric patients are violated systematically worldwide. See the United Nation *Convention on the Rights of Persons with Disabilities* (adopted 13th December 2006 and entered into force on 3rd May 2008). [online] Available at: <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html> [Accessed 3 Jan. 2017].

⁷⁹ The United Nations Committee on the Rights of Persons with Disabilities reiterated at para. 42 of its General Comment No.1 on Article 12 of the CRPD that “forced treatment by psychiatric and other health and medical professionals is a violation of the right to equal recognition before the law and an infringement of the rights to personal integrity (adopted 11th April 2014. [online.] <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G14/031/20/PDF/G1403120.pdf?OpenElement> [Accessed 17 Feb. 2017]. For further discussion of this, see the chapter by Dainius Pūras, and Julie Hannah in this book.

⁸⁰ See European Network of (ex-) Users and Survivors of Psychiatry, World Network of Users and Survivors of Psychiatry and MindFreedom International (7th June 2007), *Declaration of Dresden Against Coerced Psychiatric Treatment*. Dresden (Germany). [online] Available at: <http://www.peter-lehmann-publishing.com/articles/enusp/dresden/ddec.pdf> [Accessed 17 Feb. 2017].

⁸¹ See Lehmann, P. (2015), Psychiatrische Zwangsbehandlung, Menschenrechte und UN-Behindertenrechtskonvention. *Recht und Psychiatrie*, 33, pp.20-33. Available at: http://www.psychiatrie-beschwerde.de/fileadmin/user_upload/MAIN-dateien/Beschwerdestelle_Psychiatrie/Patientenrechte_Gesetzestexte-Patientenrechte/lehmann-sonderdruck.pdf [Accessed 15 Aug. 2016].

be psychosocially disabled. The fact that LMICs tend to have underdeveloped health monitoring systems due to resource constraints would increase the danger to psychiatric patients' lives if the use of psychiatric drugs became more widespread. As a medical discipline, psychiatry cannot solve problems that are of a social nature.

Further, the toxicity of psychotropic drugs cannot be reduced by finding the 'right' dose. Complete information about the risks of psychiatric drugs therefore must be provided to patients and their relatives at the time that they are offered, as well as measures for competent support in drug withdrawal. Both of these actions are necessary to combat the excessive mortality rate seen amongst psychiatric patients.

It must be recognised that the traditional medical model is not the only appropriate way in which to respond to existing psychosocial problems. There is significant evidence that psychosocial support is much more effective in treating psychiatric problems than medical measures and psychotropic drugs. Research has also shown that humanistic psychosocial support can result in a better outcome for psychiatric patients. Such forms of support and rehabilitation should be implemented according to the unique culture of each country, in collaboration with self-help advocates and groups and supportive relatives, as well as professionals. Self-help based approaches like those used in Seher in India, Ghana's MindFreedom or La Cura in Sicily are good examples of approaches which have worked well in LMICs, and which also offer prototypes for high income countries. Developing systems of material, social and emotional support for people in need should go hand in hand with strengthening psychiatric patients' human and civil rights. A combination of these methods will help to reduce the excessive mortality rate of those with psychiatric difficulties and enhance patients' quality of life and promote well-being, thereby helping governments to meet their responsibilities under SDG3.



About the author

[Peter Lehmann](#) is a certified pedagogue and independent publisher, author, and freelance activist in Berlin. He survived psychiatric treatment in the 1970s and regularly speaks and publishes on alternatives beyond the psychiatric biomedical model, advocating for the human rights of psychiatric patients. In 2010 he was awarded an Honorary Doctorate by the Aristotle University of Thessaloniki, and in 2011 the Order of Merit of the Federal Republic of Germany by the President of Germany.