

Professor David Healy

Mental Health (Scotland) Bill

David Healy Background

My background is as follows. I am an internationally respected psychiatrist, and psychopharmacologist. I have been a professor of psychiatry in Wales for the last 25 years, having studied medicine in Dublin, and at Cambridge University. I am a former Secretary of the British Association for Psychopharmacology, and have authored more than 200 peer-reviewed articles, 200 other pieces, and 22 books, including *The Antidepressant Era* and *The Creation of Psychopharmacology* from Harvard University Press, *The Psychopharmacologists Volumes 1-3*, *Let Them Eat Prozac* from New York University Press, and *Mania* from Johns Hopkins University Press, and *Pharmageddon* from California University Press.

I have been an expert witness in homicide and suicide trials involving psychotropic drugs, and in bringing problems with these drugs to the attention of American and British regulators, as well as raising awareness of how pharmaceutical companies sell drugs by marketing diseases and co-opting academic opinion-leaders, ghost-writing their articles.

I am a founder of Data Based Medicine Limited, which operates through its website RxISK.org, dedicated to making medicines safer through online direct patient reporting of drug effects.

Written Evidence

I was approached by Autism Rights to submit written evidence for the committee stage of the Mental Health (Scotland) Bill because of my professional profile. I agreed because of my concern at the reports and information I have received about the treatment of people who are on the autistic spectrum within the Scottish mental health system, including patients who have consulted me from Scotland. This information tallies with reports in the rest of the UK and indeed generally within Western mental health systems.

In spite of the stipulation in legislation, regulation and policy that patients and their carers should be actively involved in their treatment, families tell me repeatedly that the exact opposite is the case and I have witnessed the same in the clinical service in which I work and repeatedly in cases on which I consult that come from out of area but who have been affected by the adverse effects of psychotropic drugs.

Again and again, as an expert in the side effects of pharmaceutical drugs, I witness carers and patients pointing out that treatment is going wrong and coming to the correct diagnosis as to what is happening only to find that the psychiatrist or the services respond dismissively or punitively, even in Mental Health Tribunals.

This is a problem that affects anyone who is vulnerable to the many adverse effects that psychotropic drugs can have, be they elderly, patients with mental illness in general, or people who are on the autistic spectrum or who have a learning disability in particular. The responses to medication in these latter two groups are much more likely to “go wrong” but patients and their relatives are even less likely to be heeded when they try to point out the problems.

The Scottish Government states that the Mental Health (Scotland) Bill is intended to bring recommendations from the McManus Review into effect. I do not wish to give evidence about this Review, so I will restrict my evidence to questions 1 and 6.

1. Do you agree with the general policy direction set by the Bill?

I would have to say no.

My main concern with mental health legislation is that it ignores the reality that, for many, the treatments do not work as intended and when this is the case the results can be destructive to the person’s physical and mental wellbeing. This reality makes any provisions about the `medical necessity` of treatment in a system that can enforce treatment questionable unless there is a properly independent system that can advocate for the patient and their carer. At present there is no such system.

Patients within mental health have less rights than prisoners within the prison system and the carers of these patients are often treated as being almost as “lacking in capacity” as the person put on treatment if they question doctors or other healthcare staff about whether the treatment is in fact delivering the intended benefits.

At present we have systems that are concerned to pick up the one person in 50 who might be abused by a relative but the systems put in place to prevent this happening – which amount to a radical dismissal of the views of relatives or carers - penalise the other 49 sets of relatives and carers who are in fact the people who deliver most of the care that is given to those who need it. Failing to capitalize on the unpaid labour of those who necessarily do most of the caring is a recipe for both financial and systemic bankruptcy.

I am an acknowledged international expert on antipsychotic, antidepressant, and mood-stabilizing drugs and regularly write about the absence of evidence for their effectiveness and the way that the current system of drug regulation covers up the problems with these drugs.

Most of the views that most doctors within mental health systems offer about the treatments they recommend stem from `ghost written` articles. Almost everything at present that goes on with current drugs in use is ghost written whether it appears in the leading medical journals or not. This is both clinically and morally inappropriate and more to the point likely to lead to poor outcomes.

A further issue is that the non-publication rate in clinical trials for psychotropic

drugs approaches 50% of trials while there is a 100% lack of access to the data from trials in all studies – published or unpublished.

It is not generally known that 80% of the problems that are identified with drugs are identified by patients and their carers and sometimes their doctors, not by clinical trials. Randomised Clinical Trials (RCTs) are in fact not designed to pick up on adverse events and are the Gold Standard way to hide adverse events.

Quite apart from the sometimes tragic consequences of adverse events, there are compelling reasons to improve the quality of adverse event reporting. Adverse events are still the best way to discover new drugs, and it is perhaps no surprise as the quality of reporting has gone down, drug pipelines have dried up. There is at least some political awareness of the regressive nature of the pharmaceutical industry's reliance on `me too` drugs, but little awareness of the ultimately self-defeating effects of the industry's denial of adverse drug events on drug development.

I would strenuously make the case that the current drug regulatory systems are not serving either patients, doctors or pharmaceutical companies well and that is why I and some of my international colleagues have set up Data Based Medicine and the Rxisk website: to collate information on adverse drug events and apply this data to drug development and patient treatment based on individual needs and susceptibilities.

Given that the prescription of psychotropic drugs in Scotland is now among the highest rates of prescribing of such drugs in the world, and that these drugs can induce both suicidal and homicidal ideation, autistic spectrum disorders, learning disabilities and others problems, there are real dangers in continuing to ignore the tricks of the international pharmaceutical trade. It is neither humane nor economically sustainable to gloss over these dangers.

6. Do you have any other comment to make about the Bill not already covered in your answers to the questions above?

There is a growing international movement amongst those, like myself, who are psychiatrists and other professionals in the mental health field whose research leads them to conclude that the mental health system is in need of radical reform. It should not be possible to force medical treatment on anyone, especially where the efficacy of that treatment is in doubt and the adverse effects can be fatal.

Few if any patients – and this includes MSPs – are taking any medications with informed consent because it is simply not possible to access the data that would inform consent. Over-riding someone's inalienable right to determine what they take into their own body should not be done lightly but is in fact, especially within mental health, been done routinely.

It should be noted that psychotropic drugs are the leading cause of death in the mental health system. The adverse effects of these drugs can only be properly reported by patients and their carers, and yet these are the very people whose observations are often disputed by my fellow psychiatrists.

As legislators, MSPs have a duty to take a balanced selection of evidence. I would be very happy to elaborate on the points above both as they apply to the psychotropic drugs given to people within mental health systems and as they might also apply to any drugs given to MSPs at present.

There is a pressing need for some healthcare system to find a way to ensure that the rights all patients are acknowledged to have in principle are realized in practice. No legislation anywhere to date has found an answer to this issue – because no legislators have in fact addressed it. I have a good deal more to offer on this issue if invited to attend and present or even just to answer questions.

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