PE1651/XXXXXXXX
Dr Terry Lynch submission of 18 June 2018

This is my **fourth** submission to your Committee in relation to this petition. This is an important and serious matter. I greatly appreciate the Committee's genuine efforts to grapple with the issues that have been presented through this petition.

My intention in this submission is to provide a critique of one of the submissions to date, originating from medical sources. I do this as a medical doctor with 35 years' experience including 10 years as a GP; an accredited psychotherapist; a best-selling mental health author; the provider of a recovery-oriented mental health service; and a mental health educator. In doing so, I believe that I can help your Committee reach a more informed and nuanced understanding of this submission, and by inference, the other medical submissions. Rather than critique every submission from medical sources – a process likely to extend well beyond ten pages – I have chosen the most recent one, dated 7th June 2018, from the Royal College of General Practitioners

My primary reason for writing my last (3rd) submission to you – dated 26th April 2018, given your decision to consult with Scottish GPs, was to alert your Committee to the strategy that I felt most likely to be adopted by the Scottish GPs in their submission. Having read the submission from the Royal College of General Practitioners I see that my concerns were accurate and well founded.

Undeclared conflict of interest: an elephant in the room

The medical profession is one of the most trusted professions. [i] Medical doctors are generally seen as possessing a welcome blend of compassion, science and objectivity. As a member of the medical profession for thirty-five years – and a keen observer of mental health matters internationally for over thirty years – I have been repeatedly struck by the importance of many themes including the following – the widespread assumption that medical doctors involved in mental health care are always objective, always primarily acting in the public interest.

I hereby advise your committee that this is not always the case. In relation to the topic of concern to your Committee, as I said in previous submissions, mental health doctors – psychiatrists and GPs – have considerable 'skin in the game', and this must be borne in mind by your Committee if a conclusion that is truly in the public interest is to be arrived at.

Medical and service provider – e.g. NHS – conflict of interest in relation to this Petition

As you are aware, the subject of this petition is the very serious matter of prescribed drug dependence. As is clear from the title of this Petition, these substances must have been prescribed at some point in order for drug dependence to have occurred. There are some exceptions to this, e.g. people who obtain these substances from various illicit sources. By and large however, these substances must have been initially prescribed by a medical doctor; without such a prescription being issued, no drug dependence could have occurred.

This reality creates an immediate potential conflict of interest for the prescribers of these substances in relation to this Petition; conflict between the welfare of the public, for whom a full and proper investigation of this matter is urgently required, as evidenced in the many submissions you have received from members of the public, and the likely desire of the prescribers of these substances (and agencies such as the NHS who have supported the widespread prescribing of these substances) to minimise their exposure to (a) public criticism for failing to adequately anticipate and manage this problem (b) censure if found to have failed in their duty to the public, and (c) a reduced credibility and status in the eyes of the public. It would therefore be foolhardy to assume that submissions from those representing the prescribers of the substances in question and their agencies (e.g. NHS) are all objective and to be totally taken at face value, without questioning or testing. There are important subtexts involved here.

I am not suggesting that any individual or group is consciously setting out to misinform or to mislead. Many such biases are held – and therefore subsequently expressed – with little or no conscious awareness of so doing, often being highly influenced by years of subscribing to common ideologies – a form of 'groupthink'.

Thirty-five years of careful observation has illustrated to me that such conflicts of interests are expressed in a number of ways, including; (1) Emphasising and/or exaggerating statements and possibilities that support the ideology and modus operandi; (2) Minimising or omitting to recognise facts and possibilities that contradict the ideology and modus operandi. Both appear on several occasions within the submission in question.

Examples pointing to this conflict of interest from this Submission by Scottish Royal College of General Practitioners, dated 7 June 2018:

This is a six-page submission, which opens with a mention of two questions this group was specifically requested by your committee to address:

> 'To what extent GPs in Scotland recognise the issues raised in the petition;
> What guidance and training is available to GPs to support people to safely withdraw from drugs such as benzodiazepines and anti-depressants.'

Not until the final page of this submission – page six – is any reference made to withdrawal problems associated with antidepressants, a group of drugs explicitly identified as a core part of the Petition. Within this submission, there is no acknowledgment of the fact that many people coming off the substances we call 'antidepressants' experience significant withdrawal problems. This position is completely at variance with many of the submissions received by your committee and with my experience as a medical doctor for 35 years, working with many people who have had major withdrawal problems trying to come off antidepressants.

Your Committee needs to remain cognisant of a phenomenon I referred to in previous submissions, which is evident within this RCGP submission. I call this phenomenon 'good drug-bad drug'. In recent years, the medical profession has been very willing to classify benzodiazepines as fundamentally 'bad drugs', and in doing so, continued to insist that antidepressants are 'good drugs'. There is a great deal at

stake for medical prescribers if indeed the truth in relation to 'antidepressants' emerged into the public arena – an example of the conflict of interest to which I referred earlier. Your Committee might also take note of the fact that far more space is devoted within this submission to justifying antidepressant prescribing than to actually addressing the issues raised in the petition.

Several specific statements within this submission merit examination.
According to this submission, p. 1:

> 'One example of areas in which these medications assist is suicide prevention. With an increased use of antidepressant medication in the past 10 years, the rates of suicide have decreased among males from 25 per 100,000 (age/sex standardised) in 2008 to 18.1 in 2016 (most recent data). In females, over the same time period, the rate has decreased from 7.8 to 7.2 per 100,000'.

The clear inference here is that suicide rates have decreased secondary to antidepressant usage. This is a highly contentious claim on several grounds. Many factors contribute to rising and falling suicide rates, including many socio-economic factors. Dr. Kelly Brogan wrote a 2018 article in which she summarised a recent Swedish study which found that being on antidepressants was no protector from suicide. [ii] There are many findings in this research that contradict the assertions in this submission, for example: 'As antidepressant prescriptions increased 270% over 15 years, suicide rates also increased'. This is just one of many examples of research that raises serious questions about the commonly-made medical claims that antidepressants reduce the suicide rate.

It is further noteworthy that, while lauding the claimed benefits of antidepressants, little effort is made within this submission to balance this with a section on problems associated with these substances, including very real concerns in relation to violence towards self and others, and the fact that an alarming number of mass killings have been carried out by people either taking antidepressants, had a recent change in dosage, or stopped them recently. [iii, iv]

According to this submission, p. 2:

> 'The efficacy of antidepressants is not disputed and indeed is well supported by evidence'.

One study is referenced to support this assertion.[v] This study has been questioned by many respected researchers, including Dr. Peter Gotszche, co-founder of the highly respected Cochrane Collaboration, an internationally-respected medical authority in researching the effectiveness of medical treatments. In his analysis of this study, Dr. Gotszche stated; 'This huge systematic review does not add anything to the knowledge we already had about depression pills. . . The average effect of these drugs, SMD 0.30, is less than what is clinically relevant. . . response rates, defined as "the total number of patients who had a reduction of ≥50% of the total score on a standardised observer-rating scale for depression", are flawed and should not be trusted.'[vi] Furthermore, the much-vaunted efficacy of antidepressants has been questioned by many experienced researchers and practitioners over the past thirty years.

The emphasising of 'depression' as a serious, common medical illness requiring medical treatment

It is common in such writings as this submission for a primary focus to be on depression as a recognised medical illness, its major prevalence, and the consequent need for treatment including antidepressants, as has been the case in this submission. This strategy legitimises depression as a medical illness and consequently also the prescribing of substances by doctors for this supposed medical illness.

In fact, 'depression' is not a known verified medical illness at all, a reality confirmed by the omission of 'depression' (and all of the main psychiatric diagnoses) from comprehensive lists of brain and neurological disorders such as those contained on the websites of the US Government-backed National Institute of Neurological Disorders and Stroke, [vii] WebMD, [viii] and the Brain Foundation. [ix] Medical diseases are characterised by known, identified and verifiable biological abnormalities – referred to as 'pathology'. No such biological abnormalities have been scientifically verified in relation to the experiences and behaviours that come to be diagnosed as 'depression', which explains why there are no laboratory tests to confirm any psychiatric diagnosis, depression included.

The experiences and behaviours that come to be diagnosed as 'depression' are of themselves real, valid, often excruciating, requiring support and appropriate interventions. Repackaging these as a medical illness called 'depression' is not a scientifically valid practice. This reality is further confirmed by four of the most influential psychiatrists internationally of the past fifty years:

1. The *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), stated by the American Psychiatric Association to be 'the authoritative guide to the diagnosis of mental disorders',[x] is regularly referred to as 'psychiatry's bible'. The *DSM* is regularly referred to by doctors as providing evidence of the legitimacy of 'depression' as a medical illness. One might assume that both the *DSM* and the concept of 'mental disorder' upon which the *DSM* is grounded are solidly scientifically established, valid and verified. This is not the case. American psychiatrist Allen Frances, the lead psychiatrist of the 1994 *DSM-4* stated in a 2010 interview that 'there is no definition of a mental disorder…I mean, you just can't define it'. [xi]

2. American psychiatrist Darrel Regier was Vice-chair of the 2013 *DSM-5* Task Force. In 2012 Dr. Regier wrote that 'mental disorder definitions . . . are almost impossible to test'.[xii]

3. In a 2004 lecture to the American Psychiatric Association, then Director of the US National Institute of Mental Health Thomas Insel MD – arguably the most influential mental health institute in the world – stated that the *DSM* had '0% validity'.[xiii]

4. The late Robert Spitzer was the lead psychiatrist of the 1980 *DSM-3* Task Force, the edition in which the criteria for depression – that have since remained widely accepted as valid and beyond questioning – were first published. One might

assume that the process of identifying criteria and deciding how a diagnosis of depression would be made would have been scientific and unquestionable. When asked by American psychiatrist Daniel Carlat as to why he and his *DSM-3* Task Force decided on the presence of five criteria being necessary for a diagnosis of depression, Robert Spitzer admitted that 'it was just consensus. We came up with the arbitrary number of five'.[xiv] Not satisfied with this reply, Daniel Carlat pressed Robert Spitzer further, asking 'But why did you choose five and not four? Or why didn't you choose six?[xv] Spitzer replied, 'Because four just seemed like not enough. And six seemed like too much.' Daniel Carlat wrote that 'Spitzer smiled impishly' as he spoke this sentence.[xvi] Such is the level of 'science' associated with the criteria for a diagnosis of 'depression'.

The major scientific weakness inherent within the 'depression' diagnostic process is illustrated in two investigations published in Irish national newspapers. In a 2009 investigation, a journalist went undercover, presenting herself to five GPs as if she had the symptoms consistent with mild depression. Four out of the five GPs she attended diagnosed depression and prescribed antidepressants.[xvii] In 2013 a journalism student carried out a similar investigation. She attended seven GPs, posing as a student experiencing stress and anxiety problems as a result of a hectic final year in college. All seven GPs diagnosed depression and prescribed antidepressants.[xviii]

These two investigations provide further stark evidence of the absence of scientific verification of a diagnosis of 'depression'. It would be impossible for an investigator to feign diabetes, or multiple sclerosis, or any other known biological illness, and leave the doctor's office with a diagnosis, since these diagnoses are never made without confirmatory laboratory or radiological investigations. This reality would suggest that your Committee consider the following words on page one of this submission – 'The recognition of these types of diagnoses (depression being specifically mentioned) has increased in recent years and all have shown a notable increase in prevalence' – with due scepticism. Increases in rates of diagnosis of depression points to increased levels of subjective diagnoses by doctors, not to an increase in a known biological medical illness such as diabetes, multiple sclerosis, cancer etc.

I was struck by the medical reaction to the above-mentioned two investigations. Rather than take the striking messages of these investigations on board – the fragility of the 'depression' diagnostic process – doctors reacted with a combination of justifying how they operate and shooting the messengers. On national radio following the publication of the 2013 investigation, one prominent Irish GP stated that the seven GPs who prescribed antidepressants to the investigator 'did nothing wrong whatsoever', whereas the researcher 'lied through her teeth'.[xix] The undeclared conflict of interest to which I referred at the outset of this submission surfaces in many ways, often subtly, without conscious awareness on the part of the defenders of the status quo.

People diagnosed with 'mental illnesses' die 15-20 years prematurely. Why?

The authors of the RCGP submission state that 'Moreover, those who suffer from a mental illness are likely to die 15-20 years prematurely because of physical ill health.'

It has been a known fact for several decades that people diagnosed with various so-called 'mental illnesses' die on average 15-20 years prematurely. I note the reason given – 'because of physical ill health'. This conclusion fails to take into account a possibility unpalatable to the prescribers of psychiatric drugs – the possibility that being on long-term medication prescribed by doctors might contribute to these premature deaths.

The late Irish psychiatrist Siobhan Barry, formerly a prominent member of the Irish Psychiatric Association, generally a supporter of mainstream psychiatric ideology, acknowledged in 2014 that thousands of people with long-term psychiatric diagnoses are dying 20 years prematurely because the adverse effects they develop from medication are not being properly monitored.[xx]

Dr. Dainius Puras, United Nations Special Rapporteur on the right to health

Dainius Pūras is a Professor and the Head of the Centre for Child psychiatry, social paediatrics at Vilnius University, and teaches at the Faculty of Medicine, Institute of International relations and political science and Faculty of Philosophy of Vilnius University, Lithuania. He is also the United Nations Special Rapporteur on the Right to Health.

In 2017 Dr. Puras reported to the United Nations on the state of mental health globally.[xxi] In the public interest, I strongly recommend that your Committee take serious note of his comments as you continue to address this petition, comments that have been largely ignored within mainstream psychiatry.

Dr. Dainius Puras called for a sea-change in mental health care around the world, urging States and psychiatrists to act with courage to reform a crisis-hit system built on outdated attitudes:

'I am calling on States to move away from traditional practices and thinking, and enable a long overdue shift to a rights-based approach. The status quo is simply unacceptable. . . Mental health policies and services are in crisis - not a crisis of chemical imbalances, but of power imbalances. We need bold political commitments, urgent policy responses and immediate remedial action.' Dr. Pūras said there was a 'grossly unmet' need for rights-based care and support. Progress was being hindered by huge power imbalances in the systems currently used in policymaking, service provision, medical education and research. Other major obstacles included the dominance of the biomedical model, with its overdependence on medication, and the 'biased' use of evidence, which was contaminating knowledge about mental health.

'There is now unequivocal evidence of the failures of a system that relies too heavily on the biomedical model of mental health services, including the front-line and excessive use of psychotropic medicines, and yet these models persist. . . This pattern occurs in countries across the national income spectrum. It represents a

failure to integrate evidence and the voices of those most affected into policy, and a failure to respect, protect and fulfil the right to health.'

In his report, Mr. Pūras warned that power and decision-making in mental health are concentrated in the hands of 'biomedical gatekeepers', particularly those representing biological psychiatry.

These gatekeepers, supported by the pharmaceutical industry, maintain this power by adhering to two outdated concepts: that people experiencing mental distress and diagnosed with 'mental disorders' are dangerous, and that biomedical interventions are medically necessary in many cases.

'These concepts perpetuate stigma and discrimination, as well as the practices of coercion that remain widely accepted in mental health systems today,' underlined Mr. Pūras, calling for a 'paradigm shift' to ensure compliance with the UN Convention on the Rights of Persons with Disabilities.

'It is crucial now to assess the root causes of failure and to chart a way forward, reaching consensus on the best way to do this . . . New ways of thinking need to permeate the public sector, and mental health must be integrated into the whole of public policy. We need bold action from within the corridors of power, specifically from within the psychiatric profession and its leadership . . . Paternalistic and excessively medicalized concepts must give way to participatory, psychosocial care and support in the community. Cost-effective and inclusive options with successful outcomes do exist and are being used around the world today - they just need to be scaled up and maintained.'

It is ***essential*** that your Committee remains mindful of the considerable potential for conflict of interest within submissions that originate from persons, groups and bodies that have may have contributed to the emergence of the major problem of prescribed drug dependence.

Much of the content of my current submission also applies to the other submissions you have received from mainstream medical sources, for whom the undeclared potential conflict of interest outlined in this submission also applies. If requested to do so by your committee, I would be prepared to provide a similar critique in relation to the other mainstream medical submissions you have received.

The Scottish doctor I would most recommend you take most heed of is Des Spence, GP, who has also made a submission. Dr. Spence has a long track record of speaking out when necessary in relation to 'depression', antidepressants and other matters.

I hope that this submission is of some help to your Committee as you attempt to make sense of all of the submissions you have received. In my last submission, I correctly predicted that there would likely be considerable variance between submissions by Scottish GPs and the many members of the public who have drawn your attention to often major antidepressant drug withdrawal problems. Also in my last submission I strongly suggested that, if your Committee finds itself faced with considerable variance between submissions from people who have taken these

drugs and the prescribers of these substances and their agents such as the NHS, go with the public and their experiences. The members of the public who have expressed their experiences to you have no vested interests to protect and no conflicts of interest in relation to the matter of prescribed drug dependence, declared or otherwise.

Finally; the introduction of a helpline, while welcome, would not nearly be a sufficient response to the problem of prescribed drug dependence. The many people who have developed dependence to these substances need organised accessible services manned by people who know what they are doing.

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[i] The five most trusted professions. Excelle website. Retrieved on 16 June 2018 from http://excelle.monster.com/benefits/articles/4763-the-five-most-trusted-professions?page=2

[ii] "Antidepressants Save People From Suicide, Right?" 31, January 2018, www.madinamerica.com

[iii] "ANTIDEPRESSANTS ARE A PRESCRIPTION FOR MASS SHOOTINGS", Citizens Commission on Human Rights of Florida

[iv] "These Popular Antidepressant Drugs Can Make You Violent -- Avoid Them", 2 February 2011, www.mercola.com

[v] Cipriani A, F.T. (2018) 'Comparative efficacy and acceptability of 21 antidepressant drugs for the acute treatment of adults with major depressive disorder: a systematic review and network meta-analysis' https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)32802-7/fulltext

[vi] "Peter Gøtzsche: Cipriani review does not add anything", 22 February 2018, www.cepuk.org

[vii] https://www.ninds.nih.gov/Disorders

[viii] https://www.webmd.com/brain/brain-diseases#1

[ix] http://brainfoundation.org.au/disorders

[x] https://www.psychiatry.org/psychiatrists/practice/dsm/feedback-and-questions/frequently-asked-questions

[xi] "Inside the battle to define mental illness", 27 December 2010, www.wired.com

[xii] Darrel A. Regier, "Diagnostic Threshold Considerations for DSM-5". In Philosophical Issues in Psychiatry II: Nosology, eds. Kenneth S. Kendler and Josef Parnas, pps. 285-97. New York: Oxford University Press, 2012, pps. 285-97

[xiii] Daniel Carlat, *Unhinged: The Trouble with Psychiatry—a Doctor's Revelations about a Profession in Crisis*, London: Free Press, 2010, pps 53-4

[xiii] Daniel Carlat, *Unhinged: The Trouble with Psychiatry—a Doctor's Revelations about a Profession in Crisis*, London: Free Press, 2010, pps 53-4

[xiii] Daniel Carlat, *Unhinged: The Trouble with Psychiatry—a Doctor's Revelations about a Profession in Crisis*, London: Free Press, 2010, pps 53-4

[xiii] http://www.mindfreedomireland.com/index.php/articles-from-2009/618-the-sunday-tribune

[xiii] "Depressing truth about treating depression in the young", 3 April 2013, www.irishexaminer.com

[xiii] "Niamh, the Waterford Seven & Dr Kelly" 3 April 2013, www.antidepaware.co.uk

[xiii] https://www.independent.ie/life/health-wellbeing/mental-health/mentally-ill-dying-20-years-early-due-to-drug-sideeffects-30219777.html

[xiii] https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=21689

[xiv] Daniel Carlat, *Unhinged: The Trouble with Psychiatry—a Doctor's Revelations about a Profession in Crisis*, London: Free Press, 2010, pps 53-4

[xv] Daniel Carlat, *Unhinged: The Trouble with Psychiatry—a Doctor's Revelations about a Profession in Crisis*, London: Free Press, 2010, pps 53-4

[xvi] Daniel Carlat, *Unhinged: The Trouble with Psychiatry—a Doctor's Revelations about a Profession in Crisis*, London: Free Press, 2010, pps 53-4

[xvii] http://www.mindfreedomireland.com/index.php/articles-from-2009/618-the-sunday-tribune

[xviii] "Depressing truth about treating depression in the young", 3 April 2013, www.irishexaminer.com

[xix] "Niamh, the Waterford Seven & Dr Kelly" 3 April 2013, www.antidepaware.co.uk

[xx] https://www.independent.ie/life/health-wellbeing/mental-health/mentally-ill-dying-20-years-early-due-to-drug-sideeffects-30219777.html

[xxi] https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=21689