

NSUE Position (Discussion) Paper on the use of Psychoactive Medication/Neuroleptics

1. Introduction:

Drugs are not only widely used but also widely debated within psychiatry and among service users and survivors of psychiatry. For example, there are fierce arguments about the benefits and dangers of psychoactive medications among psychiatrists and service users/survivors.

The aim of this **discussion paper** is to make the point that debates about drugs are socially constructed. The terms of debates are not "natural"; that is, they are not a simple reflection of the properties of the drug itself. Instead, debates reflect the nature of society, especially the influence of the groups with the greatest power over the perception and deployment of the drug in question. More precisely, debates reflect a complex process of interaction between social power and the properties of drugs. The terms of the debate are shaped by the power of the most important interest groups. Drug debates are not timeless manifestations of the nature of drugs but rather contingent features of social structure and social struggle.

2. The Problem

Neuroleptics are a group of drugs which target the dopamine neurotransmitter system of the brain and are used in psychiatric treatment to manage psychosis. They are alternatively known as major tranquillisers or antipsychotics. Prior to their discovery by French researchers in the early 1950s no suitable drugs had been available for the management of psychosis. The advent of neuroleptics is sometimes identified as a turning point in the practice of psychiatry, because it made possible for the first time the treatment and control of 'mentally ill' people outside of an institutional setting. In most developed countries a large fraction of the people suffering, or in remission from psychosis, are now treated in the community. This community-based treatment depends almost entirely on dosing with neuroleptics. But neuroleptics aren't a miracle cure and their usage promotes an on-going debate within the mainstream of the psychiatric profession and among service user/survivor groups internationally. This discussion arises primarily as a result of the serious nature and unpredictability of side effects associated with the drugs. This mainstream debate tends to focus on theories about how the side effects might be minimised. The debate is propelled by the considerable number of variables involved in the prescription of neuroleptics. A match has to be made for a particular patient, with a particular type and brand of **neuroleptic** according to individual tolerance; an appropriate dosage has to be determined for each individual patient -- with the right combination of anti-side-effect drugs; and the treatment has to be continued for an indefinite period to suppress psychotic symptoms that tend to fluctuate over time. This balancing act is further complicated by a substantial fraction of patients who don't want to take the drugs and for whom tactics have to be adopted for involuntary dosing. New research is continually feeding this mainstream debate.

3. The Position

A number of interest groups play important roles in shaping this mainstream debate, **the principal ones being the state, the psychiatric profession, the pharmaceutical industry, relatives of 'mental patients' and the 'patients' themselves.** Each of these interest groups holds different positions on the use of medication as a treatment in mental health services.

4. Justification

The state administers mental health laws which typically provide for the voluntary and involuntary care, treatment and control of people who have been identified as 'mentally ill' or 'mentally disordered'. This provision by the state is based on assumptions that such people pose a danger to themselves and other people. This assumption identifies the people in direct personal contact with 'mentally ill' people -- relatives and friends -- as being in the forefront of interested parties.

The next group is **the psychiatric profession** which has been charged with the responsibility to provide the care, treatment and control and which has collectively chosen **neuroleptic medication** as the treatment of first resort for psychosis. Associated with the psychiatric profession, as an industrial support base, is **the pharmaceutical industry** which provides a significant variety of **neuroleptic** types and brands for psychiatrists to choose from. Finally there are the **'patients' or service users** themselves who can be divided into two groups -- those who concede their 'patient' status and take the **medication** willingly, and those who resist.

In examining the roles of these interest groups in the debate some points should be noted.

The role of pharmaceutical companies in the debate is significant. They fund research selectively and even advertise **neuroleptic** brands openly in medical and psychiatric journals. In doing so, they often compete for attention with reports on new **neuroleptic** research. Their role is driven by the normal market concerns (to make profit) for the promotion of product sales as well as the need to provide sufficient information about the risks of their products to minimise legal vulnerability.

The uncertain and variable conditions that surround the prescription of neuroleptics have caused the psychiatric profession itself to split into a major and a minor camp.

The mainstream debate is concerned with matching a patient to the right brand and dosage.

The minor stream is characterised most forcefully by Drs. Peter Breggin and Dr Thomas Szasz who argue that neuroleptics are an inappropriate treatment altogether. The difference between the major and minor streams of psychiatry on the subject of **neuroleptic** treatment is characterised, according to Breggin, by the majority of psychiatrists having adopted a biological interpretation of mental illness. This majority is opposed by a residual minority who remain loyal to a belief in talking therapies and experiential causes for mental illness. A second, more extreme level of this minor stream is championed by Dr. Thomas Szasz who argues that not only is **neuroleptic** treatment inappropriate but that the whole practice of

psychiatry -- its nosology (the knowledge base of a disease), diagnoses and treatments -- is all a fraud. This is despite the fact that he is himself a professor of psychiatry.

Some further points should be noted:

The first relates to feelings of empathy and responsibility amongst relatives of 'mental patients'. In so much as neuroleptics have largely replaced earlier, cruder forms of physical treatments like lobotomy, drug therapy presents itself as a comparatively mild and normal form of treatment to impose upon a "sick" family member. Most people, after all, have themselves been required to take some form of **medication** at some time in their life.

On top of the empathy aspect is the potential for relatives of mentally ill people to experience feelings of guilt. The use of neuroleptics is part of a major shift in psychiatric thinking away from the talking approach of psychotherapy towards a more complete reliance on physical forms of intervention. The underlying rationale of this shift in treatment requires an attendant shift in assumed aetiology (causes) of 'mental illness' from being one of childhood trauma to that of assumed brain malfunction. This benefits relatives because if 'mental illness' can be seen as having a physical cause, like an imbalance in brain chemistry or a genetic defect, then it can't have been family life that drove the person mad. It isn't surprising then that support groups for relatives of mentally ill people often endorse **neuroleptic** treatment with some enthusiasm.

The group which is least heard, but which all the same probably has the most significant interest in the debate, is that fraction of patients who are dosed with neuroleptics against their will. Most mental health legislation provides for involuntary hospitalisation and treatment under certain conditions. The percentage of patients who are treated involuntarily varies from country to country.

Complaints by involuntary patients can be generally sorted into two main types: complaints made by people who claim they aren't mad and don't need any treatment at all; and complaints made by people who acknowledge having unusual and unpleasant mental experiences but who report that the side-effects of neuroleptic medication are much worse. If these patients were the dominant voice in the mainstream debate, the focus would most likely shift to the issue of "informed consent."

5. Related Work

There is a wide range of related work which discusses the positions of the various interest groups outlined.

6. Conclusion

Should different groups come to dominate particular debates, then the key issues will change. For example, if service user/carer or survivor groups rather than psychiatrists dominated the debate over antipsychotic drugs, then informed consent would become the key issue rather than choice of a drug and treatment regime. A key strategy for challengers to current social debate of drugs is to attempt to change the terms of the debate. This could be an important task for NSUE to pursue in furthering the interests of service users/survivors and family members, carers and close friends.

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