ECNP european college of neuropsychopharmacology

Ambassador Joaquín Alexander Maza Martelli
President, United Nations Human Rights Council
Office of the High Commissioner for Human Rights
United Nations
CH-1211 Geneva 10
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6 October 2017

Dear Mr. Maza Martelli,

We are writing in response to the Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, issued under the aegis of the Human Rights Council.

As Europe's largest scientific organisation dedicated to the science of treatments for disorders of the brain, the European College of Neuropsychopharmacology (ECNP) commends the Human Rights Council's commitment to protecting the rights of those with psychiatric conditions and to ensuring their access to appropriate care. We enthusiastically support the United Nations' efforts to make mental health a global health priority and to dismantle the barriers disadvantaging those suffering from mental illnesses.

We are dismayed, however, at the nature of the report's assertions and the tenor of its conclusions, many of which are misinformed and counterproductive. Indeed, the partisanship exhibited by the Special Rapporteur in the report discredits the Human Rights Council and does a grave disservice to those suffering from disorders of the brain as well as those involved in their care.

To begin with the possible effects of the report on patient care, the report states that, "A growing research base has produced evidence indicating that the status quo, preoccupied with biomedical interventions, including psychotropic medications and non-consensual measures, is no longer defensible in the context of improving mental health" (para. 10). No citation is given. Later again: "many of the concepts supporting the biomedical model in mental health have failed to be confirmed by further research" (para. 18), also without corroboration. These statements, in fact, are unsupported generalisations that, taken on their face, would significantly – and recklessly – limit the treatment options available to patients and considerably increase the sum total of patient suffering.

The assertion is later modified to refer to the efficacy of "certain" psychotropic medications, which the Special Rapporteur insists are being "increasingly challenged from both a scientific and experiential perspective" (para. 27). But this too is a distortion of the evidence, as the report's own references make clear.[1] In point of fact, an important recent meta-analysis has shown that the efficacy of psychiatric medicines is entirely comparable to those of other diseases.[2] To call the effectiveness of these treatments a "myth" (para. 19) is simply wrong.

A third modification makes an additional concession: "That these interventions can be effective in managing certain conditions is not disputed," arguing that the problem is rather one of over-prescription (para. 27). The lack of a consistent view leaves the reader baffled,

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and reinforces the sense that statements are made for inflammatory rhetorical effect, with no systematic or disciplined link to the scientific evidence.

Similarly, the report states that, "There also exist compelling arguments that forced treatment, including with psychotropic medications, is not effective, despite its widespread use" (para. 64). Two references are cited. The first, specifically about compulsory community treatment (CCT), makes clear that only tentative conclusions are possible.[3] The second cautions that there are many questions still to be resolved.[4] Neither of these papers in any way supports the Special Rapporteur's contention. This is not to discount his concerns, but it points to a worryingly cavalier use of evidence that undermines confidence in the rigour and impartiality of the report. Again, the reader is forced to conclude the Special Rapporteur's intention is polemic rather than evidence-driven analysis.

In a like vein, the report states with some insight that, "In some countries, the abandonment of asylums has created an insidious pipeline to homelessness, hospital and prison" (para. 12), but later goes on to recommend that there be an "End [to] all financial support for segregated residential mental health institutions, large psychiatric hospitals and other segregated facilities and services" (para. 92.a).

Mental health care has in decades past suffered grievously from politicisation. It is painful to see this pattern repeating itself here.

Misinformed generalisations serve not only to harm patient care, but to undermine mental health care professionals. The report states (para. 7) that, "The history of psychiatry and mental health care is marked by egregious rights violations, such as lobotomy, performed in the name of medicine."[5] The Human Rights Council must be aware that any attempt to compress into one sweeping characterisation the treatment of a very wide range of disorders across every human society throughout time courts meaningless, if not absurdity. This particular characterisation though stands out both for its ignorance and irresponsibility.

The Special Rapporteur seems unaware that most of the hard-fought improvements in psychiatric treatment standards have come from *within* the mental health care profession, or that the 'biomedical model' that he repeatedly denigrates as "narrow" and "reductionist"[6] has been long since superseded by new approaches, which are energetically exploring the linkages between genes, environment, lifestyle, experience and human biology, and their application in new and better treatments.[7]

Millions of health care professionals work daily around the world to ameliorate the suffering of those who are mentally ill. They do so often under conditions of great stress, sometimes even personal danger,[8] and most receive little in the way of rewards or recognition. To have their efforts so carelessly disparaged, and stigmatised as a "culture of coercion, isolation and excessive medicalization" (para. 88)[9] – by no less than the Human Rights Council of the United Nations – is a grave injustice, and one that cannot be allowed to stand.

We in no way impugn the Special Rapporteur's motives, which we accept as sincere and well meaning and respect his commitment to combating human rights abuses. But the Human Rights Council has an extremely important mission. Reports such as this can only damage it.

We call on the Human Rights Council to review how it is possible that a report is so apparently ignorant of the state of current scientific research and the principles of evidenced-based fact-finding could have been released under its name.

The report's tendentious assertions and truculent tone are especially unfortunate in that they diminish and distract from what in the report is of genuine value. The Special Rapporteur's observations concerning underinvestment in mental health (para. 6), the shortage of trained personnel (para. 56), the over-prescription of medicines (paras. 27, 58), the need to balance

medical and psychosocial interventions (para. 20), the importance of community-based services (para. 80), the urgency of cross-sectoral approaches to address the preconditions of poor mental health (para. 13), and the inclusion of users in health-service development and provision (para. 44) are all important points and merit serious discussion.

In the spirit of co-operation, and recognising that the report is intended as a contribution to an ongoing discussion (para. 2), we would therefore welcome further dialogue with the Special Rapporteur about how to improve the mental health and well-being of our societies.

Yours sincerely,

Celso Arango, MD PhD
President

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[1] Only A. Cipriani et al., 'Comparative efficacy and tolerability of antidepressants for major depressive disorder in children and adolescents: a network meta-analysis,' *The Lancet* 388 (2016), 881-90, in any way supports the contention, and this study is limited to antidepressants. P. Tyrer and T. Kendall, 'The spurious advance of antipsychotic drug therapy,' *The Lancet* 373 (2009), 4-5, questions the improved efficacy of *second-generation* antipsychotics, not antipsychotics overall. L. Wunderink, R. M. Nieboer, D. Wiersma, S. Sytema, and F. J. Nienhuis, 'Recovery in remitted first-episode psychosis at 7 years of follow-up of an early dose reduction/discontinuation or maintenance treatment strategy: long-term follow-up of a 2-year randomized clinical trial,' *JAMA Psychiatry* 70.9 (2013), 913-20, addresses specifically the duration of treatment with antipsychotics and concludes that a dose reduction or discontinuation strategy improved long-term recovery in people with remitted first-episode psychosis compared to maintenance therapy, but advises that "additional studies are necessary before these results are incorporated into general practice." J. Le Noury, J. M Nardo, D. Healy, J. Jureidini, M. Raven, C. Tufanaru, and E. Abi-Jaoude, 'Restoring Study 329: efficacy and harms of paroxetine and imipramine in treatment of major depression in adolescence,' *BMJ* 351 (2015), h4320, while certainly arguing for lack of efficacy, refers only to the specific cases of paroxetine and high-dose imipramine for major depression in adolescents.

[2] S. Leucht, S. Hierl, W. Kissling, M. Dold and J. M. Davis, 'Putting the efficacy of psychiatric and general medicine medication into perspective: Review of meta-analyses,' *British Journal of Psychiatry* 200 (2012), 97–106. See too Y. Zhu et al., 'How well do patients with a first episode of schizophrenia respond to antipsychotics: A systematic review and meta-analysis,' *European Neuropsychopharmacology* 27 (2017) 835-44.

[3] S. R. Kisely, L. A. Campbell and R. O'Reilly, 'Compulsory community and involuntary outpatient treatment for people with severe mental disorders,' *Cochrane Database of Systematic Reviews* 2017, Issue 3. "There was very limited information available, all results were based on three relatively small trials of low to medium quality, making it difficult to draw firm conclusions, so further research into the effects of different types of CCT is much needed."

[4] H. J. Salize and H. Dressing, 'Coercion, involuntary treatment and quality of mental health care: is there any link?' *Current Opinion in Psychiatry* 18.5 (2005), 576-584). "Research activities are remarkably few in number, especially considering the frequency of involuntary measures and the controversial perception or discussion of these measures among the persons concerned, professionals, or a wider public. Many basic research questions still remain to be adequately addressed, such as the long-term effects of involuntary treatment."

[5] Again in para. 11: "the legacy of human rights violations in mental health services."

[6] See “reductionist biomedical paradigm” (para. 8), “reductionist biomedical model” (para. 19), “reductionist biomedical interpretation” (para. 25), “narrow biomedical model” (para. 55), “reductive biomedical approaches (para. 77).
[7] To take but one example: https://www.ecnp.eu/Neuroscience-and-Psychotherapy-Meeting.
[8] The report dismisses the ‘dangerousness’ of certain mentally ill patients (para. 64) as “often based on inappropriate prejudice, rather than evidence.” This unsupported assertion belittles the experiences of those treating psychotic patients.
[9] See too para. 81: “Coercion, medicalization and exclusion, which are vestiges of traditional psychiatric care relationships.”