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Law Project for
Psychiatric Rights, Inc.

January 7, 2013

The Honorable Joseph Biden
Vice President of the United States
The White House
1600 Pennsylvania Avenue
Washington, DC 20501

Re: Gun Violence Task Force

Dear Mr. Vice President:

In the wake of the unimaginable tragedy at Sandy Hook Elementary School, there has been an understandable assumption that increased use of mental health services and a mental registry is part of the solution. Understandable, but wrong.

This reaction is wrong because of two basic facts: (1) there is no reliable way to predict who will commit such a terrible act, and (2) the pervasive use of psychiatric drugs, which is the mainstay of mental health treatment, increases rather than decreases extreme violence.

With respect to the former, there is a recent Washington Post article (attached)[1] that goes through violence research, and includes the following observations:

- "There is no instrument that is specifically useful or validated for identifying potential school shooters or mass murderers."
- "The best-known attempt to measure violence in mental patients found that mental illness by itself didn't predict an above-average risk of being violent."
- "[S]tudies have shown that psychiatrists' accuracy in identifying patients who would become violent was slightly better than chance."
- "[T]he presence of a mental disorder [is] only a small contributor to risk, outweighed by other factors such as age, previous violent acts, alcohol use, impulsivity, gang membership and lack of family support."

In short, as logical as it might appear, trying to identify potential mass murderers in advance by focusing on people diagnosed with mental illness simply won't work.

With respect to (2), the propensity of psychiatric drugs to cause violence, attached is the Statement on the Connection Between Psychotropic Drugs and Mass Murder recently issued by the International Society for Ethical Psychology and Psychiatry (ISEPP), demonstrating the clear link between psychiatric drugs and violence. As the ISEPP Statement points out:

- Christopher Pittman was on antidepressants when he killed his grandparents.
- Eric Harris, one of the gunmen in the Columbine school shooting, was taking Luvox and Dylan Klebold, his partner, had taken Zoloft and Paxil.

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[1] In the interest of full disclosure, I am quoted at the very end.

- Doug Williams, who killed five and wounded nine of his fellow Lockheed Martin employees, was on Zoloft and Celexa.
- Michael McDermott was on three antidepressants when he fired off 37 rounds and killed seven of his fellow employees in the Massachusetts Wakefield massacre.
- Kip Kinkel was on Prozac when he killed his parents and then killed 2 children and wounded 25 at a nearby school.
- In fourteen recent school shoots, the acts were committed by persons taking or withdrawing from psychiatric drugs, resulting in over 100 wounded and 58 killed.
- In other school shootings, information about the shooter's prescription drug use and other medical history were kept from public records.

This last point is very important—the involvement of psychiatric drugs in many mass shootings is being withheld from the public. There have been reports that Adam Lanza was on psychiatric drugs, but that has not been confirmed to my knowledge. It is essential that the involvement of psychiatric drugs in these tragedies be investigated and reported to the public.

What is clear, is that the involvement of the mental health system and mental health professionals does not prevent these horrors and being diagnosed with a mental illness is not a reliable predictor of violence. In this regard, if one were to analyze the small correlation between a diagnosis of mental illness and violence that the Washington Post story reports, one would find (a) that the violence causing properties of psychiatric drugs is not taken into account, (b) much of the violence by people diagnosed with mental illness was provoked by the traumatic actions of the mental health system, which is often physical violence itself (or being threatened with such action),[2] and (c) what is classified as violence often does not involve serious harm.

The bottom line is that while focusing on people diagnosed with mental illness might give one the feeling that something is being done to address the problem, the fact is that it will not. Frankly, it would just be scapegoating.

Focusing on having more coercive mental health interventions and a mental health registry is doomed to failure. The National Empowerment Center, headed by Daniel Fisher, MD, has issued a very insightful statement of what will be truly helpful (attached). I understand Dr. Fisher has been asked to contribute to the Task Force's work and I hope the Task Force pays close attention to what he has to say.

Yours truly,

James B. (Jim) Gottstein, Esq.
President/CEO

cc: Daniel Fisher, MD

Enc.

[2] There was at least one unconfirmed report that Adam Lanza was being threatened with involuntary commitment just before his rampage.

The Washington Post

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Predicting violence is a work in progress

By David Brown, Published: January 3

After every act of incomprehensible violence, the world asks whether the killer could have been identified ahead of time. It's as automatic as the call for more gun control and better mental health services.

Psychologists and psychiatrists have been working for decades to try to figure out whether there's a link between mental illness and violence, and if so, which people are likely to act. Using an ever-changing tool kit of theories and questionnaires, they've made some progress.

It's now fairly clear, for example, that people with severe mental illness, such as schizophrenia, bipolar disorder and some personality disorders, are more likely to commit violent acts than others. But the risk is small. The vast majority of mentally ill people won't commit assault, rape, arson or homicide, although the risk rises sharply among those who abuse drugs and alcohol.

These insights are proving useful to psychiatrists, psychologists, judges, school administrators and others who must decide whether someone seems too dangerous to be left alone. But they aren't good enough to identify an Adam Lanza, the young man who killed 28 people, including himself, in Newtown, Conn., last month. (Lanza's mother told friends that he had Asperger syndrome, a developmental disorder, but no evidence has emerged that Lanza was diagnosed as mentally ill.)

"There is no instrument that is specifically useful or validated for identifying potential school shooters or mass murderers," said Stephen D. Hart, a psychologist at Simon Fraser University in Vancouver who is the co-author of a widely used evaluation tool. "There are many things in life where we have an inadequate evidence base, and this is one of them."

Even when someone has a history of threatening behavior, the killing of innocent people can't necessarily be prevented.

The woman accused of pushing a man to his death in front of a New York subway train on Dec. 27 had been arrested several times for assault and treated in the psychiatric wards of two hospitals. The man who fatally shot two firefighters and himself in Webster, N.Y., on Christmas Eve had killed his 92-year-old grandmother three decades earlier.

The task of identifying violence-prone individuals is even trickier with young people, who have shorter histories and whose normal development often includes a period of antisocial behavior.

The prospect that the most recent massacre, or the next one, could lead to efforts to find young men contemplating the killing of strangers worries many people. Among those expressing concern are some psychologists and former patients forcibly swept into the mental health system and treated against their will.

"I think people are going toward wanting all their kids to be screened in high school for mental illness and violence risk — and that's a bad idea," said Gina M. Vincent, a forensic psychologist at the University of Massachusetts Medical School. "That's my biggest fear of what's going to come out of this."

"We can't go out and lock up all the socially awkward young men in the world," said Jeffrey W. Swanson, a professor of psychiatry and behavioral sciences at Duke University. "But we have to try to prevent the unpredicted."

Aggravating factors

The best-known attempt to measure violence in mental patients found that mental illness by itself didn't predict an above-average risk of being violent. People released from psychiatric wards were more violent than their neighbors only if they also had drug and alcohol problems, according to the MacArthur Violence Risk Assessment Study, which tracked almost 1,000 former patients in the early 1990s.

Other research has found a link — although not a particularly strong one — between mental illness and violence.

In a 2001 study funded by the National Institutes of Health, researchers asked 35,000 adults whether they had been diagnosed with a mental illness anytime in their lives and in the previous year. They also asked a long list of questions about the subjects' personal histories and behaviors. Re-interviews were conducted three years later, asking about violent events in the intervening period.

People who reported that they'd had both "severe mental illness" and substance abuse problems in the year before the first interview had the highest rate of violence; 9.4 percent had committed a violent act. The next most violent were people with other types of mental illness (mostly antisocial personality disorder) accompanied by substance abuse — 7.2 percent of them reported violent behavior.

Groups with lower rates of violence included people suffering only from severe mental illness, 2.9 percent of whom reported having been violent; those only with substance abuse problems (2.5 percent); and those with other mental illnesses alone (1.4 percent). People without any of these problems had just a 0.8 percent rate of violence.

Over the years, researchers have made a particular effort to study violence and schizophrenia, a disorder that emerges in young adults and often includes paranoid thoughts.

An analysis of 20 studies published three years ago found that schizophrenia increased the risk of acting violently fourfold in men and even more in women. The risk of schizophrenics committing homicide was 0.3 percent — more than 10 times greater than the average citizen.

The evidence suggests that "there's a modest relative risk" for violent behavior in people diagnosed with a serious mental illness, said Swanson, the Duke researcher.

Risk assessment

If some of the mentally ill are dangerous, can they be found?

Over the years, studies have shown that psychiatrists' accuracy in identifying patients who would become violent was slightly better than chance — "obviously not good enough, given what's at stake for public safety as well as for civil liberties," said John Monahan, a University of Virginia psychologist who helped direct the MacArthur study.

So Monahan and many others came up with a constellation of "risk factors" and "protective factors" for violent behavior — analogous to the risk factors for heart disease, such as age, blood pressure, smoking and cholesterol — and included them in questionnaires.

Some of those instruments rely heavily on adding up scores. Others put more emphasis on the interviewer's clinical judgment. The most popular current strategy combines both approaches; it forces the evaluator to include any pertinent issue.

All of the approaches consider the presence of a mental disorder as only a small contributor to risk, outweighed by other factors such as age, previous violent acts, alcohol use, impulsivity, gang membership and lack of family support.

There have been numerous efforts to test these violence-predicting tools in recent decades. For example, Monahan and his colleagues incorporated 106 risk factors into a software interview program and administered it to patients being discharged from psychiatric units in Massachusetts and Pennsylvania. Of those judged to be low-risk by this tool, 90 percent committed no violence over the next six months. Of those judged to be high-risk, 49 percent committed violent acts.

"From our research, we could quickly distinguish between a patient whose chance of being violent was 1-in-10 from one whose was 1-in-2," he said.

Last summer, a large study published in the British Medical Journal found much the same thing.

It analyzed the findings of 68 studies that involved about 25,000 people in psychiatric hospitals, prisons or court-ordered detention. (The studies used a variety of assessment tools.) Of the people predicted to "violently offend," 41 percent did. Of those predicted to be nonviolent, 91 percent were. In practical terms, that meant that if authorities used the tools for the purposes of public health, they'd have to detain two people to prevent one from becoming violent.

The authors of the analysis concluded that "risk assessment tools in their current form can only be used to roughly classify individuals at the group level, and not to safely determine criminal prognosis in an individual case."

Most of this research has been conducted on populations already "enriched" with the potential for violence: psychiatric patients, drug users, binge drinkers, people who have been arrested. But some mass shooters don't fall into any of those categories.

For the general public, there's no screening tool for violence, and nobody expects that there ever will be.

Increased awareness

Is what's known about the relationship between mental illness and violence of any use after events like the mass shooting in Connecticut?

People who study and provide mental health treatment generally say, "Yes." However, that's not because people prone to violence can be found and stopped. It's because if psychiatrists, psychologists and judges become more aware of the relationship between social circumstance, behavior and risk factors for violence, then they might be able to exert influence long before a killer's plans are made.

At least that's the current thinking.

"Most people who are thinking about violence are ambivalent about it," said Hart of Simon Fraser University. "Our job is to find people who are ambivalent and convince them that violence is a bad idea."

He cited the recent case in Vancouver of a college student who told a friend she was thinking of killing a homeless man. The friend notified authorities; the student was detained and evaluated with an assessment tool called the HCR-20. She had a "death kit" of tools in her possession and had killed a cat and dog for pleasure. She was convicted of animal cruelty but will soon be released on probation, with close supervision.

But some people warn that a more aggressive mental health system would pose its own dangers.

James B. Gottstein, a lawyer in Anchorage and head of the Law Project for Psychiatric Rights, has won four cases in his state's Supreme Court supporting patients' rights to refuse to take psychiatric medicines, limiting conditions for involuntary commitment and other issues. He learned firsthand what it's like to be forcibly drugged and stigmatized by psychiatric treatment.

In June 1982, he had a manic episode that he attributes to sleep deprivation. He was working hard, suffering from jet lag after returning from Europe and living in a place where the sun didn't set at night. He was taken by the police to a mental hospital, where he spent a month.

"One of the problems that happens when you become a psychiatric patient is that everything that you do or say can be labeled as a psychiatric symptom," said Gottstein, 59, a graduate of Harvard Law School.

"If the police knock down your door and haul you off and you get upset, you get labeled as 'hostile' and 'labile.' If you decide that you're not going to react to these provocations, you get labeled as having 'a flat affect.' If you think something is funny and you laugh to yourself, then they write down 'responding to internal stimuli,' " he said.

It's not that people don't want help, Gottstein said, but that "the system basically forces things on them that they don't want." He thinks it is "entirely possible to create a system where things are voluntary."

Essential are peer counselors — people once similarly diagnosed who might be able to connect with the mentally ill when the professionals can't. There's a largely unknown movement trying that approach. But he's quite sure that's not what people calling for "greater access to mental health services" these days are talking about.

And that worries him.

ISEPP
International Society for Ethical Psychology & Psychiatry

Statement on the Connection Between Psychotropic Drugs and Mass Murder

The Board of Directors and membership of the International Society For Ethical Psychology and Psychiatry send condolences to the people of Newtown, Connecticut on their horrific losses. Our hearts go out to the parents of the children who were killed and to the families and friends of the adults who were killed.

We are calling for an inquiry into the connection between these acts of mass murder and the use of psychotropic drugs. Although the media have cited family members and acquaintances saying Adam Lanza was taking prescription drugs to treat "a neurological-development disorder", we do not know if he was on psychotropic drugs. But we do know that James Holmes, the Colorado batman shooter, had taken 100 milligrams of Vicodin immediately before he shot up the movie theatre (1). And we do know that:

- Christopher Pittman was on antidepressants when he killed his grandparents (2).
- Eric Harris, one of the gunmen in the Columbine school shooting, was taking Luvox and Dylan Klebold, his partner, had taken Zoloft and Paxil (3).
- Doug Williams, who killed five and wounded nine of his fellow Lockheed Martin employees, was on Zoloft and Celexa (4).
- Michael McDermott was on three antidepressants when he fired off 37 rounds and killed seven of his fellow employees in the Massachusetts Wakefield massacre (5).
- Kip Kinkel was on Prozac when he killed his parents and then killed 2 children and wounded 25 at a nearby school (6).
- In fourteen recent school shoots, the acts were committed by persons taking or withdrawing from psychiatric drugs, resulting in over 100 wounded and 58 killed (7).
- In other school shootings, information about the shooter's prescription drug use and other medical history were kept from public records (7).

This connection between psychotropic drugs and mass murder is not coincidental. There is enough evidence that antidepressants cause increased risk of suicide and violence for the U.S. Food and Drug Administration and its Canadian counterpart to require that drug companies include a "black box" warning to that effect on their packages. Our first knowledge of this association between psychotropic drugs and violence came from studies completed in the early 1950s, (8). This was supported by research completed on antidepressants in the mid-1970s, (9). More recent studies have corroborated this association between antidepressants and homicide/suicide, (10, 17). Antidepressants, specifically Paxil, appear to more than double the risk of hostility events in adult and pediatric placebo-controlled trials (11).

All of the classes of psychiatric drugs can cause violent, irrational, and/or manic behavior. Among other effects, these drugs cause a neurological condition called **"akathesia,"** which means that persons who take them can't sit still and feel like they are jumping out of their skin. They behave in an agitated manner which they cannot control and experience unbearable rage, delusions, and disassociation. For a detailed explanation of the neurology, chemistry, and physiology of akathesia, see *Rethinking Psychiatric Drugs: A Guide to Informed Consent* by Dr. Grace Jackson (8).

Psychotropic drugs – antidepressants, antipsychotics, mood stabilizers – impair the ability of people to accurately and effectively process emotions. They take away caring. They dull conscience. In his book *Listening to Prozac*, psychiatrist Peter Kramer reported that his patients on Prozac didn't care as much. They lost some of their conscience. This made it easier for them to do things that were hurtful to other people (12).

In his book *Medication Madness*, psychiatrist Peter Breggin presents evidence of how psychotropic drugs cause people to lose awareness of how they are behaving and to lose control over their behavior. Such people are at greatly increased risk of committing acts of crime and violence (13).

Psychotropic drugs are toxic to the children and adults who take them. Psychiatrist Grace Jackson writes that "with the possible exception of the chemotherapies used in the treatment of cancer, it would be difficult to identify a class of medications as toxic as antipsychotics." (14). The psychiatric drugs that we give to our children and adults in the United States have significant "side effects" including apathy, abnormal dreams, acute respiratory distress, akathesia, agitation, aggression, agoraphobia, paranoia, assorted blood pressure and heart problems, breast enlargement in young boys, measurable brain damage, cerebral atrophy, disinhibition, hostility, homicidal and suicidal ideation, convulsions, diabetes, Parkinsons symptoms, tardive dyskinesia, tremors, convulsions, psychosis, cerebral vascular accident, inability to express emotion, lethargy, increased chronicity of emotional problems, early dementia and early death (8,9,10,14).

We understand that many factors are involved in acts of mass murder. We are not suggesting that psychotropic drugs are the only or the major factor. But we do know there have been 22 international drug regulatory warnings about the impact of psychotropic drugs on suicidal and homicidal ideation, mania, violence and hostility (15). We do believe that there is enough evidence of the association between psychotropic drugs and mass murder to warrant an inquiry. And we believe that psychological autopsy and complete review of all medical records should be standard operating procedure in the investigations of these tragedies.

In spite of the evidence of this connection between psychotropic drugs and mass murder, the mainstream media has failed to write about it or investigate it. Psychiatrist David Healy says: "Violence and other potentially criminal behavior caused by prescription drugs are medicine's best kept secret. Never before in the fields of medicine and law have there been so many events with so much concealed data and so little focused expertise" (16). Neither has

there been an investigation by our Federal government into this connection. It is time to open the data and focus our expertise on this issue.

In closing, we again express our sadness at the murder of children and adults at Sandy Hook Elementary School and extend our best wishes during this period of grief.

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YAHOO! NEWS

National Empowerment Center (NEC) Calls for Peer-Delivered Community Services Instead of More Forced Treatment

PR Newswire – Fri, Dec 21, 2012

WASHINGTON, Dec. 21, 2012 /PRNewswire-USNewswire/ -- In the wake of the tragic Sandy Hook Elementary School shooting, there are calls for improved mental health services. Dr. Daniel Fisher, executive director of the National Empowerment Center (NEC) and a member of the President's New Freedom Commission on Mental Health, who himself recovered from a diagnosis of schizophrenia, says, "The best means to help people recover from mental health issues is by funding more voluntary, community-based services delivered by people who have ourselves recovered: people who relate mutually, or peers. Peers uniquely connect with persons in distress in a non-stigmatizing, egalitarian manner because we have been through similar experiences. Peers operate respite centers, which are alternatives to more traumatic hospitalization, and work as wellness coaches in health centers to help integrate mental health and medical care. Peers also teach the public how to help each other through emotional distress by a peer-developed program called emotionalCPR (eCPR). Also, peers are learning community-based, voluntary Open Dialogue treatment from Finland."

Despite the lack of evidence of increased violence among persons with mental health issues, some recommend an increase in forced treatment through outpatient commitment: directing mental health personnel to forcibly medicate persons in their homes if they don't comply with psychiatric orders. Dr. Fisher concludes, "Outpatient commitment is wrong because it:

- "Destroys trust, which is the cornerstone of the therapeutic alliance and recovery;
- "Is traumatic and frightens people away from treatment; and
- "Is a gross violation of the Bill of Rights."

"It is also a mistake to call for a national database of persons labeled with mental health issues, which is a violation of civil rights and a barrier to treatment," Dr. Fisher says.

"Tragedies such as Newtown's grow from a U.S. culture of violence in which guns are accessed with ease," he says. "Other developed countries have an incidence of mental health issues similar to the U.S., yet they have a much lower rate of gun-related homicides. The difference is that there are much stricter gun control laws in other developed countries. England has only 6 guns/100 persons; the U.S. has 87 guns/100 persons. Similarly, the ratio of gun-related homicides in England compared to the U.S. last year was 1-to-50. The U.S. needs stricter gun control."

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SOURCE National Empowerment Center