

## Episode 48 - Robert Whitaker: Rethinking Psychiatric Care: If We Follow the Scientific Evidence, What Must We Do to Better Promote Long-term Recovery?

[00:00:08] Welcome to living proof A podcast series of the University at Buffalo School of Social Work at [www.socialwork.buffalo.edu](http://www.socialwork.buffalo.edu). We're glad you could join us today. The series Living Proof examines social work research and practice that makes a difference in people's lives. I'm your host Adjoa Robinson and I'd like to take a moment to tell you about a new feature of living proof. In addition to listening subscribing to and sharing podcast you can now rate and write a review of each episode of living proof to rate or write a review of a podcast. Just go to our Web site at [www.socialwork.buffalo.edu](http://www.socialwork.buffalo.edu) forward slash podcast and click on the. Create your own review button. We look forward to hearing from you. Hi I'm your host Peter Sobota at the sunny campus of the University at Buffalo. Get ready for a journey and paradox in this episode. Author and journalist Robert Whitaker turns a critical eye toward psychiatry's and society's conventional wisdom about treating mental illness. Here Mr. Whitaker describes what he has discovered as he explored the evidence that is utilized to guide the treatment of psychiatric illness in the United States. Mr. Whitaker begins by discussing the history and rationale for what is referred to as evidence of the success of the use of psychiatric medications and ends this discussion with some recommendations for what would be necessary to bring about change in the delivery of drug based treatments in the care of people with psychiatric illnesses.

[00:01:48] Along the way he offers a challenge to the sight of belief that things are much better now than in the dark days of stigma and social control in responding to mental illness. He also offers the provocative revelation that the evidence suggests that the drugs believed to cure mental illnesses may in fact make matters worse and to induce chronic illness in many patients with a focus and review on the long term evidence of drug based treatments. Mr. Whitaker argues that today's use of medications caused as much harm as they do healing. He describes what he believes the impact of current practices in psychiatry has on the training of practitioners. The decision making of patients and their families and the responsibility of therapists who attempt to assist the mentally ill. He goes on to discuss his review of evidence based practices that are both alternative and mainstream in their approach to care. Robert Whitaker is the author of four books including his latest Anatomy of an epidemic. Magic Bullets psychiatric drugs and the astonishing rise of mental illness in America. In addition he is an award winning journalist and previous to writing books. He was the science and medical reporter at the Albany Times Union newspaper in New York State. Mr. Whitaker was interviewed by Amy Manning a doctoral candidate here at the school of social the question that I had thought about when I was reading Man in America was that you wrote two other books as well. But I'm not on the laps of gods and the mapmakers wife which are very interesting and compelling novels. But in those books you use more of a character development to tell a story of the people in this time period.

[00:03:39] But man in America you really start in on more of the Investigative Reporting type approach and with reason I chose to do that with this book. It's how you begin the book. What's the intent of the book What's the focus of the book. Can they be different books lend themselves to different sort of approaches and narrative strategies and both Madden America and Anatomy of an epidemic were really invest in investigative journalism pieces ultimately I mean they are histories but nevertheless it's a sense of what do we really find and we go through the documents. I mean so a lot of it is a document based scientific story. I mean this cultural information as well. Finding out what individuals who entered the system what they think of things you do have those voices but it's really the sense the focus is on let's look at the system of care we've had through historical times and how to do it. And when you do that you really have to be sort of hard edged on the documents as well. It means it's just a different focus from dogs when we look at the anatomy of an epidemic.

One of the things that I noticed when you started this book was you did talk a little bit about why you chose to visit the topic of evidence based information and mental health treatment. I think many of our readers and listeners would be interested to hear a little bit more about why you chose that. This is really key. That's a great question and I think it's important to understand the sense of evidence based medicine and how really this is an exercise in evidence based medicine.

[00:05:11] There's a reason why in my background why I believe in evidence based medicine and sort of even as a journalist trained to think that way and evidence based medicine just means that you know doctors can be a little bit deluded about their merits and therapies and that's what the history of medicine tells us. And so that and we also know that anecdotes. This is you know this destroys of individual patients really can't cover care because individuals have very different responses to therapies. So evidence based medicine is this idea that science will give us this light this sort of ability to look in a big picture at our therapies working not in what ways are they working and what are they not. So that was the sort of mindset that had brought to this book and now why did I think it was necessary to bring that to the story of psychiatric treatments today. Because of course if you had a leading psychiatrist sitting in this chair and say well we have plenty of evidence for our form of care it's you know our drug treatments far in fact evidence based and we use drugs in a way that is consistent with that evidence base. But the question that sort of immediately calls that into question of whether this form of care we have right now is really working in the big picture sense is I looked at the number of people who were on disability due to mental illness and this was just a starting point to sort of measure as we've embraced this form of care.

[00:06:31] Are we seeing disability rates go down and are we seeing even if it's not just the total number of disability but is there good evidence that really the long term course of these disorders is improving and you find of course very quickly that the disability rates have risen dramatically in terms of people with disability due to mental illness and that just raises a question what's going on. Do we have evidence that the drugs work will surprise psychiatry and say that it doesn't fact there is a certain type of evidence there. Do we have a cultural and societal belief that the medications as care has represented a dramatic improvement in here. Absolutely. So we have all these reasons to believe that in fact Thorazine should be in the psycho pharmacological revolution right. And yet we have this one question Why are we getting this rising disability rates so there's a conundrum there that I sought to explore and the only way to explore that is to look at well what is the evidence saying if we're going to try to trace the evidence all the way back through 50 years of outcomes literature what does the evidence say about this form of treatment. Is it shifting outcomes for the better or is it shifting outcomes for some odd reason for the worse. Look I'm trying to see what mainstream research can tell us about and that's really the focus of the book but that the key thing here is it's taking this main principle within medicine medicine treatment should be evidence based and supplying that to this topic. That's absolutely the approach. You briefly mentioned a piece that psychiatry has a and evidence base for the use of medication. Can you talk to us a little bit about what happens face. It's yes it's it's two parts OK.

[00:08:06] And it doesn't matter really which which when you're talking about whether it's schizophrenia or depression itself. The first is that in randomised trials so you take let's say and these are six trials to see if the drugs are effective in curbing acute episodes of psychiatric distress whether they be psychotic symptoms of depression and in these randomised trials of course should you say you take 100 people you put 50 on drug and you put 50 on placebo and then you have a target symptom of say depression and how we're going to measure that and then you have a target center or say psychosis if it's a drug for schizophrenia and then you just see after six weeks has a target symptom a bit more and the drug treated group or the placebo group and generally it's the target symptom of it's more the drug treated group. OK. And that becomes that that's why the drugs get approved by the FDA and that becomes evidence for use in sort of short curving acute episode

of psychiatric distress. And one small thing the debate will happen. Oh right now about the merits of antidepressants is really about do they need that standard of curbing acute episodes of depression better than placebo over a six week period. That's what sort of a surface research. So that's the first part of the evidence phase. The second evidence base is ok once people are on meds how long should they be maintained. That's OK. And what researchers did was a study like this. They would take say 100 people who've stabilized well on the medication and the reason you have to have good responder's is of course because the symptoms must have abated.

[00:09:32] You can't be treating people who are actively depressed or are psychotic. We get to see people were victims that were baited and then in these studies what they do is after people they abruptly withdraw the drug from. And they actually are most nearly all are abrupt withdrawal design. The other people you maintain the people on the drugs and regularly those who are abruptly withdrawn from the drug relapse at a greater rate than those maintained the drug. This was perceived as evidence that the disease returned when the drug was taken away and therefore that drugs in fact prevented relapse. They prevented the return of the symptoms and that became the rationale for using medications whether it be antipsychotics vanity Prestons long term on a regular basis OK because they prevented relapse. But now you can see there's a hole in the evidence base. And by the way this is not just me identifying the hole. There was a gentleman named Emmanuel Stip well-known psychiatrist and researcher and Desmet analyses and these sort of things who who it was 2002 tried to find out are we really nevertheless improving the long term outcome schizophrenia with these drugs. And that means her long term are they less symptomatic or more symptomatic or are they more likely to work or are less likely to work.

[00:10:43] Questions like that function whether or not function well and he said you know when it comes to long term outcomes we really just don't have that evidence and then he says something about psychiatry as a whole and he says if we really want psychiatry to be based on evidence based medicine and we take another look at the evidence we run a genuine risk of finding out things that are contrary to our beliefs as well he says. And the reason is what you're looking at depression schizophrenia there is an absence of evidence in the evidence base that shows that we're really improving the course of these disorders for the better and maybe even put that in the mind in terms of a sense of what I mean by this. Let's imagine now we have 100 people newly diagnosed schizophrenia. We diagnose psychosis and let's put 50 meds conventional care but this other 50 let's try to treat say with community care but not put them on Bense. This is going to be an not initially exposed group. Theoretically we're going to see in this not Expo's group something more of the natural course of schizophrenia the natural course of psychosis where if we follow both groups out now three years who will be doing better. What this is very different than the drug exposed and drug which one group is has never exposed to and that's really what you need to know because that tells you whether you're improving over the natural course of the disorder. And that's a very different thing and that's what is missing from the evidence phase and that's what I try to flesh out here what's sort of the natural course and how are we shifting it for the better for the worst and also looking at non-clinical outcomes. By that I mean is the evidence patients are cankers associated with the diminishment of distressing symptoms. It really isn't talking about employment rates functionality or people getting in what's their social lives like it's not looking at those questions and I think you do need to look at those questions.

[00:12:34] Do you think there's anything that's preventing us as researchers are as as from going ahead and looking at those outcomes for people. Yes and this is very unfortunate and tragic I'd say this is one of the things that I'm trying to do with this book and hopefully we will broaden our understanding with the evidence base is there have been a number of studies actually done of this sort of going to talk about whether it be for schizophrenia or depression that I've tried to look at the long term outcomes and I'll give you a very specific one in the late 1970s and early 1980s the National Institute of Mental Health began following a group research funded by the National

Institute of Mental Health named Martin Herro a psychologist at the University of. He began. It began following a group of 60 for schizophrenia patients. OK now this is going to be our best long term observational study that we've really ever had in the entire history to cure people's schizophrenia. Since the drug for one year two and a half years four and a half years seven a half years 10 and 15. He just looks how are the patients doing okay. Are they asymptomatic or are they working the hours of social life they've been in the hospital and are they on or off medication. And it's just it's not randomised so people there are some self selection going on. And here's what he finds.

[00:13:49] He finds that after two years there is a group of patients that's got Naaf medication and they are now starting to do a little bit better than those on medication and then by the year over the next course the next two and a half years that group off medication as a group actually improves quite a bit whereas those on medication they sort of stay at the same level such that by the end of four and a half years roughly 40 percent of those off medication are in recovery and more than 60 percent of working by the way and in terms of those on medication it's only five percent in recovery or 6 percent at that time and very few are working. So we see this startling finding it's totally contrary to what we think should be happening now they fall that forward for 15 years another 10 years and 15 years. That's still the divergence remain recovery and the OFT medicated group 40 percent recovery recovery in the unmedicated group only 5 percent. You'll also see that there are very few there's only about 16 percent of the medicated group and the worst outcomes section whereas nearly half of the unmedicated group are in the worst outcomes section. So at the very least this study raises questions and when we need to incorporate it into our understanding of the merits of psychiatry and psychotic schizophrenia we can have a debate. What this means what happened in this study he published his results in 2007 and no newspaper reported that it did not appear in any American newspaper any magazine anywhere. Why not. Well the the National Institute of Mental Health did not put out a press release. The American Psychiatric Association did not put out a press release and the national lines for mentally ill did not put out a press release to was no attempt to alert the press.

[00:15:30] OK now imagine just for a second if the results were reverse and that medicated group was 40 percent recovery versus 5 percent you can be sure that what had been press releases and that news would have been announced in the papers the same as confirming our societal beliefs and psychiatry's blues. Anyway it's part of what I do in Anatomy of an epidemic is identify study after study like this. I mean it earned numerous studies about long term but unfortunately do not support the conventional wisdom that challenge the conventional wisdom and raise questions about whether we really should be medicating people as a matter of course long term they never appear and they don't appear in the psychiatric textbooks either. So residents aren't learning this information either. And the reason they don't appear of course is a capitalistic cancer. It's when you do see these long term studies. It makes you think that maybe we need to use the medications in a very different manner or maybe much more of a select limited manner and that's the threatening to this enterprise that is very financially successful and frankly it is successful for the psychiatric profession as well. So that's the problem the storytellers in our society have decided to selectively present evidence to the population and even some of the evidence they present rather spun and they have with great consistency kept this long term evidence from the population that the first time that Martin Harris study appeared in any American newspapers. After I gave a talk in Wooster on this very subject that was the first time that was in 2009. I think that's part of my plea.

[00:17:00] We need to know all the evidence and if we get these outcomes that are contrary to what we believe we should discuss them as well and try to say well what does this mean in terms of the Martin Harris study. How was that presented in the 2009 AP textbook. What did they say. Because it is such a high visible study they have to mention. So they put it this way they did not give the data. There's nothing about the divergence in outcomes. But the officer right this study showed that

there are a few people who can do OK without the continuous benefit of medication. Spin is incredible. They don't give that actual information. And obviously we need actual animation and the study they are referencing you said there are 64 people that were followed for a long time. Is that a much different number than on the medication trials that last recently some of the medication trials with the higher numbers because it's easier to sort of keep track of people for six weeks than it is for 15 years. It started 15 years and plus there's obviously going to be considerable expense in going around interviewing 64 people as they split into different areas whereas that's actually a large number for a long term study. And his follow up was very good by the way surgeons mountains and people you know some of especially the drug trials funded by the drug company. So I have a lot of patience. I mean and as I Praxiteles I think there was 2500 patients in all the trials together.

[00:18:25] So there are a lot of patients who speak throughout your box you get a few examples of people who do suffer from mental illnesses or parents of children who have been diagnosed with my illness. And you talk about them making the decision to either use medication or not use medication and how families or clients look at the information that's presented and sometimes come up with drastically different conclusions as to what they're going to do for their course of treatment. Could you talk to us a little bit about how some people you've encountered have experienced their decisions to either take medication or not take medication. I think there's a real commonality here and the commonality is that they're not given much information. They're sort of saying take this sort of work. And that's really it. And these are safe. You don't really have to worry about the side effects so so often the immediate moment as she got this problem these drugs work is really not much more than that. I hate to say that with a parent deciding whether or not to put his child his or her child on medication that is a profound moment in life that is extraordinarily profound moment because when you do put your child on medication clearly there are putting down a certain path. OK. And those drugs as everyone would agree do cause changes in the brain. So that is extraordinarily profound and difficult decision. And I think we should the parents I interviewed both said we just didn't have any information. We don't really know what we're doing. You never told the children had chemical imbalances. Well the problem that's a story that is often told to parents about kids are often even to adults.

[00:20:05] But if you actually look on the science of that that's a marketing story that's a story to try to present the drugs in a certain way to the public as if they're antidotes to a known disease. And unfortunately that's just not true. I mean they haven't found chemical imbalances. The drugs actually do something very different. And this is part of the misinformation that goes into the decision making process. And I think people should be told the truth is that if your child has some symptom that is bothersome or vexing or whatever the symptom might be ok fine. But we really don't know why. OK. We do not know the biology. It's not that they have a known disease. OK. It's not that we know that this is what's happening in the brain. We just don't. OK. And in that sense we don't really know how to fix it. We're not fixing anything. That is known to be wrong. We have these drugs that act on the brain in certain ways and we have a pretty good sense of how they act on the brain. Pretty good sense of how the brain reacts to that drug. That's a very different paradigm. And I think we should be honest about that. And unfortunately in this field of medicine there hasn't been the great breakthrough in understanding the biology and it's undoubtably because it could be many reasons. But the brain is a very complicated place but there just hasn't and unfortunately many great medical advances come from when you understand the pathology. You really can't craft a treatment for that. That's one thing I think that's missing.

[00:21:33] So I think there's misinformation as if you have a chemical imbalance and that's going to fix it. That's really not true. The other lack of information is what are the long term ramifications. Do you have evidence that this is going to help your child prosper will school be healthy grow to a healthy adult. Get a job. What's the evidence show. And once you take that long term perspective especially with medicating children it can be problematic. And I think people need to know that

long term and have some sense of long term ramifications too. I think that should be part of the evidence base should you be part of what we talk about and what the response was also with with therapists to incorporate that information into their own forms of care and to the information they do give to patients and and their own decision making process. So we all need it a whole society needs a broader understanding of what these drugs really do and what is the evidence base in your book Madam America you talk a lot about the history and how people with mental illness have been treated in our society pretty much over the course of modern time. Can you talk to us a little bit about how the medications that have come about in the last 50 or so years have changed how people are treated the societal belief is that in the modern era we were much better. OK. If we look back in the Predrag era the Praet Thorazine era there was a lot of stigma and a lot of sort of Castaño shunning that whole thing.

[00:23:04] And even if you miss the sense that sometimes people were you know put away in sheds and all that sort of thing. It's a true history is a bit more complicated than that. But anyway the studies and now we are much more humanistic. OK. And that this is sort of a enlightened era get rid of the stigma and we're much more compassionate. I think we're being a little bit too self-congratulatory. I'm not sure things are as terrific as people think. I mean I think there is a sense something that happened I think are really good. I think there in some ways the stigma is decreasing. I think in terms of the sort of how care is delivered and in sort of therapeutic environments the voice of the person being treated is actually being listened to a lot more and the voice of people who've been in the system whether you call them peers or consumers or whatever is starting to be recognized more. I think it's sort of an academic level seen in state government levels and all that's really great. That's a real improvement. On the other hand you know if you're a patient who doesn't want to take the medication you get a lot of resistance pretty fast especially if you're seen as someone with bipolar disorder or schizophrenia you can be under a quarter or very fast. And when we look back at Forest treatments that we now see is not good. We think that is really sort of oppressive and abusive. Well there are certainly many patients for example today who do not like to be on anti psychotics OK for whatever reason they don't they don't like how it makes them feel and make them feel like zombies etc..

[00:24:42] Well you know our system is set up to force people to take anti psychotics with sort of state authority as well. And that's happening on a scale that never used to happen. I mean in the state hospitals the roughly 360000 people with a psychiatric diagnosis in the mental hospitals in 1955 where we have four million people now on SSI SSD and many of those people in essence are in a system that requires them to take medication. So and I do have to say with the kids today and being put on anti psychotics it is hard to find much of an evidence base that anti psychotic actually helping foster kids for example. Is it helping them grow up. Is it helping them learn coping skills. Is it just helping them to be healthy. You just don't find that. And so what's happened to the foster kids who have been under court orders are basically under sort of a lot of pressure to take and I say colleagues I think the day will come that we see this as an extraordinary mistake. So are we making progress since the arrival of the drugs and medications. In some ways yes. And a lot by the way of saying the last 15 years and sort of honoring the wishes of those treated. But there's a lot that we need to do better as well. And I do think it has to go with even honoring the voice of those who maybe don't like the medications. That's number one. And really rethinking whether this use of anti psychotic medications with kids and is that really justifies that medically justified.

[00:26:09] Because that's a profound moral dilemma I think talk a lot about the number of people that are currently on SSI or SSD eye due to mental illness or mental impairment. What are some of the things that you think have led to this dramatic increase in the number of people. Right. Well the book is meant to explore one possibility. I mean there could be many factors leading to OK there could be cultural factors. Let's say our society is breaking down in a certain way and people are lonely and therefore have more psychiatric distress or let's say it's hard to get a good job. And you

know if you're in a family where there's financial pressures that can lead to psychiatric distress and it can also lead to a need to be on SSI SSD and maybe the way you do it is through the mental illness door. There's a lot of possibilities. What I want to look at those specially since we've seen this extraordinary rise since the rival Prozac really embraced a big picture way the use of these medications and including the use of the medications for many people initially aren't really very you know they're not dysfunctional or anything like that. It's people that say with a milder bout of depression or anxiety and so I wanted to look and I know this is controversial but I wanted to look it is it possible that in fact based paradigm of care the way we're using these drugs is contributing to this is it fueling this epidemic. And you know the minute you even raise that question you get people angry at each and that question actually raises two subsidiary questions.

[00:27:41] The first one is along sort of spoke about when we look at the long term course of disorder say medicated depression medicated schizophrenia do we see that these this treatment enables people to increase sort work rates or decrease over the long term or does it increase disability or decrease disability that sort of thing. So that's question number one. OK and that's one of the things I look at from four major disorders depression anxiety schizophrenia bipolar disorder. I will tell you on that I was completely stunned by the consistency of the evidence. That does tell over the long term long term outcomes can be really problematic. The second possibility is this. You can have let's say you have people entering into care with a mild out of depression. OK. So the natural course of things they would just get better. I mean they could expect to get better if you go back much more situationally et cetera. Now let's say that person goes on an SSRI and has a manic episode and we do know that mania is a risk of drug induced mania. The rest of us SRI's not typically what happens on that they then get diagnosed with bipolar because they had this manic episode and outcomes other medications and often more powerful medications including Antisec. Well that person now is at much greater risk of going on disability than that person was when they first came into the system. In fact many of the men end up going on disability. And if that's the case and actually you do see this real clearly then you have sort of an eye estrogenic pathway to disability.

[00:29:17] You can take people with a mild disorder and two years later whatever with a bipolar diagnosis or on a cocktail and now they really are. So Cyrus is today and you see this with stimulants with accessorise that happens to a certain percentage with the kids you see it a lot with A.D.H.D drugs as well a certain percentage will have bad reactions to the stimulants. Same thing with the antidepressants. So we really need to be aware of this risk and maybe when it happens then they'll say oh we're not treating bipolar disorder we're we're we need to realize we're treating drug induced mania and let's try to let's not keep going down this path. We've got to get back to baseline. So those two things are clearly contributing to the rise in the number of SS people in SSI insisted the last part of anatomy of an epidemic. You write about some solutions. Can you give us some examples of therapeutic approaches that have been shown to produce good long term outcome. Yeah absolutely. I think the important thing is the solutions. I'm not looking at alternative solutions like herbs or anything like that. I'm looking at Mayne's what the mainstream providers do other words people associated with the government care societal care what are they searching out for solutions and finding better. OK just so this is again really evidence based mainstream stuff. I think the best example of this is the program in northern Finland in western Lapland. It's been going since 1992 in terms of how they should switch their use of medications. And it's designed to treat people with percept so it's a program that begins with the first episodes of psychosis.

[00:30:53] And when they when they do their research they follow first episodes when people first come into the system and they're following them for two and five years et cetera. So which is really nice because we're getting this initial moment and what they found and it's she a out of a national finish. OK. So what they what they found is that if you take people with that first episode of psychosis and they have something called a need adapted approach and that means some people

have different needs than others. And if you do not initially put people in and I said OK you actually try and see if the psychosis will beat with community care support intensive sort of therapy. But it's really about bringing the community around and providing some safety etc. Can you get some people through their psychotic break without putting them on neuroleptic training psychotics and with their families. Yes. Oh by the way during this time I benzo is to help people go to sleep and so it's not even during this time it's not no drug thing sort of as needed sleep medication. And what they found is this they studied this histones people who can recover without getting the medications. They have the best long term outcomes and the onus rather than becoming chronic psychosis becomes more of an episodic break and much less of a lifelong break now. So they do find that after a period of time some people in fact need to go on the medications and it might be three weeks four weeks in six weeks. It's all in the eyes of the doctor.

[00:32:14] That decision is made in conjunction with the patient and about a third of their patients. At some point in the first five years go on and I said guys that means two thirds are never exposed to the drugs and then when that once a person is on the they look to see if they still want to get the person off. That's the goal. So it's exactly the opposite that we have. And they find that only about 20 percent are patients really needs to be on medications long term comes. And by the way that the best study group of patients I think anywhere in Europe because they have this constant five year outcome studies to keep I've been doing since 1992 and they publish the results peer reviewed journals and at the end of five years roughly 85 percent of their first patients are either working or back in school. Only 15 percent from disability. Now as you know in the United States it's like practically a pathway to disability sort of said you had a psychotic break sort of expect to be on the. You need to take these trencher life. Only 15 percent on disability. Of that 85 percent. And that's the group in essence in the workforce. They have a lower unemployment rate in that group than the Finnish background population as a whole. That's how successful getting people back to work. The other thing that's really remarkable here is that schizophrenia is disappearing in northern. And here's why schizophrenia of course is a diagnosis made after someone's been psychotic for six months some can see that from the city setting in.

[00:33:42] Well they're getting people very early on with their psychotic symptoms and very few people now are going on to where they sort of become chronically ill in it before they adopted this selective use approach of medications. They had one of the highest incidences of schizophrenia and all of Europe. They were getting this a population of about 70000 and they were getting about 25 to 30 new cases of schizophrenia a year. And if you look at the incidence rate that's a lot. OK. That's almost double what it is in most parts of Europe. You know they are down now to now today two cases per year a 90 percent reduction in schizophrenia. They also now have the lowest per capita expenditures on psychiatric services of any financial district. Amazingly the other health districts haven't embraced the reasons why. But anyway that's an evidence based model you know led by psycho psychiatrist led by psychologists. It's actually you know the people work in the hospital there care putus hospital. But it's absolutely has a proven track record of 20 years. So that's an example of it's not a medication thing. It's a best use of medication practice. And as we see today there's reasons for this and they've gotten better out. So why don't we model after that. And that's one of the solutions I do in the book. Another solution. Britain is beginning to embrace for people with depression is they're saying you know the biggest risk benefit profile for first episodes of depression really isn't very good for might be with the drug. It's not very good for mild to moderate depression. It's just really not a very favorable the benefit really doesn't outweigh the risk.

[00:35:17] So they were starting to say well let's try alternatives and this is at a national level. So this is a group called the National Institute of Clinical Excellence that provides advice to the National Health Service. OK. And they said we should be trying alternatives and one of the alternatives is in fact exercise. So now in Britain you can go to your general practitioner and instead of getting a prescription for it and pressing you get a prescription for exercise. And what is a



prescription get you get you meeting with an exercise counsellor and regular meetings that gets you either free or discounted access to a gym. You get supervision to be in classes. They also want to make sure that your exercise is done in the social environment to sort of break the isolation of depression. Now there are studies about the benefits of exercise over the long term. One was done by Duke. After 10 months and a Duke study had 3 3 groups that had exercised only exercise plus drug and drug only and by far it was the exercise only group that had the best state. Well wait. After ten months they expected it would be exercise plus drug but that wasn't the case. So again what you're seeing in Britain there is very much an evidence based solution type of therapy. And I it's hard to imagine anybody would object to that. Seems like a healthy thing to do. And of course as they say this brings all sorts of other benefits it's not just the depression is there and happening in better shape they get better cardiovascular she died and turnout tends to improve.

[00:36:48] So it's almost this whole world body thing starts to happen with the exercise. And by the way the patients in terms of their response to exercise as opposed to response to drugs. When they do the sort of questionnaires about which do you like exercise comes out way ahead. So it's something like feels that that gives them a sense of agency of control of depression. They can do something. So all the evidence there says this really will be a superior first response than just getting people to think of some really wonderful examples of things that could potentially be done. We think that our society. What do you think it's going to take for society to these approaches are strictly medication models. We need to have a open and full body discussion of the sort that we're having here today and we need people to become informed about the long term outcomes data. Because once you do that we all share it because I think we do believe in evidence based means. OK. And the debate has been polarized too long in this field between drug no drug and unfortunately sometimes just because my writing does bring up questions about the drug based paradigm that's pushed into the no drug category. But I think everything you've heard today that's not what I'm at and if you read the book that's not me. So what do we need. We need honest information and we need to have discussions about this. So we need to bring out the long term data and then you and Catherine and all the social workers from this area need to have a conference and they need to discuss. Well here's the data.

[00:38:27] What does it mean. And what are what can we do differently. And I think what you're seeing for example I presented this data provider of services last night in New York City. And you know what they said oh well we need to start a house first episode psychosis modeled on the Finland model. They immediately said why don't we do that. That's a good possibility. There's another guy that's featured in the book a psychiatrist who oversees services in Framingham which is Houston. He wrote me an e-mail. He read the book. And he said you know love the book. We are going to change what we're going to do and we're going to change in a couple of ways. We're going to try to set up a pilot project where we do not medicate everybody. First episode right away. And he said frankly we're going to set up a project for those who want to try withdrawing from the medications. We're going to give them support. We're going to see how that goes. No that's inevitable evidence based strategy too. If you see that long term there are in fact many people do well off medications that's not an anti medication. It's again it's consistent with the evidence. Thank you so much for joining us today. Seems like we're an exciting time for human space study and for the recovery of meds in mental health. Thank you and thank you for having me. Pleasure. You've been listening to Robert Whitaker discuss evidence based treatment in psychiatric care and living proof. The podcast series at University of Buffalo' School of Social Work.

[00:40:01] Hi I'm Nancy Smyth Professor and dean at the university and public school of social work. Thanks for listening to our podcast. For more information about who we are our history our programs and what we do we invite you to visit our website at [www.socialwork.buffalo.edu](http://www.socialwork.buffalo.edu). At UB we are living proof that social work makes a difference in people's lives.