CITIZENS COMMISSION ON HUMAN RIGHTS

The Citizens Commission on Human Rights (CCHR) was established in 1969 by the Church of Scientology to investigate and expose psychiatric violations of human rights, and to clean up the field of mental healing. Its co-founder is Dr. Thomas Szasz, professor of psychiatry emeritus and an internationally renowned author. Today, CCHR has more than 130 chapters in over 30 countries. Its board of advisors, called Commissioners, includes doctors, lawyers, educators, artists, business professionals, and civil and human rights representatives.

CCHR has inspired and caused many hundreds of reforms by testifying before legislative hearings and conducting public hearings into psychiatric abuse, as well as working with media, law enforcement and public officials the world over.

FOR FURTHER INFORMATION:

CCHR International
6616 Sunset Blvd.
Los Angeles, CA, USA 90028
Telephone: (323) 467-4242
(800) 869-2247 • Fax: (323) 467-3720
www.cchr.org
e-mail: humanrights@cchr.org

ELDERLY ABUSE

CRUEL MENTAL HEALTH PROGRAMS

A Public Service Report from
Citizens Commission on Human Rights

"Rather than being cherished and respected, too often our senior citizens suffer the indignity of having their minds heartlessly nullified by psychiatric treatments."
— Jan Eastgate

RECOMMENDATIONS

1 Insist that any nursing home where an elderly person is to be admitted has a policy of respecting the resident's wishes not to undergo any form of psychiatric treatment, including psychoactive drugs. Sign a "Psychiatric Living Will" (available on CCHR's website) to prepare for this and give a copy to the nursing home staff.

2 File a complaint with the police about any mental health practitioner using coercion, threats or malice to get people to "accept" psychiatric treatment. Send a copy of the complaint to CCHR.

3 If you or a relative or friend have been falsely imprisoned in a psychiatric facility, assaulted, abused or damaged by a mental health practitioner, seek attorney advice about filing a civil suit against any offending psychiatrist and his or her hospital, associations and teaching institutions.

Caution: *No one should stop taking any psychiatric drug without the advice and assistance of a competent non-psychiatric medical doctor.*

This publication was made possible by a grant from the United States International Association of Scientologists Members' Trust.

1 Tracey McVeigh, "Tranquilizers 'More Lethal Than Heroin,'" *The Observer*, 5 Nov. 2000.
2 Beverly K. Eakman, "Anything That Ails You, Women on Tranqs in a Self-Serve Society," *Chronicles*, Aug. 2004.
3 *Op. cit.*, Tracey McVeigh; Matt Clark, Mary Hager, "Valium Abuse: The Yellow Peril," *Newsweek*, 24 Sept. 1979.
4 "Some Psychotropics May Be Inappropriate for the Elderly," *Geriatric Times*, Vol. II, Issue 2, Mar./Apr. 2001; Mort JR, Aparasu RR, "Antianxiety Drugs and the Elderly; For Many, Psychiatric Medications are Inappropriately Prescribed," *Archives of Internal Medicine*, Vol. 106, 2000, pp. 2825-2831.
5 Mike Masterson and Chuck Cook, "Mentally Sound Given Psychoactive Drugs," series on "Drugging Our Elderly," *The Arizona Republic*, 26 June 1988.
6 Dennis Cauchon, "Patients Often Aren't Informed of Full Danger," *USA Today*, 6 Dec. 1995.
7 Leonard Roy Frank, "San Francisco Puts Electroshock on Public Trial," *The Rights Tenet*, Winter 1991, p. 5.
8 Testimony of Dr. Colin Ross, M. D., 10 May 2004.
9 David Kroesser, M.D., Barry S. Fogel, M.D., "Electroconvulsive Therapy for Major Depression in the Oldest Old," *The American Journal of Geriatric Psychiatry*, No. 1, Winter 1993, p. 34.
10 Don Weitz, "Electroshocking Elderly People: Another Psychiatric Abuse" *Changes: An International Journal of Psychology and Psychotherapy*, Vol. 15 No. 2 May 1997.
11 H. Gregory Meyer, "Patient Deaths Led to U.S. Probe," *Chicago Tribune*, 4 Oct., 2002; H. Gregory Meyer, "Closed Hospital Probed on Medicare," *Chicago Tribune*, 2 Oct., 2002.
12 Hanna Albert, et al., "Against Their Will—Involuntary Commitment of Seniors," 20/20, ABC, 26 Jan. 1996.
13 Stanley Jacobson, "Overselling Depression to the Old Folks," *The Atlantic Monthly*, Apr. 1995, p. 46.
14 "Alzheimer's Disease and Senile Dementia," *Health Conditions, Alternative Medicine: The Definitive Guide* (Future Medicine Publishing, Inc. Washington, 1993), p. 552.

PHOTO CREDITS: 13: Jose Luis Pelaez, Inc/Corbis.

© 2004 CCHR. All Rights Reserved. CITIZENS COMMISSION ON HUMAN RIGHTS, CCHR and the CCHR logo are trademarks and service marks owned by Citizens Commission on Human Rights. Printed in the U.S.A. Item #FLO 19137

itself is reason to be sad if you dwell on it, and it is in any event a matter of life and death to contend with."

"When all doctors are aware of the reactions of old people to drugs, specialists will be out of business," Australia's Dr. Richard Lefroy said, adding that regular hospitals should be the primary center for care for the elderly, just as they are for everyone else, not nursing homes which are frequently run for profit and do not have acceptable standards—especially where they are based on a psychiatric model.

Medical studies have shown time and again that for many patients, what appear to be mental problems are actually caused by an undiagnosed physical illness or condition. This does not mean a "chemical imbalance" or a "brain-based disease." It does not mean that mental illness is physical. It does mean that ordinary medical problems can affect behavior and outlook.

Gary Oberg, M.D., past president of the American Academy of Environmental Medicine, says, "Toxins such as chemicals in food and tap water, carbon monoxide, diesel fumes, solvents, aerosol sprays, and industrial chemicals can cause symptoms of brain dysfunction which may lead to an inaccurate diagnosis of Alzheimer's or senile dementia."[14]

The very least our senior citizens deserve is to be able to enjoy their Golden Years, safe in the knowledge that they won't be taken from their homes, incarcerated in what amounts to prison conditions, drugged until they are mindless and have electrodes strapped to their heads. To render them inactive and mindless through powerful mind-altering drugs with horrendous side effects is an unforgivable assault.

Without the use of drugs or coercion, Italian physician Dr. Giorgio Antonucci salvaged the lives of hundreds of patients deemed incurable and condemned to live out their old age in institutions. He taught his patients living skills, organized concerts and field trips as part of their therapy. Subsequently many were discharged to live successful lives in the community.

INTRODUCTION
PREYING ON THE ELDERLY

In today's high-pressure world, tradition is too often replaced by more "modern" means of dealing with the demands of life. For example, while once heavily community-, church- and family-based, today the task of caring for our parents and grandparents routinely falls to organizations such as nursing homes or aged care centers. Here we trust that professionally trained staff will take care of our elders as we would care for them.

Doubtless, 67-year-old Pierre Charbonneau's wife and family felt this way when he was rushed to a hospital suffering from a severe anxiety attack reportedly related to Alzheimer's disease. Displaying "acute agitation," Pierre was prescribed a tranquilizer. Ten days later he was transferred to a nursing home where the drug dosage was immediately doubled, and then tripled three days after that. Shortly after, his wife, Lucette, found him bent over in his wheelchair with his chin touching his chest, unable to walk and capable of swallowing only a few teaspoons of pureed food.

A pharmacist warned Lucette that her husband was possibly suffering irreversible nervous system damage caused by major tranquilizers. The family called the nursing home and requested that the drugs be stopped. It was too late. Mr. Charbonneau's tongue was permanently paralyzed, a doctor later explained, and he would never regain his ability to swallow. Nine days later, Mr. Charbonneau died. The cause of death was listed as a heart attack.

For those who contemplate how to arrange care for much loved and aging parents or grandparents, it is vital to know that this tragic story is not an exception in elder care today.

The reality of nursing home and aged care center life today is often far from the stylized image of communicative, interactive and interested elderly residents living in an idyllic environment. By contrast, more often than not, the institutionalized elderly of today appear submissive, quiet, somehow vacant, a sort of

19137 CCHR Pamphlet - Elderly 10/28/04 5:07 PM Page 8

lifelessness about them, perhaps blankly staring or deeply introspective and withdrawn. If not by drugs, these conditions can also be brought on by the use of electroconvulsive treatment (ECT) or simply the threat of painful and demeaning restraints.

Rather than the failure of nursing hospital and aged care staff generally, however, this is the legacy of the widespread introduction of *psychiatric* treatment into the care of the elderly over the last few decades.

Consider the following facts about the "treatments" they receive:

- Tranquilizers, also known as benzodiazepines, can be addictive after 14 days of use.[1] In fact, medical literature clearly cautions against prescribing tranquilizers to the elderly because of the numerous dangerous drug side effects.
- Data from coroners' reports compiled by Britain's Home Office showed benzodiazepines as a more frequently contributing factor to causes of unnatural death each year than cocaine, heroin, ecstasy, and all other *illegal* drugs.[2]
- In the United States, 65-year-olds receive 360% more shock treatment than 64-year-olds, because at age 65 government insurance coverage for shock typically takes effect.

Studies show ECT shortens the lives of elderly people significantly. Specific figures are not kept, as causes of death are usually listed as heart attacks or other conditions.

The abuse is the result of psychiatry maneuvering itself into an authoritative position over aged care. From there psychiatry has broadly perpetrated the tragic but lucrative hoax that aging is a mental disorder requiring *extensive* and *expensive* psychiatric services.

The end result is that rather than being cherished and respected, too often our senior citizens suffer the extreme indignity of having their mental capacity heartlessly nullified by psychiatric treatments or their lives simply brought to a tragic and premature end. Such betrayal of the elderly and their loved ones must never be tolerated in a civilized society.

Jan Eastgate
President, Citizens Commission
on Human Rights International

CHAPTER FOUR
THE ELDERLY DESERVE BETTER

According to internationally renowned author and Professor of Psychiatry Emeritus, Thomas Szasz, "Most elderly people can care for themselves, both economically and physically, at least for awhile. … However, with the relentless advance of age, these assets gradually erode. Unless the old person receives continuous stimulation and support through human contacts at work or in the family, he becomes idle and lonely, often ending up in a nursing home, drugged into mindless passivity. If he remains alert, he may become depressed and tell himself something like this: 'No one needs me any more. I am of no use to others. I cannot even take care of myself. I am worthless. I would be better off dead.'"

Dr. Stanley Jacobson, Ph.D., wrote that "depression" among the elderly is currently a "hot topic" in the world of mental health: "If the elderly are not sad but make too much of minor ailments, or imagine disease when none can be found, the experts say they are depressed and need professional help. And if the elderly are not sad or hypochondriacal but have problems relating to appetite, sleep or energy, the experts say they are clinically depressed and need professional help."[13]

Jacobson says the "experts" are wrong. "Oldness

In his book *Prescription for Nutritional Healing*, well-known medical/health columnist and broadcaster, Dr. James Balch, says, "Senility occurs in old age but it is really not very common in the elderly. Many of those diagnosed as senile are actually suffering from the effects of drugs, depression, deafness, brain tumors, thyroid problems, or liver or kidney problems. Nervous disturbances, stroke, and cerebral dysfunction are considered symptoms of the senility syndrome. Often, a nutritional deficiency is the cause."

In most cases, the elderly are merely suffering from physical problems related to their age. However, Dr. Roberto Cestari, M.D., from Italy, says: "Psychiatry's answer to the basic problems of aging is to label them as 'depression,' as a loss of mental faculties, or even a disease and, when the person complains or protests this indignity, their protest is further labeled as a mental illness, often 'dementia.'"

"Psychiatry's answer to the basic problems of aging is to label them as 'depression' and, when the person complains or protests this indignity, this protest is further labeled as a mental illness, often 'dementia.'"

— Dr. Roberto Cestari, M.D., Italy, 2004

Underlying this is an entire foundation of fraudulent "diagnostic" criteria, specifically the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*). Through this psychiatry has any mental impairment of the aged corralled as a "mental illness." The labels are then used to involuntarily commit the elderly to a psychiatric facility, take control of their finances, override their wishes regarding their business, property or health care needs and defraud their health insurance.

Dementia and Alzheimer's disease are very lucrative fields for psychiatry, even though they are the proper domain of neurologists. Medical experts on Alzheimer's say that 99% of these cases don't belong in psychiatric hands.[12]

In the same way, psychiatrists do not belong in aged care.

CHAPTER ONE
BETRAYING OUR SENIOR CITIZENS

What is the sense of prescribing a senior citizen a tranquilizer that is more lethal and harder to withdraw from than heroin, one that leads to a 45% increase in the risk of having a car accident within seven days of taking it?[3] Why give them an antidepressant that could increase the risk of their falling by 80%, or could cause them to become agitated or aggressive or even suicidal?[4]

Common sense and decency dictate that the last thing a fragile, anxious or vulnerable elderly person needs is the additional physical and mental stress associated with heavy, addictive psychiatric drugs.

As Dr. Richard Lefroy, formerly of the Sir Charles Gardiner Hospital in Western Australia, warned his colleagues, "[Drugs] can alter older people's ability to orient themselves and can reduce their reason. As a result people want to

put them in institutions." Lefroy further stated that some *medical* drugs affect the brain and upset the patient, who is then typically prescribed tranquilizers. Irrationality, belligerence or a "dopey" appearance often result.

Dr. Jerome Avorn, an associate professor of social medicine at Harvard University, bluntly explained: "Drugs do...quiet them down. So does a lead pipe to the head."[5]

Ninety-seven-year-old Mary Whelan, previously happy at her nursing home, was labeled with "dementia" and locked up in a Florida psychiatric hospital, despite her daughter's objections. "She was so drugged that she could not keep her head up to eat her dinner. She just wanted to go to sleep. It broke my heart," her daughter told a local newspaper.

The last thing a fragile, anxious or vulnerable elderly person needs is the additional physical and mental stress associated with heavy, addictive psychiatric drugs.

In 2002, Dr. Eleonore Prochazka, a German pharmacist and toxicology expert, warned of the dangers of "using psychiatric drugs and other methods, which can lead to a destruction of the personality—even cause death."

Thomas J. Moore, a senior fellow in health policy at the George Washington University, Medical Center, reports that more than 100,000 people die every year in America from the adverse effects of prescription drugs. Moore warns: "In such a poorly managed, inherently dangerous system, consumers must pay far more attention to risks and benefits of the drugs they take. Can they recognize the adverse effects of the drugs they're taking, especially the subtle ones like fatigue or mild depression? Is this one of the drugs where a small overdose is dangerous?"

However, these are hardly questions and responsibilities that should be shouldered by the elderly. Protection from such risks must be afforded them as an intrinsic part of aged care systems.

CHAPTER THREE MISDIAGNOSING FOR PROFIT

To psychiatrists old age is a "mental disorder," a for-profit disease for which they have no cure, but will happily supply endless prescriptions of psychoactive drugs or ECT. In 1999, $194 million was paid for psychiatric services in nursing homes in the United States. An additional $1 billion was paid for treatment of the elderly in psychiatric hospitals.

In the United States, federal law provides an open door for psychiatry: each nursing home resident must have a "mental health evaluation." This excludes testing for physical illnesses, determining nutritional deficiencies or ruling out other causes of distress.

On June 28, 2001, a nurse at the Rock Creek Center Psychiatric Hospital in Illinois, found a 53-year-old patient unresponsive 12 hours after he was drugged. Hours later the man died. A mandated autopsy revealed the man died of multiple sclerosis. On the admission form, "MS" was clearly entered. However, the multiple sclerosis was ignored by psychiatric staff. Officials of the facility told later investigators they believed "MS" stood for "mental status."[11]

In 1991, psychologist Robert F. Morgan testified before a hearing into ECT that an elderly person's "depression" is often triggered or worsened by their fears of losing their memory and health, both of which electroshock is known to affect adversely.[7]

In 2004, psychiatrist Harold A. Sackheim, a major proponent of ECT, when addressing the frequency with which patients complain of memory loss, stated, "As a field, we have more readily acknowledged the possibility of death due to ECT than the possibility of profound memory loss, despite the fact that adverse effects on cognition [consciousness] are by far ECT's most common side effects."

"This is gross mistreatment on a national scale."

— Dr. Nathaniel Lehrman, retired clinical director, Kingsboro State Mental Hospital, New York

Dr. Colin Ross, a Texas psychiatrist, says that existing ECT literature shows "there is a lot of brain damage, there is memory loss, the death rate does go up, the suicide rate doesn't go down."[8]

A 1993 study revealed that ECT shortens the lives of elderly people—that "patients over 80 years old who receive ECT for major depression are at increased risk of death over the two years following treatment."[9] A Canadian study reported in 1997 that when patients receiving ECT were 80 or older, 27% died within *one* year of the "treatment."[10]

The U.S. psychiatric industry alone today reaps an estimated $5 billion a year from the administration of ECT. In addition, psychiatrists have an almost "malpractice-free" domain because any elderly patient complaints after ECT can easily be attributed to the patient's senility.

Of the estimated 300 people who die each year from ECT in America, approximately 250 of them are elderly patients. Yet, *USA Today* reported that doctors rarely report shock treatment on death certificates, even when the connection seems apparent and when death certificate instructions clearly call for it.

PSYCHIATRIC DRUGS — DESTROYING LIVES

Anyone who has pushed their way through the "clinical pharmacology" section of drug information packaging to read the list of "adverse reactions," knows that "informed consent" is something of a misnomer. In the case of the elderly it is a cruel charade. For ease of reference, the following is a partial list of the side effects of psychiatric drugs routinely prescribed for seniors:

MINOR TRANQUILIZERS

Minor tranquilizers or benzodiazepines can cause lethargy, lightheadedness, confusion, nervousness, sexual problems, hallucinations, nightmares, severe depression, extreme restlessness, insomnia, nausea and muscle tremors. Epileptic seizures and death have resulted from suddenly stopping the use of minor tranquilizers. Thus, it is important to cease taking these drugs only under proper medical supervision, even if the drugs have only been taken for a couple of weeks.

MAJOR TRANQUILIZERS

Major tranquilizers, also called antipsychotics, or "neuroleptics" (nerve-seizing), frequently cause difficulty in thinking, poor concentration, nightmares, emotional dullness, depression, despair and sexual dysfunction. Physically, they can cause *tardive dyskinesia*—sudden, uncontrollable, painful muscle cramps and spasms, writhing, squirming, twisting and grimacing movements, especially of the legs, face, mouth and tongue, drawing the face into a hideous scowl. They also induce *akathisia*, a

severe restlessness that studies show can cause agitation and psychosis. A potentially fatal effect is "Neuroleptic Malignant Syndrome," which includes muscle rigidity, altered mental states, irregular pulse or blood pressure and cardiac problems. Moreover, silent coronary death " … may be one of the most serious threats of prolonged drug use," according to William H. Philpott, M.D. and Dwight K. Kalita, Ph.D., in *Brain Allergies*.

SELECTIVE SEROTONIN REUPTAKE INHIBITORS

Selective Serotonin Reuptake Inhibitor (SSRI) antidepressants can cause headaches, nausea, anxiety and agitation, insomnia and bizarre dreams, loss of appetite, impotence and confusion. It is estimated that between 10% and 25% of SSRI users experience akathisia, often in conjunction with suicidal thoughts, hostility and violent behavior. Withdrawal syndromes are estimated to affect up to 50% of patients, depending on the particular SSRI drug. In 1998, Japanese researchers also reported in *The Lancet*, the journal of the British Medical Association, that substantial amounts of these antidepressants can accumulate in the lungs and may be released in *toxic* levels when a second antidepressant is prescribed.

NEWER ANTIPSYCHOTICS

One in every 145 patients who entered clinical trials for four atypical (new) antipsychotic drugs died, yet those deaths were never mentioned in the scientific literature. Thirty-six patients involved in the clinical trials committed suicide. Eighty-four patients experienced a "serious adverse event" of some type, which the Food and Drug Administration (FDA) defines as a life-threatening event, or one that requires hospitalization. Nine percent of the patients dropped out of the clinical trials because of adverse events, which was a similar rate to those treated with the older antipsychotics—therefore, there was no greater improvement over the older treatments, as originally touted.

CHAPTER TWO
BRUTAL TREATMENT

Jennifer Martin's 70-year-old mother started having headaches and nausea. She stopped eating and couldn't talk. A psychiatrist claimed the elderly woman was in shock from recent deaths in her family and that she needed ECT to bring her out of it. Less than 24 hours after the treatment, Jennifer's mother was dead. An autopsy revealed that her problem was not depression, but something wrong with her brain stem. "Shock treatment killed her," Jennifer said in 1997.

Although rarely referred to as shock treatment by psychiatrists, ECT involves the application of up to 460 volts of electricity through the brain, causing a grand mal seizure and irreversible brain damage.

While psychiatrists openly admit they have no idea how ECT works, they have no hesitation in shocking people, including the elderly.

Dr. Nathaniel Lehrman, retired clinical director of Kingsboro State Mental Hospital, New York, warned that elderly people can least stand the rigors of ECT. "This is gross mistreatment on a national scale," he stated.[6] Yet people 65 years of age and older comprise almost 50% of those getting electroshock today.