

## 1AC

### **Marilyn Elias, USA Today, 05/02/2006**

“New antipsychotic drugs carry risks for children”

Nancy Thomas remembers the bad old days when she had to wear long-sleeve clothes to church to cover bite marks all over her arms from her daughter Alexa's rages. At age 8, Alexa was diagnosed with bipolar disorder. She was a violent child with sharp mood swings and meltdowns that drove her to tear up the house. A mix of medicines including so-called atypical antipsychotics — drugs approved only for adults — finally stabilized Alexa's moods. Now at 15, she is able to live a more normal life — as long as she takes the medication. Even so, the teen is paying a price: On atypical antipsychotics, Alexa gained about 100 pounds in a year, putting her at risk for a host of health problems, including diabetes.

**This is why I stand resolved:**

**The United States Federal Government should substantially reform the provision of mental health services for the chronically mentally ill.**

**All definitions will be contextually defined and the affirmative reserves the right to clarify upon further scrutiny.**

**Contention One is the Harms: Unforeseen Waistlines**

- 1. More than 500,000 children are taking antipsychotics. The rate of prescription for 2 to 5 year olds is increasing the fastest.**

### **Duff Wilson, The New York Times, 09/01/2010**

“Child’s Ordeal Shows Risks of Psychosis Drugs for Young”

More than 500,000 children and adolescents in America are now taking antipsychotic drugs, according to a September 2009 report by the Food and Drug Administration. Their use is growing not only among older teenagers, when schizophrenia is believed to emerge, but also among tens of thousands of preschoolers. A Columbia University study recently found a doubling of the rate of prescribing antipsychotic drugs for privately insured 2- to 5-year-olds from 2000 to 2007. Only 40 percent of them had received a proper mental health assessment, violating practice standards from the American Academy of Child and Adolescent Psychiatry.

“There are too many children getting on too many of these drugs too soon.” Dr. Mark Olfson, professor of clinical psychiatry and lead researcher in the government-financed study, said. Such radical treatments are indeed needed, some doctors and experts say, to help young children with severe problems stay safe and in school or day care. In 2006, the F.D.A. did approve treating children as young as 5 with Risperdal if they had autistic disorder and aggressive behavior, self-injury tendencies, tantrums or severe mood swings. Two other drugs, Seroquel from AstraZeneca and Abilify from Bristol-Myers Squibb, are permitted for youths 10 or older with bipolar disorder. But many doctors say prescribing them for younger and younger children may pose grave risks to development of both their fast-growing brains and their bodies. Doctors can legally prescribe them for off-label use, including in preschoolers, even though research has not shown them to be safe or effective for children.

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2. **30% of people taking antipsychotics experience an average of 11 pounds of weight gain a year. This situation is especially significant for underage children as 36% of them become clinically obese within 11 weeks.**

**Tammy Worth, CNN.com, 11/09/2010**

"Healthy weight or healthy mind? Psych drugs can pile on pounds"

Studies have found that between 7 percent and 30 percent of people taking atypical antipsychotics experience "clinically significant" weight gain, which is defined as gaining 7 percent or more of your body weight. In those studies, the percentage of people on an atypical antipsychotic who gained a clinically significant amount of weight was between 2 and 10 times greater than the comparable rate among people taking placebo. Psychiatrists say these ranges are in line with what they see in practice. Dr. Merrill Herman, M.D., an associate clinical professor of psychiatry at the Albert Einstein College of Medicine, in New York City, says that about one-fifth of his patients who take atypical antipsychotics gain weight. Phelps says that he, too, sees the problem often. "Glucose numbers go up quickly with a lot of my patients," he says, referring to blood-sugar levels. "Most people who take Zyprexa get a profound weight gain, even though the studies don't seem to come out like that." Dropout rates are one reason weight gain may be understated in studies. The percentage of study participants who, for a variety of reasons, stopped taking antipsychotics (both first- and second-generation) has been as high as 82 percent. Weight gain is a common reason for discontinuing treatment, so the people who stay with a drug until the end of a study may be less prone to its metabolic side effects. Health.com: Signs you should stop, adjust, or switch antidepressants In addition, the manufacturers of some atypical antipsychotics have been accused of suppressing data. In a now-notorious internal email from 1999 that came to light during the recent lawsuits, a manager at AstraZeneca described the company as having "buried" (i.e., declined to publish or publicize) at least three clinical trials involving Seroquel. In one of those studies, 45 percent of the patients who took the drug experienced substantial weight gain -- 11 pounds in one year, on average. (A spokesperson for AstraZeneca, which has agreed to pay hundreds of millions to settle lawsuits related to Seroquel, has said that the company disclosed this study to the FDA, and that Seroquel's side effects, including weight gain, are listed in the prescribing information.) The study populations may also explain in part why weight gain appears to be less common in studies than in the real world, says Dr. Stephen Greevich, M.D., a child and adolescent psychiatrist in Chagrin Falls, Ohio, and a professor of psychiatry at Case Western University. Many of the children who enroll in studies that drug companies conduct for FDA approval have already tried other antipsychotics, and thus may have already experienced some weight gain, Greevich says. A 2005 study in the Journal of the American Medical Association that did look at children and teenagers who were taking an atypical antipsychotic for the first time found that 10 percent to 36 percent became overweight or obese after just 11 weeks on the drugs.

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### **3. Atypical antipsychotics lead to childhood obesity and increases the risk of health problems associated with obesity.**

#### **Science Daily, 09/03/2008**

"Risks And Benefits Of Antipsychotics In Children And Adolescents" <http://www.sciencedaily.com/releases/2008/09/080901205624.htm>

Childhood obesity is increasing worldwide and is associated with an increase in other cardiovascular risk factors in childhood, such as dyslipidemia, hypertension, and impaired glucose tolerance (Weiss et al., 2004). In addition, there is increasing concern about second-generation antipsychotics having metabolic side effects such as weight gain, hyperglycaemia, and dyslipidemia in the paediatric population (Correll, 2008). In the first study directly comparing weight gain and other metabolic and hormonal risk factors after treatment with 3 different new-generation antipsychotics in children and adolescents (mean age 15.2 years), it was shown that, after 6 months, body mass index scores and total cholesterol levels increased significantly, with 33 patients (50.0%) with no previous antipsychotic exposure showing significant weight gain (Fraguas et al., in press). The number of patients at risk for adverse health outcomes increased from 11 (16.7%) to 25 (37.9%). These changes in metabolic parameters were different for the different antipsychotics studied. In the naturalistic study conducted by our group in early-onset psychosis patients, weight gain was also greater with olanzapine than with risperidone or quetiapine (Castro-Fornieles et al., in press). **Weight gain in children raises the concern that, if treated for long periods, these patients may be at higher risk of insulin resistance, diabetes, hypertension, and cardiovascular disease in the future.** If drugs likely to induce weight gain must be used, compensatory behavioural or pharmacological approaches should be implemented (Laita et al. 2007; Correll, 2007).

### **4. Obese children become obese adults and results in a multitude of health risks leading to a lower quality of life.**

#### **US Department of Health and Human Services**

"Childhood Obesity" [http://aspe.hhs.gov/health/reports/child\\_obesity/](http://aspe.hhs.gov/health/reports/child_obesity/)

Being overweight during childhood and adolescence increases the risk of developing high cholesterol, hypertension, respiratory ailments, orthopedic problems, depression and type 2 diabetes as a youth. One disease of particular concern is Type 2 diabetes, which is linked to overweight and obesity and has increased dramatically in children and adolescents, particularly in American Indian, African American and Hispanic/Latino populations.[9] The hospital costs alone associated with childhood obesity were estimated at \$127 million during 1997–1999 (in 2001 constant U.S. dollars), up from \$35 million during 1979–1981.[10] Looking at the long-term consequences, overweight adolescents have a 70 percent chance of becoming overweight or obese adults, which increases to 80 percent if one or more parent is overweight or obese.[11] Obesity in adulthood increases the risk of diabetes, high blood pressure, high cholesterol, asthma, arthritis, and a general poor health status.[12] In 2000, the total cost of obesity for children and adults in the United States was estimated to be \$117 billion (\$61 billion in direct medical costs).[13]

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**Contention 2 is Inherency.**

**Atypical antipsychotics are overused in the status quo because pharmaceutical companies have been massively promoting them and they profit from the process.**

**Maia Szalavitz, Time Magazine, 11/05/2010**

"Why Has Childhood Bipolar Disorder Become an Epidemic?"

Unfortunately, drug companies looking to increase sales have used parents' desperation very much to their advantage, and their strategy has been especially successful given the backdrop of a fragmented health system with a chronic shortage of child psychiatrists and little insurance coverage for psychological or behavioral therapies that don't carry the risk that medications do. (More on TIME.com: Mind Reading: Carl Elliott on the Dark Side of Medicine). Bioethicist Carl Elliott recently also told me that the rise in bipolar diagnoses has contributed to a huge spike in the sales of antipsychotic medications. "Bipolar is the big one here," he said. "Now, everybody's got it. It used to be rare, but you can chart the rise, and it goes up with the introduction of 'atypical' antipsychotics." Now, more than 500,000 children take antipsychotic drugs. And the biggest fines in U.S. history — to the tune of several billion dollars — have been paid by pharmaceutical companies over the last few years for marketing these medications without FDA approval to treat children and the elderly. There still is no conclusive data about their long-term effectiveness or safety. Our kids deserve better!

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**The United States Federal Government should substantially reform the provision of mental health services for the chronically mentally ill through the following steps:**

**First, the USFG should ban the prescription of atypical antipsychotics for bipolar disorder to persons under the age of 18 in the United States.**

**Second, the USFG should recommend lithium as the primary form of treatment for bipolar disorder for persons living under the age of 18 in the US.**

**The agency will be Food and Drug Administration.**

**Funding and Enforcement will be through normal means.**

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### Contention 3 is Solvency:

1. **Plan prevents atypical antipsychotics from being prescribed.**
2. **Lithium is historically shown to be the most effective mood stabilizer for bipolar disorder. It results in a 82% reduction of suicide.**

### David L. Dunner, MD from University of Washington, 2004

"Correlates of Suicidal Behavior and Lithium Treatment in Bipolar Disorder" Center for Anxiety and Depression and the Department of Psychiatry and Behavioral Sciences

One area of research agreement is that lithium effectively decreases suicidal behavior in patients with bipolar disorder. In a review of the literature concerning the efficacy of lithium in treating affective disorders, Muller Oerlinghausen reported that lithium should be considered a first line mood stabilizer in affective disorders particularly in patients with a history of suicide attempts. In fact, Muller Oerlinghausen stressed that psychiatrists and other physicians should exercise extreme caution when discontinuing lithium treatment or switching to another mood stabilizer, because a patient might have been protected against suicidal impulses despite an incomplete response in the number and quality of depressive and manic episodes. Baldessarini et al. conducted a recent meta-analysis in which lithium was shown to have a profound effect on reducing suicidal behavior in patients with bipolar depression. Data from 34 studies comprising 42 groups receiving an average of 3.36 years of lithium maintenance treatment and 25 groups with no lithium treatment were followed for 5.88 years. A total of 16,221 patients were included with a gross experience of 64,233 person years. As illustrated in Figure 1, rates for suicide attempts were 0.94 without lithium versus 0.17 with treatment (an 82% difference, versus approximately 0.02 for the general population. Risk for all suicidal acts was reduced for unipolar depressive disorder by 100%, for bipolar II disorder by 82%, and for bipolar I disorder by 67%.