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Essay

Psychiatric Drugging of Children and Youth as a Form of Child Abuse: Not a Radical Proposition

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Although affirming that the psychiatric drugging of children constitutes both adultism (oppression based on treating adult behavior as normative) and sanism (oppression based on prioritizing what are seen as "normal" states of mind), and noting the role of pharmaceutical profit in what is happening, this article argues that in the strictest sense of the term the psychiatric drugging of children is a form of child abuse. It attempts to demonstrate not only that is this a form of child abuse but also that such a claim itself, as radical as it seems, follows from a combination of drug research and conventional understandings of abuse. The article further examines inaccurate claims about psychiatric drugs and the damage which they actually do. It proceeds to demonstrate that what is happening with respect to children constitutes child abuse as conventionally defined. Particularly focal is the United Nations Convention on the Rights of the Child. Action recommendations made in accordance with the findings include consciousness-raising and the launching of law suits at all levels.

Keywords: psychiatric drugs; abuse; children; child abuse; United Nations Convention on the Rights of the Child (UNCRC); United Nations

The context in which this article is written is the enormous psychiatric drugging of children—a major phenomenon throughout the world, particularly pronounced in North America and especially the United States. Breggin (2010), for instance, estimates that in the United States, 20% of all children are on psychiatric drugs. A related context is the emergence of a new discourse which frames all such drugging as a form of child abuse in the strictest sense of the term (Baughman & Hovey, 2006; Breggin, 2010, 2014; Healy, 2009). This article engages with, fleshes out, and lends further support to that proposition.

My major contention in this article is that the psychiatric drugging of children—and what I write about children should be read as applying to youth as well—is at once a violation of the rights of the child and beyond that a form of child abuse. I am aware, of course, that this is a difficult proposition for most people to wrap their mind around for, as Healy (2009) so astutely points out, harm committed by "helping professionals" is generally only seen as abuse when it departs from what is professionally recognized as "standard care"—however oppressive that "care" may be. Yet, to be clear, it is not simply the extreme, that is, what typically is called "overdrugging," nor is it simply what I would suspect is rare,

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maliciously intended drugging, but rather it is precisely the everyday psychiatric drugging of children that is being identified here as a form of abuse.

Lest there be any misunderstanding, I would add, at this point, that I agree, of course, that practitioners' every day delivery of psychiatric drugs to children and that educators' every day cooperation with such drugging are instances of people doing what they have been trained to do—not instances of intent to harm. Correspondingly, parents for the most part are trying to be "good parents" by following doctors' orders. One must indeed feel for their plight and lament the terrible situation in which we as a society have placed them. All the more reason, I would suggest, to gain clarity and to act on it.

The purpose of this article is twofold: (a) to demonstrate that the psychiatric drugging of children is a form of child abuse and (b) to fill a major gap in the literature. In that last respect, scholarship in this area has overwhelmingly concentrated on the medical nature of what is being done—the fact that the drugs create physical harm (e.g., Breggin, 2010, 2014; Healy, 2009). The point is well taken. Having convincingly argued that the drugs do not help but damage, however, authors typically make a leap for which they have not provided grounding. That is, they go from articulating the harm done to concluding child abuse, offering no or negligible additional rationale for the application of this label. To put this another way, they proceed as if no argument needs be made to equate harm done to the child to violation of the child's rights on one hand and to child abuse on the other, as if such equations are a matter of common sense. To be clear, I do not dispute the equation. This notwithstanding, I would suggest that we need to articulate with greater care what makes this an infringement of rights or child abuse. What is common sense to one person may not seem like common sense to another. What is likewise significant, insofar as there are social consensuses codified into guidelines and principles, we would do well to draw on them if they can provide grounding for the claims being advanced.

This understood, this article goes from establishing the medical and emotional harm done to examining the various ways in which the psychiatric drugging of children fits *established* societal frames around what constitutes the violation of children's rights and what constitutes child abuse. The United Nations Convention of the Rights of the Child (UNCRC, 2010) is particularly focal—the relevance of which initially started to be theorized by LeFrançois and Coppock (2014). A meticulous demonstration of the fit, I would add, is critical for, insofar as it can be shown that what is happening to the children constitutes child abuse as *conventionally* defined or rights abuse as defined by an institution recognized as a moral authority, such a demonstration provides ammunition for any fight ahead to put a stop to it. Moreover, it changes the status of the claim being made. Precisely by embedding the claim in both various standard definitions of abuse as well as in the constructions of well-recognized moral authorities, this article places the identification of the psychiatry drugging of children as child abuse as common sense —something, to put it another way, that cannot be dismissed as "extreme." How can it be an extreme or even a radical proposition to claim that this drugging violates rights, when, for example, the instruments of the United Nations (UN) in essence establish this? Hence the importance of this article. To wit: It takes a concern of those of us who are committed to antioppression praxis in this area and turns it into something that *all* people can align with.

This article begins with a discussion of the psychiatric drugs. It goes on to examine the fit with various conceptualizations of abuse, child abuse, and rights violations. It concludes that on various counts such drugging violates the rights of the child and constitutes abuse. Critical questions taken up along the way include the following: What makes the

psychiatric drugging harmful? What makes the psychiatric drugging of children a violation of rights and child abuse? What specific UNCRC articles are violated? And it ends with concrete suggestions on how we might address the situation.

PSYCHIATRIC DRUGS AND THEIR USE WITH CHILDREN

It is generally assumed that many children need to be on psychiatric drugs because of a psychiatric disorder which they have and which the drug hypothetically addresses. The rationale is that the child has a mental disorder and that there are specific drugs tailored for the disorder—hence the appropriateness of the "treatment." However, as painstakingly shown by Burstow (2015), Breggin (2008a), and Colbert (2001), there is no physical foundation for any of the so-called mental disorders. Correspondingly, as clearly demonstrated by numerous authors (e.g., Burstow, 2015; Kirk & Kutchins, 1997), diagnoses lack at once coherence, validity, and reliability. By the same token, although the drugs in question are claimed to correct chemical imbalances, as authors like Burstow (2015), Breggin (2008a), and Colbert (2001) in various ways demonstrate not only is there no proof that any of the individuals labeled with "mental disorder" have imbalances and not only is nothing "corrected" but research establishes conclusively that each and every one of the drugs creates chemical imbalances. However one understands "effectiveness," nor has it been shown that in the long run that any of these substances are any more effective than placebo (see Healy, 2009). For example, it is hypothesized that use of stimulants results in better grades at school. However, Barkley (1978) long ago established that stimulants lead to no long-term academic improvement (for an overview of more recent studies that show the same, see Currie, Stabile, & Jones, 2014).

This evidence casts serious doubt on use of psychiatric drugs. The issue of abuse *per se* becomes clear as we focus in on what the drugs actually do. Each and every class disrupts normal chemical levels, creating both short-term and permanent imbalances. Each and every class can lead to structural abnormalities in the brain and as well cause the brain to either to shrink (particularly common) or enlarge. Each and every class obstructs the child's ability to navigate life. Each and every class commonly creates agonizing neurological disorders—agonizing both physically and emotionally as well as creating other bodily dysfunctions. And in all too many cases, it is as if the child's brain were being put into a straight-jacket, for the recipients are seriously impeded in their ability to think, feel, move, and act (e.g., see, Breggin, 2008a, 2010; Burstow, 2015; Gøtzsche, 2015). And it is precisely this disabling which is being interpreted as "improvement."

To list a few salient details class by class, the major psychiatric drugs on which children are placed are antipsychotics, antidepressants, and stimulants. Antipsychotics are prescribed for behavior and thinking seen as seriously abnormal. Given that to a significant degree, what is happening is that children are being altered so as to be more in line with the expectations of adults, whatever else may be involved, evident here is the intersection of adultism (oppression based on prioritizing the ways of operating and the vantage point of adults) and sanism (oppression based on the prioritizing of what is construed as normal; for a detailed discussion of the relevance of these concepts for understanding the psychiatrization of children, see LeFrançois & Coppock, 2014). Antipsychotics by their nature impede the transmission of dopamine, leading to a dopamine deficiency, which in turn impedes the workings of the mesolimbic system, the nigrostriatal system, and the

mesocortical system, culminating in a blunting of the emotions, cognitive impairment, and movement dysfunction (Jackson, 2005; Whitaker, 2010). They arrest what is commonly thought of as normal development and frequently lead to despair, suicidality, and feelings of inferiority (Breggin, 2014). Over time, permanent brain shrinkage is likewise standard. As demonstrated by Sparks and Duncan (2012), in addition, a major effect in the pediatric population is weight gain and related metabolic problems. Correspondingly, examples of more general minute physical consequences include parkinsonian symptoms (e.g., shuffling and rigidity), tardive dyskinesia (a highly unpleasant, progressive, and generally irreversible movement disorder), and tardive akathisia, characterized by "painful spasm in the neck and shoulders, abnormal posture and gait, or constant agitated body movement" (Breggin, 2014, pp. 232–233). Torturous in themselves, these conditions additionally set the child up to be ridiculed by the children around them.

The second class, antidepressants, are technically prescribed for depression, in more common parlance, being sad, which is now conceptualized as a disorder. Their use leads to an excess of serotonin, with the brain desperately attempting to compensate for the overabundance by killing off its own receptors (Burstow, 2015). Consequences include cognitive impairment, movement impairment, agitation, and violence (Burstow, 2015). Correspondingly, despite the fact that they are given for depression, it has been shown that antidepressants can culminate in depression and increased suicidality irrespective of who takes them (see Healy, 2009). This is markedly the case with children—hence the U.S. Food and Drug Administration (FDA) in the United States requiring a child-specific black box warning on antidepressant labels (Breggin, 2001; Sparks & Duncan, 2013). And hence, researchers in the United Kingdom issued a warning that children on antidepressants experience "a doubling of suicidal acts or ideation compared to placebo" (Healy, 2009, p. 128).

Stimulants (amphetamines) are the class of drugs overwhelmingly given to children (see Whitaker, 2010). What happens with stimulants is to a large extent paradigmatic of the psychiatric drugging of children overall—that is, it provides a revealing glimpse into the psychiatric drugging of children as a whole. As shown by Baughman and Hovey (2006), these drugs are given frequently for controlling children, however much that control is seen as help. Schools are deeply implicated, ordering attention-deficit/hyperactivity disorder (ADHD) testing and actively encouraging stimulant use with children seen as disruptive or having too short an attention span—in other words, children acting like children and not acting in the way which adults would prefer. Stimulants work much like antidepressants, causing an overabundance of the transmitters serotonin and dopamine (Gøtzche, 2015). The brain attempts to compensate for the attack on itself by killing off the respective receptors (see Gøtzsche, 2015; Whitaker, 2010). Effects include enduring chemical imbalance, extreme agitation, frontal lobe impairment, highly uncomfortable movement disorders, an inability to appreciate the nature of one's actions (intoxication anosognosia; see Breggin, 2008b), violence, suicidality, growth retardation, mechanical robotic-like behavior, diminished spontaneity (for further details, see Burstow, 2015), and addiction. In this last regard, by way of example, there has been research that suggests that stimulant use in childhood is positively correlated with lifetime use of cocaine (e.g., Lambert, 1998).

Why is this drugging happening? As Whitaker (2002, 2010) convincingly demonstrates, on one level, children are being sacrificed for the benefit of the multinational pharmaceutical companies and related industries, which have in essence discovered a new

market and gone after it aggressively. On a societal level more generally, what we can see here is a combination of sanism and adultism. In addition, we see behavior that was once viewed as normal redefined as a medical problem and needing to be controlled. In the process, moreover, we see the wishes and perceptions of children largely ignored for, as Breggin (2014) shows, children tend to greatly dislike being on these substances. What goes along with this, what is transpiring here is happening because educators and practitioners are being tragically miseducated and are in turn miseducating others (Baughman & Hovey, 2006)—generally in the process of trying diligently to do their job, as institutionally defined (Burstow, 2016; Hande, Taylor, & Zorn, 2016). Moreover, what is equally important and what puts families in a truly impossible position, parents are not being given the medical information which they sorely need (Burstow, 2015). Most parents, that is, are not made aware of the risks of psychiatric drugs for children and adolescents but rather are being told that these drugs are necessary. As such, they may feel compelled to cooperate with what correct information would show is blatantly not in the interest of their children (Burstow, 2015). This only magnifies the seriousness of what is happening, which brings us to the question of abuse.

STANDARD DEFINITIONS OF ABUSE AND CHILD ABUSE

General or nonspecific definitions of abuse abound on the Internet. They are fairly similar to one another and are useful in that the general by virtue of being general is applicable to the particular—that is, it can be used to shed light on individual instances. Some of these definitions slip out of definitional mode and into denotation, in essence, pointing to standard examples of abuse rather than actually "defining" abuse. Others, however, are true definitions in that they stick with principles and criteria—and it is the latter which is applicable here.

Kelowna Women's Shelter

A typical definition of abuse, this one from a women's shelter site, reads as follows, "Abuse is any behaviour that is used to gain and/or maintain power and control over another person" (Kelowna Women's Shelter, n.d.). The fit with the psychiatric drugging of children is demonstrable. As already suggested, control—not just influence—over the child's thoughts, feelings, and actions are gained and maintained through the application of the psychiatric drugs, and whatever else may be going on, to some degree at least, the drugs are administered with this in mind. The child, for example, is fidgeting in school and not paying attention—and a drug is administered and continues to be administered which in essence takes control over the child and enforces robotic-like attention.

Now without question, this particular definition could be improved on by, for example, excluding very time-limited attempts to get control over a person when they are in the process of hurting another. But the point is that such an improvement would in no way stop this definition from applying. That noted, from a whole different perspective, there are, of course, people who would argue that a definition like this cannot cover the area of child abuse because, irrespective of other considerations, it is always critical to do what is in the best interests of the child. However, in the area of psychiatry minimally

(and don't claims like this frequently underlie oppression?), it is precisely "best interests" claims that have enabled abuse and, as Breggin (2014) has argued, especially when it comes to children. As a corrective, accordingly, I would introduce a touchstone principle here: If something constitutes abuse, it is not in the best interests of the person being subjected to it—not with women being battered, not with children being assaulted with harmful drugs. That noted, the point remains that based on such typical definitions of abuse, the psychiatric drugging of children qualifies as abuse.

Royal Canadian Mounted Police

For a typical definition of *child abuse* more pointedly, I would turn to the definition provided by the Royal Canadian Mounted Police (RCMP). On their website, they delineate child abuse as follows:

> Child abuse refers to any form of physical, psychological, social, emotional, or sexual maltreatment of a child whereby the survival, safety, self-esteem, growth, and development of the child are endangered. There are four main types of child abuse: neglect, emotional, physical, and sexual. (RCMP, 2012)

Now although I am in no way claiming that the RCMP would agree that the psychiatric drugging of children qualifies as child abuse or indeed that any instrument of the state would, what I am suggesting is that the psychiatric drugging fits such definitions—and on multiple fronts.

To touch on the various components one by one and to begin with the first noun (maltreatment), clearly, subjecting children to these drugs is maltreatment, for as we have already seen, the child is being substantially harmed and based on untenable claims. In the definition per se, the type of maltreatment needed for it to qualify as child abuse is further delimited with the words, "Any form of physical, psychological, social, emotional or sexual" maltreatment. "Any form," by definition does not rule out psychiatric drugs delivered by professionals—for the word signifies that *all forms* qualify. That noted, to assess the psychiatric drugging of children in light of this definition and to begin with the most obvious, given the physical damage wreaked by these drugs as already outlined, clearly the psychiatric drugging of children fits the descriptor "physical damage." On numerous levels, note, the psychiatric drugging in question involves a physical attack on the brain and other parts of the body, one arguably more damaging than most traditional battery—it goes on, significantly, every solitary day, with some of the damage enduring for life. I would remind the reader in this regard of the dieback which is forced, whereby the brain destroys its own receptors in a desperate attempt to maintain its own physical integrity. I would remind readers likewise of how the chemical assault in question can force the brain to shrink (Breggin, 2010, 2014).

By the same token, psychological and emotional maltreatment is involved. In this regard, as already discussed, there is a profound interference with and a dulling of the emotions, and as already noted, the child may feel depressed. On a whole different level, psychological maltreatment, in addition, is inherent in the implicit message conveyed to children by virtue of subjecting them to psychiatric drugs—that is, that they are not all right as they are, in effect that they have a "mental illness"—a message which cannot but erode their self-esteem. This brings us to the qualification included in the definition, which reads "whereby the survival, safety, self-esteem, growth and development of the child are endangered."

Although only one of these factors are needed for the definition to apply, what is significant here is that each of these alternate criteria set out by RCMP are satisfied. I have already commented on self-esteem. Correspondingly, we have already seen that the safety and growth and development of the child are severely compromised. Given the tendency of these drugs to culminate in suicide, so too, at an utterly basic level is survival. The point here is, insofar as you are doubling the likelihood of suicidality, you are demonstrably jeopardizing the child's chances of survival.

I would note in passing that the administration of psychiatric drugs to children fits two of four primary classifications of child abuse according to the definition put forward by RCMP—physical abuse and emotional abuse. As such, there can be little question but that insofar as these criteria are used, it easily qualifies as child abuse, this despite the fact the framers of the definition are highly unlikely to have had the psychiatric drugging of children in mind when they constructed the definition and might even be taken aback by the equation.

To reiterate what has been established to date, psychiatric drugging of children fits standard definitions of abuse, and as such, given that it is happening to children, it qualifies as child abuse. By the same token, the psychiatric drugging of children fits with standard definitions of child abuse itself—and indeed, it fits them on multiple fronts.

THE UNITED NATIONS CONVENTION ON THE RIGHTS OF THE CHILD

With the RCMP definition, we entered territory that might be thought of as official, and as such, as having added weight. With the UN recognized as a worldwide moral beacon, UN pronouncements are more important still.

The primary document of relevance to this discussion is the United Nations Convention on the Rights of the Child (UNCRC, 2010), although it would be important to read it in concert with the United Nations Convention on the Rights of Persons With Disabilities (CRPD, n.d.) as well as with specific statements by the UN Special Rapporteur on Torture. The purpose of the UNCRC is to spell out the basic rights of the child to oblige the signatories to safeguard them, moreover, to act as a moral force to impel their observation regardless of *whether or not a state officially signs on*. The UNCRC does not explicitly name violations of the rights of the child as a form of child abuse as, for the most part, it does not employ discourse of this ilk but rather speaks the language of rights. Philosophically speaking, nonetheless, it is clear that the violation of a person's rights is a violation of that person at least in some measure. And I contend that to violate a person, whether in a minor or major way is *a form of abuse*, especially if substantial control over the person is being exercised in the process. By the same token, a violation of the rights of a *child* where control over the child is being exercised constitutes *child abuse*. I would add that as the state is explicitly named as the body responsible to safeguard against that such violation, it follows that when it fails to do so, the state itself is culpable.

Now irrespective of whether or not instruments of the UN (the UN bodies authorized to make determinations) would ever identify any of the psychiatric drugging of children per se as a violation as enunciated in the UNCRC, such is the implication of quite a number of its articles. To articulate the three most clear-cut of these, together with their various components, Article 18 states, "State parties shall take all the appropriate legislative,

administrative, social, and educational measures to protect the child from all forms of physical or mental violence, injury or abuse" (UNCRC, Article 18). Again, I would call attention to the inclusivity suggested by "all forms." Of the general types mentioned— "physical or mental violence, injury, or abuse," the various and predictable injuries to the brain and other parts of the body already outlined clearly qualify as physical injury. Correspondingly, the ongoing subjection of the child to that injury constitutes violence. By the same token, the dismal state in which the child is commonly thrust (e.g., the depression, confusion, extreme agitation) clearly qualifies as mental violence. Significantly, not only do just about all of the governments around the world currently fail to prevent such injury from happening, it is done under their authority and to varying degrees, with their active promotion.

Philosophically speaking, there is likewise a violation of Article 6, which reads

1. State parties recognize that every child has the inherent right to life
2. State parties shall ensure to the maximum extent possible the survival and the development of the child (UNCRC, Article 6).

As noted previously, the development of the child is compromised by psychiatric drugs. Correspondingly, the dramatic difference in the rate of suicide and suicide ideation between the child on these drugs and the child on placebo suggests that, in at least some instances, the child's right to life is being violated.

Similarly, there is a fit between the psychiatric drugging of children and the prohibited violation of children spelled out in Article 37, which reads

State parties shall unsure that

1. No child shall be subjected to torture or other cruel or unusual punishment.
2. No child shall be deprived of his or her liberty unlawfully or arbitrarily (UNCRC, Article 37).

With respect to torture, I would suggest that the agonous sensations and bodily disorders commonly created by the drugs constitute torture and as such, the administration of these drugs to children fits the frame. For example, I would ask the reader to reflect on the following description of movement disorders commonly caused, by antipsychotics:

> Tardive dyskinesia can impact any muscle functions, including the face, eyes, tongue, jaw, neck, back, abdomen, extremities, diaphragm, oesophagus, and vocal cords. . . . Tardive akathisia, a variant of TD causes a torture-like inner sensation that can drive patients into despair, psychosis, violence, and suicide . . . TD is a major threat to children. . . . Even "mild" cases of eye blinking and grimacing can be humiliating. More severe cases disable children with painful spasms in the neck and shoulders, abnormal posture and gait, or constant agitated body movements and a need to constantly, frantically pace. (Breggin, 2014, pp. 233–244)

There is a blatantly torturous quality to what is happening here, and although admittedly, it is not the torture itself that is aimed it, it is predictable, it is done knowingly, and as such, it violates Item 1 of Article 37. Moreover, two different instruments of the UN have already declared involuntary psychiatric treatment torture regardless of the fact that torture is not the goal (for details, see Minkowitz, 2014). Correspondingly, as already noted, what is happening to these children is typically not voluntary. Which brings us to another consideration: Given that most psychiatric drugging of children is not voluntary,

the psychiatric drugging of children is inherently suspect in light of the UN's psychiatric treatment determinations. Of relevance here is the fact that involuntary use of antipsychotics is explicitly problematized in Article 15 of the CRPD. Of relevance likewise is the following statement by the UN Special Rapporteur on Torture, "Medical treatment of an intrusive and irreversible nature when they . . . aim at correcting or alleviating a disability, may constitute torture" (Minkowitz, 2014, p. 137). A reminder in this regard, these putative psychiatric disorders are theorized as a disability, and much of the harm which psychiatric drugs wreak is irreversible (e.g., the dieback, the sprouting of extra receptors, the shrinking of the brain; see Burstow, 2015).

A case additionally could be made that there is an implicit violation as well of the spirit of the second part of Article 36 of the UNCRC, which prohibits depriving children of their freedom unlawfully or arbitrarily. In this regard, as several theorists have pointed out, these drugs create what might be described as internal imprisonment (e.g., see Fabris, 2011)—taking possession of the brain, stopping thought and feeling, impeding either the transmission or the reuptake of neurotransmitters, forcing the brain, as it were, into lock-down. In this regard, it would be important to remember that antipsychotics, for example, were originally called "neuroleptics"—a name which means *seizing the nerves* (see Burstow, 2015). The point here is that chemical imprisonment is indeed a type of imprisonment—and a particularly pernicious kind at that—and although this imprisonment is not being done unlawfully, given that there is no valid reason for the drugs, a case could be made that it is arbitrary.

To be clear, once again, I am not claiming that the UN officials charged with monitoring compliance with the UNCRC would accept these arguments—nor is that the issue at hand. Rather than, I am suggesting that there is a fit between the UNCRC conceptualizations of what constitutes a violation of the rights of the child, and what the administration of psychiatric drugs to children actually involves. Correspondingly, the convention makes it very clear that signatories to it are obligated to guard against such violations. What is happening here goes beyond a failure to guard against such practices—for governments around the world actively promote and fund such practices and as such, in accordance with the logic of this article, are actively complicit in child abuse.

All this being the case, the UNCRC, like the Kelowna shelter definition of abuse and the definition of child abuse found on the Canadian Mounted Police website, lends substantial support to the proposition that the subjection of children to psychiatric drugs constitutes child abuse. To put this another way, we can reasonably conclude based on these documents that the psychiatric drugging of children constitutes child abuse, with the documents in question providing social grounding for the claim. In addition, the UNCRC provides what is at very least philosophic warrant for holding the state accountable.

CONCLUDING REMARKS

This article set out to show that in accordance with *standard and official* definitions of abuse and of child abuse, the psychiatric drugging of children constitutes child abuse. This, I would suggest, has been established. In the process, it has also demonstrated that the psychiatric drugging of children conflicts with the rights of the child as spelled out in Articles 6, 18, and 37 of the UNCRC, with the state bearing responsibility for allowing and indeed promoting such violation.

Although it is beyond the scope of this article to spell out in any detail what to do about this situation, in ending, I would offer some preliminary suggestions. Raising public consciousness that this is a form of child abuse is critical, perhaps with reference to some of the definitions and articles discussed here and such education might well be accompanied by consciousness-raising with respect to sanism and adultism more generally. The point here is that not only do we need to name such drugging as child abuse, we need to co-construct a child-centric society where adultism, convenience, and maximization of profits no longer prevail. Likewise on an educational level, it would be important to start providing training geared to enabling professionals to detect more readily when they are being caught up in the logic of an institution in a way detrimental to their clients, children in particular. A branch of sociology and a research approach called "institutional ethnography" is devoted to recognizing and tracing precisely such processes, and as such, might be of help to us here (Burstow, 2016; Smith, 2005).

On a more immediate and instrumental level, lobbying government to disallow the psychiatric drugging of children (i.e., to begin phasing it out) is crucial. A promising initial move (although it would be important for this to start to be conceived of as part of a more extensive "phasing out" agenda) are the recent judicial actions in California which provide for the monitoring and curbing of the psychiatric drugging of children in foster care (e.g., see Corry, 2015). Likewise a possible direction and what could be conceived of as part of a "phasing out effort" would be pressuring government to stop issuing and stop allowing the dissemination of guides which target children for psychiatric drugging, especially ones which depict it as an acceptable and benign "treatment" (American Academy of Child & Adolescent Psychiatry, 2017). On a more aggressive note, filing law suits at all levels should be actively considered and, in some cases, pursued. In addition, traction could be gained if credible and influential advocates such the World Network of Users and Survivors of Psychiatry began actively lobbying the UN to issue more direct statements about the psychiatric drugging of children, using current UN conventions as leverage.

In short, there is a large variety of viable avenues that could be pursued in the attempt to safeguard our young. Moreover, there is a role here for everyone, whether you are a seasoned social worker who is positioned to influence your professional association, or a parent who views with dismay what has happened to your child on these substances. As a social worker, for example, that is, as someone professionally bound to defend the rights of the vulnerable (Canadian Association of Social Workers, 2005), you could argue the importance of altering social work practices and codes so as to protect children and youth from psychiatric drugs, using the UN convention as leverage as well as such passages in current codes as "Social workers are committed to human rights as enshrined in Canadian law, as well as in international conventions on human rights created or supported by the United Nations" (Canadian Association of Social Workers, 2005, p .3). By the same token, as a parent, you could at once bear testimony and join with fellow parents to petition government.

The help of everyone is needed. Correspondingly, there is mammoth work to do here—work that goes way beyond such paradigmatically limited and otherwise insufficient agendas as curbing what is euphemistically termed *overdrugging*. With a compelling analysis now in hand, as practitioners, as educators, as activists, as legislators, as

survivors, as parents, as everyday members of local and global communities, let us "roll up our sleeves"—and do it!

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