N. McLAREN MBBS FRANZCP **CONSULTANT PSYCHIATRIST**
Provider No. 020297AL

NORTHERN PSYCHIATRIC SERVICES Pty. Ltd., PO Box 5346, Kenmore East Qld 4069
A.C.N. 077 835 557

SUBMISSION TO PRODUCTIVITY COMMISSION ENQUIRY INTO MENTAL HEALTH.

SUMMARY:

In many countries, particularly in Australia, rates of diagnosis, costs of treatment and the social burden of mental disorder are rising remorselessly, with no indication that this is likely to change. This submission will argue that, over the past century, mainstream psychiatry in this country has institutionalised egregiously inefficient and/or seriously corrupt practices that cost taxpayers, individual sufferers and their carers dearly. In short, modern psychiatry costs far too much; a very large part of the money is misspent; measured outcomes are poor and deteriorating; and yet institutional psychiatry not only refuses to address these points but actively attacks anybody who dares. This has not arisen through chance but is the predictable outcome of psychiatry's failure to attend to its theoretical basis.

It is an established fact that modern psychiatry has no formal, articulated model of mental disorder. Therefore, and despite all claims to the contrary, modern psychiatry fails to meet the most elementary criterion for any field claiming to be science. The claim that all mental disorder is, in some meaningful sense or other, a brain disorder is not justified in the literature. It is an ideology of mental disorder, but it is not and never can be a science of mental disorder. This is the basis for psychiatry's failure to develop rational forms of diagnosis and treatment, leading to massive cost over-runs and often devastating clinical failures. Invariably, instutitutional psychiatry's answer is not to look critically at itself but to beg for more money.

It will be recognised that these are bold assertions but they have all been justified, using, where necessary, figures derived from mainstream psychiatric research. Unfortunately, mainstream psychiatry in Australia is bitterly antagonistic to this type of criticism. All such claims in this submission are justified in the bibliography.

Section I consists of a brief outline of the scientific status of the orthodox position in psychiatry, showing that it is devoid of a rational basis. In **Section II**, by using readily available figures, it will be shown that the steadily increasing reach and costs of modern psychiatry are resulting not in better outcomes but worse, and that this information has long been known to the profession. This includes a series of brief case studies which look at different forms of treatment, including antidepressant, stimulant and antipsychotic drugs, and at electoconvulsive treatment (ECT), especially involuntary treatment imposed via mental health tribunals. This will give evidence in relation to the costs of private psychiatry, state hospital psychiatry and of one Commonwealth Government department. **Section III** will look at how professional bodies and drug companies engage in particular practices that increase their profits while preventing proper analysis of their claims and investigation of their results.

I feel I should apologise in advance for the length of this submission but the material kept growing. The subject is, however, of critical importance.

Section I: The Logical Status of Modern Psychiatry.

The question of what is or is not correctly termed "science" has preoccupied philosophers for many years. Any apparently scientific endeavour can be classed as normal science or revolutionary science, as poor science, boring science, misdirected science (scientism), protoscience, pseudoscience - and charlatinism. One of the most important features of any scientific field is that its practitioners have articulated a publically available, testable model of their field of study. There may in fact be competing models but each must generate a research program designed to elaborate the model. Eventually, the research will lead to some or all models being discarded in favour of a more highly developed concept. It is the unwavering duty of all people engaged in any sort of scientific endeavour to examine critically not just their opponents' models but also their own: there is no such thing as a science devoid of self-criticism.

For historical reasons, orthodox psychiatry has never articulated a model of mental disorder [1]. Therefore, and despite its artfully-contrived narrative, modern psychiatry cannot be considered a scientific field. This conclusion comes as a shock to most psychiatrists, who like to boast that their discipline is firmly-based in the most reliable biological science but they are wrong. There is, however, an even bigger problem in that not only does psychiatry lack a formal model of mental disorder, it has no model of mind. Overwhelmingly, psychiatrists never even think about the mind; their concern is with diseases of the brain, not with ephemera such as human hopes and failings, fears and despairs. Similarly, it has no model of personality and, therefore, no model of personality disorder. This means that psychiatry's diagnostic manuals, such as DSM5 or ICD-10, have no rational basis. They are an attempt to impose order on the bewildering variety of psychiatric symptoms without having any knowledge of how those symptoms fit together into a larger whole. Psychiatry's diagnostic categories can be seen as unrelated islands of description floating in a sea of ignorance but they too are built upon a careful deception [2].

The oft-repeated claim that "all mental disorder is brain disorder" is an ideological claim, not an established scientific fact. Essentially, it is wishful thinking presented as a viable scientific program. The program known as biological reductionism, of which modern psychiatry is an unwitting part, says that basic biological research will tell us everything we need to know about mental disorder with no questions left unanswered. Unfortunately, there is nothing in the psychiatric literature, or psychology, or neurosciences, or biology in general, or in philosophy, that can be taken as a remotely convincing case that biological research will ever tell us anything interesting about mental disorder. The most recent development in this field, the program known as the Research Domain Criteria, embraced by the US NIMH, is profoundly flawed and is best characterised as pseudoscience [3]. Unfortunately, it is very expensive pseudoscience but we may have to wait decades before it follows its predecessors, the Research Diagnostic Criteria and psychoanalytic theory, into history.

In the main, psychiatrists don't actually say that biology will tell us everything we need to know about mental disorder, not least because, to the layman, it is manifestly false (cf. George Orwell: One has to belong to the intelligentsia to believe things like that: no ordinary man could be such a fool). Instead, they tell patients they have a "chemical imbalance of the brain," without realising that the only proven "chemical imbalances" in the brains of psychiatric patients are those induced by psychiatric medication. The concept fhat mental disorder is the result of some undefined and essentially indefinable "chemical imbalance" is little better than an old wives' tale.

In the main, Australian psychiatrists prefer to avoid the more extreme swings of American psychiatry, endorsing instead a more eclectic approach to psychiatry known as the "biopsychosocial model." Starting in October 1998 and for the next five years, the website of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) claimed that psychiatrists are trained in this model, which gives them specialist status due to skills not possessed by any other discipline. This was a little unexpected because, in April that year, in the main journal of the RANZCP, I showed that the biopsychosocial model did not exist [4]. This was problematic for the college as, without it, psychiatry couldn't justify itself as a speciality. Since then, the response of mainstream psychiatry has been to pretend that my paper was never written [5], that the "biopsychosocial model" is alive and well and nobody should pay attention to the naysayers. That is, it has become the figleaf of moderate psychiatrists who would otherwise be forced to admit they have no model of mental disorder. Alarmingly, psychiatrists have nothing *in science* to justify their authority:

> Nothing could be more profoundly and meticulously deliberate than the measured footsteps of a man who no longer knows where he is going, though he is on his way (Thorsten Veblen, 1915).

All the effort and expense that goes into what appears to be basic biological research in psychiatry is misdirected. Vast sums of money are spent each year on biochemistry of the brain, on genetic studies, hugely expensive programs to look at brain function using a variety of high-powered scanners, studies on genetically-altered rats and mice, on and on. Biological psychiatry has research laboratories, journals, big international conventions, awards... all the paraphernalia of a science, except they forgot to answer one basic question: Is mental disorder the sort of phenomenon that can be investigated by the physical sciences, or is it of an entirely different nature altogether? Put like that, the question is absolutely elementary but in its rush to be granted specialist status, to stand shoulder to shoulder with all other medical specialties (and to charge specialist fees), psychiatry managed to overlook this critical point.

Extensive critical analysis of the claims of biological psychiatry has shown them to be unsubstantiated. The notion that mental disorder can be reduced to brain disorder can be interpreted either as a broad claim or as a narrow claim. As a broad claim, it is meaningless truism while, as a narrow claim, it is conceptually and empirically wrong [6].

Similarly, the far-reaching claims made for the genetic basis of psychiatry have been shown to be based on seriously flawed research [7]. This means that, at a level of near-certainty, the flood of genetic studies of mental disorder are a complete waste of time and money: they are searching for something that doesn't actually exist, yet it is the only approach their concept of science permits (one is reminded of the drunk man searching for his house key under the streat lamp). Before another penny is spent on this type of research, its exponents need to show how a mental event can be explained in physical terms. Unless and until they do that, we are wasting fortunes on wrong-headed research.

> It's difficult to get a man to understand something when his salary depends on his not understanding it (Upton Sinclair, 1935).

Regretably, there is no historical reason to believe that orthodox psychiatry has the self-reflective and self-critical capacity to consider these points itself. My experience over nearly half a century is that reminding psychiatrists of their error provokes the most bitter hostility. They go to quite extreme lengths to prevent any criticism becoming public.

Section II: What can we learn from psychiatry's own figures?

(a) Toxicity of psychiatric drugs

In Australia, anybody who consumes psychiatric drugs in the long to very long term, meaning almost everybody on involuntary treatment orders and many voluntary patients, will die, on average, 19yrs younger than his undrugged peers. In the US, where people are prescribed more drugs at larger doses, that figure is 25yrs [8]. Sophisticated analysis shows that this effect is due to the drugs, not to any other compounding factor. That is, any person who, under threat of immediate violence, is forced to take drugs to save his life or, remarkably, his reputation, will die young *because* of his treatment, not in spite of it. These figures have long been known to psychiatrists.

Overwhelmingly, psychiatric drugs are approved on the basis of short-term studies, commonly 6-12 weeks, yet they are routinely prescribed in the very long term, 25-30yrs or more. There are no studies whatsoever that look at the effects of chronic administration of these drugs: Are they necessary? Are they effective? Are they dangerous? Are there less troublesome alternatives? Is their cost justified? Nobody knows. From the beginning, absence of proof of danger has been taken as amounting to proof of safety, but the reason nobody knows of the long-term dangers is simply that the research has never been done. In essence, every person taking these drugs in the long-term is an unwitting, and very often unwilling, participant in an experiment, except that the drug manufacturers own the evidence of the risks of their products, and carefully ensure it is never released.

Drug companies, those quintessential capitalist ventures whose primary responsibility is to their shareholders, promote the view that they cannot and do not shape the technology, that the technology shapes itself because it is driven by science, and that society is the passive but fortunate recipient of science's cornucopia. Their carefully-crafted narrative states that there is only one technology available to treat mental disorder, and it just happens to be the technology that guarantees their outrageous profits. In a million ways, they put this across as scientific truth, a choice forced upon us by the only available science, but nothing could be further from the truth. The concept that all mental disorder is a biological disturbance of brain function is wholly ideological. It is a social, political and commercial decision, but it is not science.

As it now happens, there are some indications from a variety of sources that any beneficial effect has been lost after at most a few years [e.g. 9]. Increasingly, it is becoming clear that people continue taking them just because the withdrawal effects of these highly addictive drugs are intolerable [10]. From the manufacturers' point of view, this is a staggeringly successful business model.

(b) Addictive properties of psychotropic drugs

Drug companies and mainstream psychiatrists are greatly offended by the suggestion that their drugs cause "withdrawal" symptoms. Only illegal drugs cause withdrawal effects; cessation of their good drugs causes effects known by the precious euphemism "discontinuation syndrome." Any website maintained by drug companies (practically all websites talking about drugs are financed by drug companies) or mainstream psychiatrists (all the rest) insist that symptoms caused by cessation of psychotropic drugs are minor, harmless and short-lived. Once again, this claim has no basis in fact: withdrawal effects from psychiatric drugs are severe, often dangerous (suicidal and/or homicidal impulses), and can last up to two years. However, nobody is told this. Instead, everybody who experiences withdrawal effects is told: "That's your disease coming back, you'd better get back on your drugs quickly."

The website of the Qld Mental Health Services (MHS) includes a section on "patient information leaflets" (it is not easy to find). Part of this section is a long series of leaflets on drugs used in psychiatry, using the format of questions and answers. In each case, there is a question: "Is (drug X) addictive?" Quite often, the answer is: "No, X is not addictive as it doesn't cause euphoria." This is manifestly false: tobacco is highly addictive yet it doesn't cause euphoria. Others may say that a drug is not addictive because it doesn't cause craving. It does, but only after about 36hrs of withdrawal, and people generally don't see the connection, or are told "You're getting sick again." Or it may be said psychiatric drugs aren't addictive because people don't need to take increasing doses. They most certainly do, but it's usually in the form of additional drugs ("Isn't that working? Oh well, let's add this drug and see what happens"). Also, tobacco doesn't require increasing doses: most smokers can tell you exactly how many they burn through each day. The Qld MHS site actively minimises withdrawal effects from psychiatric drugs, repeatedly stating they are short-term, minor and rarely of more than nuisance value. This is completely false.

Safe reduction of psychotropic drugs can be achieved - slowly. For most drugs, reduction of 5-10% per month will usually provoke no more than mild withdrawal symptoms lasting up to ten days for each reduction. With no exceptions, the minimum dose of all psychotropic drugs available in Australia is higher, often many times higher, than the maximum permissible reduction. This is deliberate: the lowest dose of aripiprazole (antipsychotic) is 5mg but this is not available on PBS (i.e. the manufacturer has not applied to have it listed). The lowest dose of quetiapine is 25mg but patients can only have one prescription with no repeats. Safe withdrawal from amisulpride would require dosages of 50mg, 20mg and 10mg so that the patient could go to 90mg, then 80mg and so on. The smallest dose available is 100mg, and carries the warning "Do not stop this medicine abruptly."

However, even though smaller doses are necessary, it is impossible to import these dosages. It costs $150,000 to register each dosage of each drug, even when the drug is already being imported from an approved manufacturer in different doses. Since the drug is already approved and on sale, there is no indication as to why this very large sum of money is necessary, beyond making it impossible for anybody to break Big Pharma's stranglehold on drugs. At first glance, it looks like the regulator has been captured by the companies it is supposed to supervise.

It is most definitely in the national interest for each manufacturer to be required to make available what are called "tapering dosages," meaning a range of doses of each drug they sell so that successful withdrawal from the drugs can become the norm instead of a rare exception. Drug companies will not do this voluntarily, as it is most assuredly not in their financial interest to make it easier to for consumers to cease their products.

Mainstream psychiatry resolutely refuses to accept that its drugs are addictive. This question could only be finally resolved by running a trial where normal people take them. If, after six months of a standard dose, they found it very difficult to stop, then the question would be settled. I am of the view it would be unethical to run such a trial, as the risk of addiction is so high. People sometimes suggest using prisoners as test subjects for this type of trial but they have enough problems without giving them iatrogenic mental disorders. The only suitable group of mentally healthy people who could possibly form such a test group would be, of course, the people who prescribe them: psychiatrists themselves. If mental disorder is genetic, as they insist, then 10% of psychiatrists should take antidepressants. I have never heard of a psychiatrist who takes these drugs. I am also certain no psychiatrist would willingly take his drugs in a trial. They would dismiss it as a ridiculous suggestion, without offering any reason why it is ridiculous. The real answer is they wouldn't dare.

(c) Overuse of ECT in Australia

In the UK, from 1985-2015, use of ECT declined about 90%. In Australia, from 2006-15, the use of ECT in private practice rose an average of 85%, including a remarkable surge of 191% in Western Australia:

	2007	2016	% Increase
Australia	18,183	33,641	85
NSW	4,936	8,039	63
Victoria	4,895	8,639	76
Queensland	4,852	9,274	91
South Australia	1,163	2,487	114
Western Australia	1,457	4,242	191

According to the RANZCP [11], the main indication for ECT is severe, life-threatening depression. However, the overwhelming bulk of ECT is given to distressed, middle-aged, middle class women, the specific demographic with the lowest rate of suicide in the community. The groups with the highest rates of suicide, men aged 30-50, don't get ECT. Young tradesmen, whose rate of suicide is a remarkable 2.3 times that of men in general, which is itself 350% higher than for women, almost never get ECT. As a form of treatment, ECT is given to the group which is least likely to object to it and is most likely to pay the grossly inflated fees being charged.

As shown in [12; copy attached as **Appendix A**], Australia uses ECT 600% more than New Zealand, 1000% more than the UK, 5000% more than Poland, 6250% more than Italy (where it was invented). Qld uses ECT 135,000% more than the northern Italian province of Pavia, and infinitely more than Slovakia, where it is banned. The notion that ECT stands between us and a flood of suicides in our middle-aged women is risible. In one word, the major impetus to the rapid rise in usage of ECT in this country is financial. Abuse of medical services for financial gain is not restricted to psychiatry, as rising rates of caesarean sections show.

In the Kimberley Health Region of Western Australia in the late 1980s, the rate of deliveries by caesarean section was about 21%. This was for an almost exclusively Aboriginal population where, despite the best efforts of medical and nursing staff, maternal health standards were generally poor. Woman in the region had high rates of diabetes, cardiac and renal disease, asthma and COPD, hypertension, alcohol abuse, liver disease, etc, as well as high rates of teenage pregnancy. At the same time, the rate of caesarean section in the wealthy eastern suburbs of Sydney, where women enjoy the very highest standards of health and of medical care, was about 40% and rising. That is, the wealthy suburbs were over-using a medical service for their convenience, which had the effect of diverting a substantial part of the health budget away from people who needed it to people who, by any impartial standard, didn't show any medical need for it. Among OECD-33 countries, Finland has the lowest rate of caesarean section, at 15% of all births; improbably, Turkey has the highest, of 53%. Australia and US are now about 33% but rising fast. This is purely a social phenomenon, not medical, but it is funded by the unwitting taxpayers who are led to believe they are supporting an essential medical service. We could cure the "epidemic" of caesarian sections at a stroke, by refusing to pay for it privately. If all women who needed the operation had to be referred to a public hospital, the rates would plummet.

We see exactly the same thing happening in psychiatry today, where large numbers of women are admitted to private hospitals by male psychiatrists to get ECT when, by any objective standard, they don't need it. Indeed, most would probably get better without medical intervention, and all would be better off without it. Large numbers of psychiatrists working in private hospitals are making very large amounts of money giving ECT, not because it is clinically necessary but because they can do so without being questioned. If all patients who "needed" ECT had to be admitted to a public hospital for the procedure, Australian rates for ECT would immediatly drop to the level in New Zealand, which has practically no private psychiatric sector.

In April 2018, a private hospital in Brisbane quoted a middle-aged female patient $620 for each episode of ECT. This is split between the psychiatrist (taking about $210 for two minutes' "work" for which the Medicare rebate is about $73.00), the anaesthetist and the hospital's theatre fee. The normal course of ECT is twelve episodes, three per week for four weeks, during which the patient will remain in hospital. A five week admission for twelve ECT will cost about $55,000. However, it must be understood that it is almost impossible to get firm information on costs. The comfortable and exclusive duopoly of private psychiatrists and private hospitals is ferociously possessive of their figures. If the Productivity Commission does not gain access to their figures, then this Enquiry will not achieve its goals.

Even its most ardent proponents agree that ECT is effective in only 55-65% of cases, while the improvement declines quite rapidly and the benefit is largely lost after about twelve months. In the overwhelming majority of cases, it should be possible to get the same results as an outpatient for a total cost well under $1000, i.e. 98% saving.

In W.A. its use is banned for children under 14yrs while in A.C.T. it is banned for those under 12yrs. However, in NSW and other states there are no restrictions on what age ECT can be given. For example: In 2013/14 there were 134 electroshocks given to Victorian children aged 10-19 and in Qld in 2014/15 there were 23 treatments given to children aged 10-15. This practice continues on Australian children despite the World Health Organisation stating, “There are no indications for the use of ECT on minors, and hence this should be prohibited through legislation.” In March 2017, India banned the use of ECT for all children under 18.

Psychiatry claims that its use of ECT is soundly-based in a scientific model of mental disorder. If this were true, it should be subject to the normal critical processes of science. However, when anybody attempts to criticise the ever-increasing use of ECT, its protagonists block the criticism on the basis that it damages their business. Long ago, psychiatrists were granted the privilege of being able to charge for a unique "scientific model" of treatment, but they have since turned it into a hugely profitable, even extortionate, business model.

When, in October 2016, I gave some of these figures in a newspaper interview, some psychiatrists in Brisbane complained to the RANZCP that I was "demeaning the profession." The anonymous complaint, heard in camera by an unnamed committee, was upheld even though the facts I used in the interview were not disputed. They took offence at my stating that the primary impetus for Australia's high rates of ECT was financial. It was then, and it still is. Subsequently, all these figures were assembled into a paper [12]. Nobody has faulted the figures in this paper.

There are only three reasons why a psychiatrist would give ECT:
"I believe you are suffering a biological disease of the brain for which the only conceivable cure is a physical treatment, like ECT."
"I have reached the limits of my skill set. I don't know what else to do."
"It pays well."
The first of these has been refuted; the second is an indictment; and the third speaks for itself.

In over forty years as a consultant, in a wide variety of settings, most of it working alone, I have personally assessed and managed somewhere between 12-15,000 patients. Almost all of this has been at the rough end of psychiatry: prisons, remote areas, military, public hospitals, working class districts. In that time, I have never once used ECT. My attitude is that if I can do without it, so can every other psychiatrist in Australia - if they choose to.

In his short polemic, *War is a Racket* (1935), retired US Marine Maj.Gen. Smedley Butler said:

> A racket is best described, I believe, as something that is not what it seems to the majority of the people. Only a small “inside” group knows what it is about. It is conducted for the benefit of the very few, at the expense of the very many. Out of (the racket), a few people make huge fortunes.

By this definition, ECT in Australia is a racket.

(d) Efficacy of antidepressant drugs and overuse.

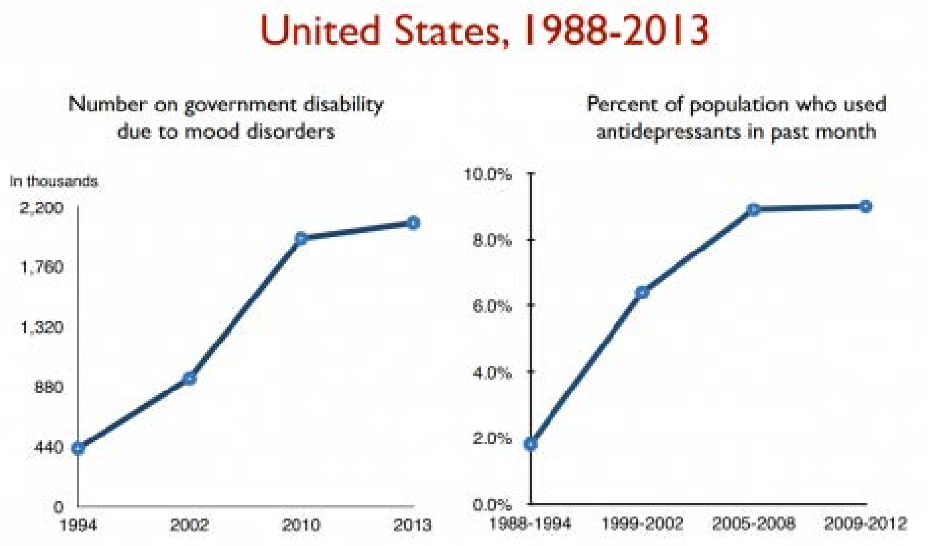
In 1991, 1% of the adult population in this country was taking antidepressants. By 2016, that figure had risen to 9.8%. In the US, it is now 12%; in New Zealand, 13% and the UK, 16%. Early in that period, suicide rates had started to decline but that trend didn't last long. Suicide rates in Australia have recently hit a twelve year peak, meaning the more we treat depression (drugs and ECT), the worse the outcome. Extensive studies in Australia and internationally show clear evidence that this association is universal, not local: more treatment corresponds with worse outcomes (for succinct summaries with citations, see [13, 14]). Australian researchers reached a similar conclusion:

> ...data from 1990 to 2015 were reviewed from four English-speaking countries: Australia, Canada, England and the US. These data show that the prevalence of mood and anxiety disorders and symptoms has not decreased, despite substantial increases in the provision of treatment, particularly antidepressants [15].

This often provokes the response that merely talking about depression and suicide encourages the impressionable to think they are depressed when, with a bit of self-discipline, they could pull themselves out of it, or the histrionic to engage in dangerous attention-seeking behaviour. There is, however, a valid alternative explanation: that the drugs we use are actually making things worse.

Needless to say, mainstream psychiatrists (and drug companies) react ferociously to this idea but it is critically important, and cannot be dismissed so lightly. History is replete with examples of medical treatment actually being worse than no treatment (Gen. George Washington, for example, didn't die of malaria, his physicians bled him to death; psychiatry's decades-long flirtation with cutting brains did no good to the victims; the anti-inflammatory, rofecoxib, is thought to have caused at least 60,000 cardiac deaths in the five years it was on the market, and perhaps ten times as many; I should add that I am totally unconvinced that the current "epidemic" of so-called autism spectrum disorder has anything to do with immunisation).

Around the world, as the numbers of people taking prescribed psychiatric drugs rises, so does the numbers of people who are unable to work because of mental disorder. The following graph [16] demonstrates this phenomenon in the US, which is not renowned for its generosity in awarding pensions to its mentally-disabled citizenry:



United States, 1988-2013

Number on government disability due to mood disorders

Percent of population who used antidepressants in past month

Source: R. Rosenheck. "The growth of psychopharmacology in the 1990s." *Int J of Law and Psychiatry* 28 (2005):467-83. U.S. Social Security Administration, Annual Statistical Report on the Social Security Disability Insurance Program, and SSI Annual Statistical Report, 2010-2013.

Source: U.S. Dept. of Health and Human Services, Centers for Disease Control and Prevention. "Health, United States, 2014."

With regard to the nexus between suicide and antidepressants, there is a rapidly-growing body of evidence to support the notion that antidepressants, particularly the group known as SSRIs, directly contribute to sudden, unexpected and lethal suicide bids in the weeks after they are started or, ominously, in the weeks *after* they are reduced or ceased. The mechanism appears to be two-fold. First, there is the intentional effect of these drugs in inducing a state of emotional numbing and psychic detachment: events lose their emotional significance and people are no longer so distressed. Second, they routinely induce a very unpleasant physical side effect known as akathisia, a sense of inner restlessness and inability to settle, both mentally and physically. Sufferers regularly describe this as "torture" [17]. That is, patients experience a lethal combination of a ferocious and apparently irremediable agitation, coupled with an emotional detachment from life itself, leading them to say: "If this is their treatment, I feel a million times worse so I may as well hang myself now and be done with it."

This has long been known to drug companies who actively suppressed the information by distorting or misrepresenting their research results. In 2015, results of a decade-long, international effort to unearth the incriminating evidence were published [18]. The prestigious group of researchers showed that the manufacturer of paroxetine, one of the first of the group of SSRIs and still widely prescribed, deliberately concealed suicides in the study group, thereby inflating the efficacy of the drug and reducing its adverse effects when compared with placebo. For example, cases of suicide were reported as "failed to complete the study," meaning they were taken out of the study rather than being recorded as a catastrophic failure of the drug.

(e) Cost effectiveness of second generation antipsychotic drugs

Starting in about 1990, so-called "second generation" antipsychotic drugs were launched in a welter of what are now known to have been grotesquely exaggerated claims about their efficacy, safety and cost-effectiveness. We can now state flatly that they are no more effective and no safer than the older drugs they replaced. Their side-effect profile is exactly the same although some of them are worse in certain respects, e.g. massive weight gain from olanzapine and quetiapine. However, when we come to costs, we see how the community has been completely misled. The new drugs are routinely as much as one hundred or even two hundred times as expensive as the drugs they replaced (i.e. 10,000-20,000% more per patient per month). As an extreme example, a month's supply of the older depot antipsychotic fluphenazine costs about AU$1.30 if bought from the (entirely reputable) manufacturers in India. A month of the equivalent modern drug, risperidone, costs about AU$700 (55,000% more, although that is exceptional). There is no evidence to indicate that risperidone offers any clinical advantage over the older drug, or that it is better tolerated by the patient.

Thioridazine, a widely-used and proven antipsychotic drug, was removed from the Western market on the basis that it may predispose to a cardiac arrhythmia (*torsade de points*). The evidence apparently came from rats exposed to high doses of the drug. In 25yrs, I had never seen a case of sudden death in anybody taking that drug, which I prescribed for years as it was very effective in patients with acute psychotic states who needed to be transported by air. However, it was blocking uptake of the newer drugs so it had to go. At the same time, amitriptyline, a notoriously toxic antidepressant which has certainly caused many tens, if not hundreds, of thousands of deaths over the past 60 years, is still available, albeit not very widely prescribed:

> Relative to other compounds, tricyclic antidepressants were associated with higher rates of acidosis, cardiac conduction problems, respiratory depression, and seizures... Amitriptyline was

> responsible for two thirds of all tricyclic antidepressant exposures and 39.5% of deaths from all antidepressants [19].

Some 40% of all deaths due to antidepressants are attributable to a drug which would not account for more than 3% of antidepressant prescriptions, if that. There has been no move to delist it, since its very unpleasant side-effects mean it doesn't affect sales of the more expensive modern drugs. Anyway, psychiatrists are no different from the rest of the population, they rush to the latest fad regardless of the facts. As it happens, 87% of antidepressants prescribed in this country are initiated by GPs, 7% by other specialists and only 7% by psychiatrists. Until just recently, GPs were reluctant to initiate antipsychotic drugs but, with the broadening of the diagnosis of "bipolar disorder," they now commonly prescribe either quetiapine or olanzapine, which are both highly addictive. In hospitals and prisons, these two drugs are widely used as first-line hypnotics. Once started, they are very difficult to stop.

(f) Reliability of drug manufacturers' studies

The question of the reliability of psychiatric drug trials has become an area of specialist enquiry in its own right (see [18]). In the interests of brevity, I won't attempt to summarise this topic but it would now be fair to make the following statement:

> Drugs are dangerous until *proven* otherwise. No patient, no relative of a patient, no medical practitioner, no insurer, no funding agency and no government can afford to take at face value the claims of drug manufacturers regarding their own products.

The burden of disproving this assertion rests with the drug companies and their captive academic psychiatrists who have fashioned their careers out of finding disorders to name, and drugs to treat them. In the US over the past ten or so years, drug manufacturers have been fined a staggering $42billion for deliberately false and/or misleading claims about their products. Bearing in mind that they sell about $80billion of psychotropic drugs in that country alone, year after year, this cost is trivial. It is also tax deductible. Drug companies routinely pay psychiatrists to promote their products, and these psychiatrists are remarkably adept at insinuating themselves into the committees that write guidelines or control training programs [19].

(g) Novel treatments for depression.

To a large extent, the major drug companies have given up on developing new psychotropic drugs [16]. This contradicts the perennial claim by psychiatrists that we are "on the cusp of major breakthroughs" in the diagnosis and treatment of mental disorder: if we are, the drug companies haven't been told (psychiatrists love to talk about their glowing future; it distracts attention from their truly dreadful past [20, 21]). This vacuum leaves psychiatrists needing something dramatic to flourish to convince people they are moving ahead as fast as other fields of medicine.

In this respect, two recent developments should be mentioned. Transcranial magnetic stimulation (TMS) is used to treat depression. There is absolutely nothing in the entire literature to establish that depression is a unitary entity of the type for which a single physical "treatment" can be effective. Depression is a reaction to life events. TMS is yet another very expensive fad deployed in private hospitals to produce mediocre results in people who probably don't need it but who can afford it and aren't likely to argue; results that can easily be obtained by routine psychological methods at vastly less expense.

Similarly, there is great excitement among the "biological" psychiatrists over using the dissociative anaesthetic agent, ketamine, to treat depression. In addition to its notorious unpredictability, this drug is highly addictive and is widely abused among young people who go to "rave" or "thrash" parties. After taking it with a handful of other drugs such as amphetamines and alcohol, they stay awake the whole weekend to jump around in strobe-lit darkness to deafening techno "music." This slight risk seems to have escaped the attention of those who are determined to find a "physical cure" for depression, even when the gigantic multinational drug companies have given it up as a fool's errand.

The justification for these new treatments is the concept of "treatment-resistant depression." This has been defined as "failure to respond to adequate trials of two antidepressants," where adequate means 6-8 weeks. The problem is simple: if depression is not the sort of condition for which physical treatments are appropriate, then failure to respond to drug and physical treatments will be common.

(h) Stimulants.

Questioning the role and value of stimulants normally brings all the demons in hell down on one's shoulders. So many people (drug companies, psychiatrists, paediatricans, pharmacists) are making so much money out of them, and so many parents use them to excuse themselves of responsibility for everything they don't like about their children's behaviour, that objective facts and figures are lost in the furore [22]. The enormous discrepancies in prescription rates, the generally poor long-term outcomes, the fact that so many of the drugs leak on to the black market, and the close relationship between legal use of stimulants and later addiction to amphetamines, argue powerfully against the claim that they are necessary. Compounding the case, after decades of intensive biological research, there is no convincing evidence that there is a formal, underlying brain disorder for the drugs to treat. The most that could be said is that the drugs are not a medical need, just another social phenomenon responding to an artificially-contrived need.

In over forty years, I have commenced these drugs twice. The first was for a child whose parents were aggressively persistent in demanding a trial of the drugs. As soon as were given a trial prescription, they disappeared and arranged for another practitioner to continue the prescription (permissible under the legislation). The second was for an engineering student who was on the verge of being expelled from his course. Two months after he was given the script, he returned and handed it back, saying he had not told the truth about his symptoms. He passed his course, anyway, by the old-fashioned method of diligence.

(i) Costs of private practice.

The runaway costs of private specialist medical practice in Australia are cause for the very greatest of concern, and this is equally true of psychiatry. There is a standard, established by the Health Insurance Commission in its Medical Benefits Schedule (MBS). Three items stand as the benchmark. Item 296 comprises the initial assessment for a treatment program. The assessment must cover a range of material in one hour, and the psychiatrist must review relevant reports before writing a letter to the referring GP. The current fee for Item 296 is about $225. Item 291 is an initial assessment where the patient is referred back to the GP for management. Its purpose is to assist the GP in management, thereby reducing costs. The rebate is $385 because the report is meant to be more comprehensive. Continuing treatment (Items 300-306) is valued at approximately $150 per hour. These are the fees paid to a bulk-billing private psychiatric practice.

In their daily work, psychiatrists are expected to exercise a certain level of skill and diligence, which is why they are paid as specialists. In an initial assessment, psychiatrists must bring all their training and devotion to the task. Medicare fees for their services are not plucked from the air but are reached after a considered actuarial process. While I run a bulk-billing psychiatric practice, I am not aware of any other in the country. Private psychiatrists normally charge twice or even three times the standard rate, giving the patient very substantial out-of-pocket costs:

> Psychiatrist A in a provincial city charges $735 for an initial consultation (i.e. about 325 % of the MBS fee) and continuing treatment at $450 per hr (300%). However, the reception staff inform callers that the rebate for the initial assessment is $385, which cannot be true if there is continuing treatment. Patients will be left with an out-of-pocket fee of $510 for an hour's consultation. The receptionists do not mention the rebate for follow-up appointments.
>
> Psychiatrist B in another city charges $720 for Item 296 and $450-550 for follow-up appointments.
>
> Psychiatrist C books each follow-up appointment for fifty minutes, charging $480.00. The rebate for Item 306 (45-75mins review consultation) is about $150.00, so patients are $230 out of pocket. He cheerfully boasts he sees ten patients a day but he "works" only 40 weeks a year, meaning an income approaching $1million a year.

However, the most telling point is that their patients will get only the most superficial assessment followed by prescriptions. To be perfectly blunt, the psychiatrists charging these outrageous fees don't know enough to justify the expense, they aren't good enough at their job.

We see this more clearly when people are required to obtain psychiatric reports for legal proceedings. For some reason, a psychiatrist at daily work is valued at, say, $150 per hour. However, when he puts on his legal hat, suddenly, he feels his value has jumped to $500-600 per hour, or even more. People routinely pay $5000 for a psychiatric report for forensic matters. It is not as if the psychiatrist suddenly finds wellsprings of knowledge and care that he isn't able to access for a public case, it is simply that he knows he can gouge the desperate litigant. This is rife, and probably at its worst in the Family Court. Over the years, I have seen many of these reports. Most of them are embarrassingly awful, page after double-spaced page of heavily-padded, vacuous twaddle.

A well-known professor in Brisbane recently quoted a family $7000 for a report on their relative. I completed it in about six hours ($900 at the Medicare base rate). Assuming he had given it the same amount of time (not a wise assumption), he valued his services at $1200 per hr. I have met him, have heard him speaking and have read some of his publications. He is not worth $1200 of anybody's money. Another psychiatrist was questioned about the breath-taking fee he had quoted. He replied: "Well, if you want the best, you have to pay for it." I can vouch he is not the best by any means. What he meant was: "If you want me to write a report that supports your case, you'll find the money." A psychiatrist who charges about $460 per hr for follow-up appointments says on her website that God has led her to psychiatry. She doesn't say which God: perhaps Mammon? Stripped of its religiosity, this is naked greed.

It is worth noting that the RANZCP Code of Ethics forbids psychiatrists from "exploiting" patients. These sorts of charges are pure exploitation.

(j) Costs of public practice.

It is not just in private practice that we see systematised gouging but it also happens in public practice. Public mental health services are grotesquely inefficient but nobody cares. The report at **Appendix B** was sent to the chief psychiatrist of Qld MHS, Dr J Allan, who is currently director of MHS and also president-elect of the RANZCP. One figure stands out: the cost of a routine out-patient consultation at the Community MHS, 90 Queen St, Goodna, Qld, in July 2014. A half-hour consult by registrars, nurses, psychologists or social workers was costing the Qld Government about $275.00. Meanwhile, just down the road, at my bulk-billing practice at 128 Queen St, Goodna, a half-hour consultation by a very experienced senior consultant psychiatrist was costing the Federal Government about $73.00. Costs of public practice have risen dramatically since then; costs of bulk-billed private psychiatric services have risen by something of the order 0.75% in the same time.

There are other examples of truly outrageous inefficiency in that report, all of which were sent to the then Minister for Health. However, on advice from his senior departmental officers, meaning the people who had allowed the situation to develop, nothing came of it.

Section III: Psychiatry as a professional institution.

(a) Training.

During my training, many years ago. I was warned a number of times not to question the professors or the director of MHS otherwise I would not be permitted to continue. Those were the 'bad old days'; these days, psychiatrists in training have all the advantages of modern educational theories and of the rapidly advancing neurosciences to assist their intellectual development. The RANZCP has sole responsibility for training and certifying psychiatrists in this country. It cannot fill training posts. The reason is that, under the American influence, modern psychiatry is seen as so boring and so dehumanising that medical students have no interest in specialising. The training itself turns out hacks who are largely unable to take a history and who have no skill in psychotherapy. Above all, graduate psychiatrists have been trained in an ideology masquerading as science, which they may not question. Several trainees have told me that when they quoted my published work, they were taken aside and warned in the clearest terms that if they wanted to succeed in their courses, they had better not question orthodox opinion, precisely as happened to me. Since the essence of a scientific education is to question the establishment [23], modern psychiatric training amounts to little more than brainwashing. *Plus ça change, plus c'est la même chose.*

(b) Psychiatric publishing.

Wikipedia gives a list of fifty psychiatric journals in the world but it is certainly incomplete (e.g. *Ethical Human Psychology and Psychiatry* is not listed). While they give the impression of being validly scientific in nature, Richard Smith, the former deputy editor of the British Medical Journal, has said that 40% of journal articles should never be published. Dr Smith is scheduled to give a lecture at a medical conference in Copenhagen on March 9th this year, on the topic: *Medical journals are an extension of the marketing arm of pharmaceutical companies*. It is highly likely that senior psychiatrists giving evidence to this enquiry will quote the psychiatric literature as though that settles the question. Most emphatically, it does not. I have provided a critique of psychiatric publishing [24] which has never been refuted.

In an interview on their long-term study on the damaging effects of antidepressants, Michael Hengartner, the lead author said:

> …due to institutional corruption within academic psychiatry, it is quite difficult to successfully pass the review process with such papers (i.e. critical). Most psychiatric experts reviewing for the leading scientific journals refuse peremptorily any report calling into question the merits of psychiatric drugs [25].

In 2006, I did a little study on the Australian and New Zealand Journal of Psychiatry (ANZJP), the main publication of the RANZCP. Of something like 1154 original papers, articles, reports, editorials etc published from January 1996 to December 2005, only ten qualified as critical of the mainstream. Seven of these were very minor criticisms, e.g. a Melbourne psychiatrist said that psychiatrists should pay more attention to people's religious beliefs, which is hardly contentious. Three were genuinely critical of the mainstream. Of these, two were by overseas authors while the last was my paper showing that the so-called biopsychosocial model did not exist [3] (I should mention that my paper was published with two highly critical commentaries commissioned by the editor. I had not seen them before they were published; both of them failed to address the point that the biopsychosocial model did not exist; and the editor refused me the right of reply to those commentaries).

My study showed a grand total of about one tenth of one word of critical material published per Australian psychiatrist per year. This hardly satisfies the definition given above, that "the essence of a scientific education is to question the establishment." It must not be overlooked that the establishment has absolute control over whether material critical of their position will ever see the light of day. The editor's decision is final, even when the editor has published the most ludicrous rubbish just because it was written by one of his friends (see [24]).

The most important point about psychiatric publishing is that academics must publish to get ahead. What they publish doesn't matter because:

(i) psychiatrists are not trained to think critically,
(ii) the material is actively filtered to remove anything remotely critical, and
(iii) nobody takes any notice of it anyway.

Psychiatrists do not read journals in order to challenge their views. They quickly scan journals in order to find material supportive of their positions. For example, psychiatrists who use ECT *never* read anything remotely critical of their practice, but mainstream editors wouldn't publish it anyway.

The following recent small example is absolutely typical. On March 9th 2018, the RANZCP issued a press statement which said, inter alia:

> The prescription of antidepressant or antipsychotic medications is something that a psychiatrist *only ever* does in partnership with the patient and after due consideration of the risks and benefits (emphasis added). (Attached as **Appendix C**)

I immediately wrote to the president of the RANZCP pointing out that this was a complete fabrication. Needless to say, the president of the college rejected my complaint (and refused to deal with it as a complaint, so it has now gone to the Medical Board). However, I did a quick survey of my 174 active files and found that while half my patients were taking prescribed drugs at the time they were referrred, not one of them had been given even remotely adequate information about their drugs. I submitted this as an original paper to an RANZCP journal, *Australasian Psychiatry*. As I had predicted to friends, it was rejected without being sent for review:

> We thank you for your submission to the journal and regret that we cannot publish your paper on this occasion. Although this is a worthy topic of investigation, there is no methods section within your paper and it is assumed that you have reviewed the files of a single clinic. The results are influenced by subjectivity and recall bias.

This was a little surprising, as the methods section specifically said it was a survey of my own patients (i.e. necessarily a single clinic) but this journal and all others routinely publish surveys from single clinics (the study is available at [26]. I urge the members of this Commission to read it because the matter is of grave importance).

(c) Continuing Professional Development (CPD).

Every medical speciality has a continuing education program, now mandated by the National Law. The RANZCP maintains a website where members are required to log their program for the year, then show how they are meeting it. At the end of the year, they can add their points and get a certificate which they present to the Medical Board. Educational activities sponsored by the RANZCP include the two journals, the annual psychiatric conference, annual conferences for the different sections such as social psychiatry or forensic psychiatry etc., and various activities at branch level. These include regular meetings of the different sections and there are also regular sponsored meetings which qualify.

It is the case that the RANZCP puts considerable emphasis on the idea that psychiatrists are professionals in every sense of the word, which justifies their enormous powers to detain people and force them to accept treatment against their will, as well as their right to charge very considerable fees. I will submit that the entire process of CPD in psychiatry is a sham, that it has the *form* of continuing education but not the *content*. The following examples are so common as to be typical:

> (i) In July 2017, a 2nd Year law student in Darwin hanged herself [27]. She had been managed by junior staff from Mental Health Services but it emerged that the psychiatrist who had been ordering changes in her drugs had never seen her nor spoken to any member of her family. There was absolutely nothing in her file that would amount to a psychiatric assessment. The records indicate that she died of complications of her drug treatment, not despite it. This was a complete breach of stated RANZCP policy but the college has done nothing about it.
>
> (ii) At the age of 30yrs, Ms TA was referred to a psychiatrist. Over the next ten years, she received some 438 ECT. At no stage in some 2000 pages of the psychiatrist's records is there anything approximating a proper assessment. She has no idea how much all this cost but she now has no money left to pay for a report on her management which she needs in order to initiate a complaint.
>
> (iii) Mr GD spent perhaps twenty of his 43yrs in mental hospitals at a cost to the community of at least $10million. In 2014, he was tied to his bed for about 120 days while he was given some 103 ECT in succession. His files showed that at no stage had anybody taken a proper history. It emerged that the first eight years of his files had been lost (they were apparently in archives but nobody knew where because nobody had ever looked for them). None of the approximately 450 psychiatrists and registrars who had been involved in his management over the years knew anything about his original presentation, which was actually a drug-induced psychosis.
>
> (iv) Mr OD was referred to a psychiatrist for assessment for departmental purposes. The psychiatrist submitted his account but not the report. For three months, the medical officer involved rang his office to get a report, then she sent the patient elsewhere, incurring further costs. Some time later, she received a handwritten letter of about fifty words from the first psychiatrist. The same psychiatrist saw another member of that department, who said of the

interview: "After about twenty minutes, he put his pen away, looked at me with a big grin and said, 'Well, you might as well go and kill yourself.' Then he told me to go. I don't know whether he thought he was being funny but it was the worst day of my life." A third patient said of the same psychiatrist: "He let me talk for about 20 minutes, then he stood up and took a photo of me and said 'That's it, you can go.' He didn't ask any of the questions you've asked and just made a few notes."

(v) Mr RM, aged 72yrs, was referred to a psychiatrist after he suffered a head injury. The initial assessment, which led to him losing all his civil rights, consisted of 79 scribbled and largely illegible words, i.e. less than three times the length of this sentence.

(vi) Starting at age 19yrs, Mr DH saw one psychiatrist for the next 34yrs. During this time, Mr H passed his degree, gained his professional qualifications, started his own business, married, and raised his children. He was on large doses of drugs throughout but his mental state was never stable. Eventually, he stopped all the drugs and started to improve. He did not know that, from the beginning, the psychiatrist had diagnosed him as suffering paranoid schizophrenia and had told a lot of people. There is absolutely nothing in the history or his current presentation to suggest this man is or ever has been schizophrenic. Over the years, his treatment has cost him hundreds of thousands of dollars but he was never treated for schizophrenia. His case notes do not include an initial assessment. There are just 68 pages of case notes, i.e. two pages per year of treatment. Mr DH has no idea how much it cost him.

(vii) Ms PE, a 66yo retired nurse, came from a very well-known and financially secure Brisbane family. Starting at the age of seventeen, she saw one psychiatrist each week for about 30yrs until he died, then another, also weekly, for 15yrs until he retired. At this point, she was referred for reassessment. She had always been an anxious person but this had never been treated. She spent her entire inheritance, which would now be about $1million, on seeing psychiatrists and now lives on the old age pension. At some stage in the mid-70s, she was given unmodified ECT in the psychiatrist's office. Questioned about this, as it had long been superseded, she was adamant. Her description, such as she could remember, was very clearly of that procedure, especially as she had many standard ECT and remembered that incident as especially terrifying.

(viii) In July 2017, I lodged a submission with the Human Rights and Equal Opportunity Commission (HREOC) regarding their enquiry into the implementation of the Optional Protocol to the Convention Against Torture. I showed that, using the definitions provided in the Convention and by HREOC, most detained psychiatric patients in this country were held in

> breach of the Convention Against Torture (attached as **Appendix C**). I circulated this to the local group of the RANZCP Section on Philosophy, History and Ethics of Psychiatry, of which I was a foundation member and on whose national committee I had served until a few weeks beforehand. As a result, I was promptly excluded from the philosophy section and a complaint was lodged with the Medical Board to the effect that I was practising outside my specialty. The complaint was dismissed as baseless but it consumed a great deal of my time. The Qld Branch of RANZCP has resolutely refused to provide any explanation of why I was excluded from the philosophy group.

In psychiatry, horror stories abound but the crucial point is this: all of the psychiatrists involved attend zealously to amassing their CPD points. As it stands, the CPD process developed by the RANZCP is inadequate to its goal of detecting substandard practice and, at the same time, has no capacity to correct it. That is, the current CPD program is incapable of leading to an improvement in standards. Nonetheless, it is wholly effective at deflecting criticism. We are left with the unhappy conclusion that is its entire purpose, but with the added bonus of lots of wining and dining and travel to exotic locations at the taxpayer's expense.

(d) The integrity of the psychiatric profession.

To expand on the incident described in **pt (b)** above, in February 2018, a visiting academic gave an interview to a newspaper in New Zealand in which he voiced very strong criticism of the relentlessly growing use of antidepressants. Using the superb resources of his centre, Prof. Peter Gotszche, head of the Nordic Cochrane Centre in Copenhagen, has published extensively on this question, and is better qualified to speak on the topic of adverse effects of antidepressants than any psychiatrist in Australia or New Zealand. The RANZCP took strong exception to his opinion, issuing a press release dated March 9th 2018, which stated, inter alia:

> The prescription of antidepressant or antipsychotic medications is something that a psychiatrist only ever does in partnership with the patient and after due consideration of the risks and benefits (see **Appendix C**).

It is impossible to understand what motivated the board of the RANZCP to make this claim. Every psychiatrist knows, and every psychiatric patient knows (not to mention all medical practitioners, nurses, relatives, police, administrators, etc) that every day in a hundred or more centres in this country, patients are wrestled to the ground and forcibly injected with drugs without so much as a whisper of what the drug is for, or the harm it can do. A complaint was lodged with the RANZCP, alleging that not only was this claim false but every person involved in issuing the press release knew it to be false. That is to say, on this matter of grave importance, there was a *prima facie* case that the president and board of the RANZCP had been caught in the act of lying to the general public. Unsurprisingly, the complaint was rejected; it was resubmitted, only to be rejected again. Further correspondence went nowhere.

As a result, the matter was referred to the Australian Charities and Not-for-profits Commission, which governs the RANZCP as a company limited by guarantee and a registered charity. They rejected the complaint on the unconvincing grounds that it didn't bring the field into disrepute (the terms 'field' and 'disrepute' were not defined). The complaint was then submitted to AHPRA, which rejected it within 24hrs on the basis that none of the members of the board was in Qld. It was pointed out that the president-elect of the RANZCP and director of Qld MHS, Dr John Allan, is a board member. A month later, the complaint was rejected on the basis that it didn't mention any patients by name. My subsequent objection that, as director of MHS, Dr Allan not only never saw psychiatric patients but he had full statutory responsibility for every patient treated by MHS, was dismissed on the basis that their decision had already been made. Further objections have not been answered, so the matter has been referred to somebody called the National Health Practitioner Ombudsman and Privacy Commissioner.

Pending a decision by the NHPOPC, it now appears to be the case, backed by the full authority of the professional and statutory authorities, that the peak professional body of psychiatrists in Australia and New Zealand can mislead the general public with the most egregious falsehoods but, remarkably, nobody cares. Does it matter that psychiatric patients are *almost never* told the side effects of drugs? For example, that the drugs are both highly addictive and little better than placebos? That patients may double their weight, or lose their sexual function in the very long term? That they will die younger from taking them? I believe it does matter, and so does every patient I have ever spoken to. Psychiatrists, however, and on the authority of their governing board, clearly don't. This raises the critical question of regulatory capture: AHPRA, the body charged with supervising the psychiatric profession, is now subservient to it. This needs to be investigated separately.

What this says is that everything the RANZCP says is tainted in that not only does the governing board appear to lie to the public, but they then make the most strenuous efforts to conceal their actions.

(e) Corruption in psychiatry.

Deleted on legal advice, specifically "risk of action for defamation".

Conclusion

It is highly likely that a great deal of the material in this submission will come as a surprise to Commissioners but every point is substantiated in the literature. It is not new. What is new is that a psychiatrist is prepared to state this in public. Normally, psychiatry's response to bad news is to suppress it, to conceal it under a welter of claims that psychiatry is making huge strides and stands on the cusp of enormous improvements in the care of the mentally disturbed, etc. This is mere propaganda but, when it doesn't succeed, the reflex response is to launch an *ad hominum* attack on the bearer of bad tidings. For example, in 2017, the UN Human Rights Council received the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. This was critical of mainstream psychiatry but, far from paying attention to the findings of this august body, the *Australian and New Zealand Journal of Psychiatry* published a commentary [28] which blamed the criticism, not on psychiatry's manifold shortcomings but on something they called a "global anti-psychiatry movement." There is, of course, no such thing, it is a figment of imagination of a group which abhores criticism and firmly believes it has almost divine authority to decide all matters relating to mental disorder [29].

That attitude is destructive and antiscientific but it is accepted without question at all levels of the profession. Not only was the *Journal's* commentary intellectually immature and self-serving, but the editorial board and its reviewers failed to see its many faults. In the echo chamber that psychiatry has become, they all agreed, that Yes, we're doing a wonderful job, yes, we need more money and, above all, no, we don't need critics.

An important point arising from the Special Rapporteur's findings is that mainstream psychiatry is now the outlier. Every group approached saw problems with psychiatry; every group but psychiatry itself, which saw in the Report a conspiracy to limit its powers. Driven by its guilds [16], the public face of psychiatry is dominated by two groups who brook no opposition. The first is the very public face of a caring psychiatry, with its telegenic professors and earnest researchers who never miss a chance to tell the public that psychiatry is making great strides, so anybody who feels a little off-colour should rush to their general practitioner - who will, of course, prescribe the drugs the professors are paid to tout. The second is less obvious but no less potent, the large group of psychiatrists who are making small fortunes ($500-750,000 a year) from "treating" people for disorders that either didn't exist until a few years ago, or are either equally likely to get better without any intervention, or be rendered chronic by psychiatry's clumsy tools.

The problem is that, by embracing what it calls the "biomedical model of psychiatry," psychiatry has painted itself into a very dangerous corner. It has no Plan B. As far as mainstream psychiatry is concerned, all mental disorder is biological, meaning a full understanding of the brain will tell us everything there is to know about mental disorder, with no questions unanswered. Despite the huge sums of money spent each year on biological research in mental disorder, this is not just unproven but is almost certainly false [6]. However, the people in the two groups described above who have driven psychiatry into this intellectual cul-de-sac are not just unaware of their intellectual shortcomings, but are bitterly antagonistic to anybody who has the audacity to point them out: Critics must be part of a "global anti-psychiatry conspiracy," so we don't have to listen to them. The danger and absurdity of this stance is manifest.

The institution of psychiatry wants everybody to believe that they have the matter firmly in hand, that theirs is the only conceivable approach to mental disorder and that all criticism is malicious: "Move on, nothing to see here." Nothing could be further from the truth. We have reached the point where we have to ask: Is psychiatry doing anything useful for society, or has it degenerated to an insatiable, high-cost and self-sustaining rentier gorging on the public purse? It is to be hoped that this honourable Enquiry will assist in the process of uncovering that truth.

References:

1. McLaren N (2013). Psychiatry as Ideology. *Ethical Human Psychology and Psychiatry* 15: 7-18.

2. McLaren N (2007). The Categorical System of Diagnosis: Personality Disorder. Chapter 8 in: McLaren N 2007. *Humanizing Madness: Psychiatry and the Cognitive Neurosciences.*; Ann Arbor, Mi.: Future Psychiatry Press.

3. McLaren N. (2011). Cells, circuits and syndromes. A critique of the NIMH Research Domain Criteria project. *Ethical Human Psychology and Psychiatry* 13: 229-236.

4. McLaren N. A critical review of the biopsychosocial model. *Australian and New Zealand Journal of Psychiatry* 1998: 32; 86-92. Revised version at [24].

5. Gask L (2018). In defence of the biopsychosocial model. Essay, *Lancet Psychiatry*, 5: 548-49. Published online: April 20 2018, DOI:https://doi.org/10.1016/S2215-0366(18)30165-2

6. Stoljar D (2010). *Physicalism*. Oxford: Routledge.

7. Joseph J (2017) *Schizophrenia and Genetics: The End of an Illusion.* New York: Routledge.

8. UN figures on early death: http://www.who.int/mental_health/management/info_sheet.pdf.

9. Wunderink L et al (2013) Recovery in Remitted First-Episode Psychosis at 7 Years of Follow-up of an Early Dose Reduction/Discontinuation or Maintenance Treatment Strategy: Long-term Follow-up of a 2-Year Randomized Clinical Trial. *JAMA* Psychiatry. doi:10.1001/jamapsychiatry.2013.19
Published online July 3, 2013.

10. Lader M, Kyriacou A. Withdrawing Benzodiazepines in Patients With Anxiety Disorders. *Current Psychiatry Reports.* 2016 Jan 1;18(1):1-8. PubMed link

11. RANZCP Position Statement on ECT; No. 74, Point 7.2. Issued March 2014. Available at ranzcp.org.au.

12. McLaren N (2018). Electroconvulsive Therapy: A Critical Perspective. *Ethical Human Psychology and Psychiatry* 19: 91-104

13. Bradshaw M (2018). The Evidence That More Psychiatry Means More Suicide. Online: https://www.madinamerica.com/2014/01/evidence-that-more-psychiatry-means-more-suicide/.

14. Simons P (2018). Antidepressant Use Leads to Worse Long Term Outcomes, Study Finds. At: https://www.madinamerica.com/2018/04/antidepressant-use-leads-worse-long-term-outcomes-study-finds/

15. Jorm AF et al (2017). Has increased provision of treatment reduced the prevalence of common mental disorders? Review of the evidence from four countries. *World Psychiatry*. 2017 Feb; 16(1): 90–99. doi: 10.1002/wps.20388

16. Whitaker R, Cosgrove L (2015). *Psychiatry Under the Influence: Institutional Corruption, Social Injury, and Prescriptions for Reform.* New York: Palgrave MacMillan.

17. McLaren N (2017) Submission to HREOC OPCAT Enquiry. Also: http://www.humanrights.gov.au/submissions-opcat-australia-2017 (submission 3)

18. Le Noury J et al (2015) Restoring Study 329: efficacy and harms of paroxetine and imipramine in treatment of major depression in adolescence. *BMJ* 2015; 351 doi: https://doi.org/10.1136/bmj.h4320

19. https://www.theguardian.com/society/2016/jan/27/prozac-next-psychiatric-wonder-drug-research-medicine-mental-illness

20. Whitaker R (2002). *Mad in America: Bad Science, Bad Medicine and the Enduring Mistreatment of the Mentally Ill*. New York: Perseus Books.

21. Dean ET. *Shook over hell: Post-traumatic stress, Vietnam and the Civil War*. Harvard: University Press, 1997.

22. Whitely M (2010). Speed Up and Sit Still: the controversies of ADHD diagnosis and treatment. University of Western Australia Press: Perth, WA.

23. Popper KR (1972). *Conjectures and Refutations: the growth of scientific knowledge*. London: Routledge.

24. McLaren N (2010). A life of its own: the strange case of the biopsychosocial model. Chapter 7 in *Humanizing Psychiatrists: Toward a Humane Psychiatry*. Ann Arbor, Mi.: Future Psychiatry Press.

25. MIA editors 2018. The Long-term Consequences of Antidepressant Use: An Interview with Michael Hengartner. Available at: https://www.madinamerica.com/2018/05/long-term-consequences-antidepressants-interview-michael-hengartner/

26. McLaren N (2018). Questioning the Integrity of Psychiatry.
Available at: https://www.madinamerica.com/2018/05/questioning-integrity-psychiatry/

27. Inquest into death of Sabrina Josephine di Lembo. NT News, October 24th, 2018.
https://www.abc.net.au/news/2018-10-24/sabrina-di-lembo-inquest-medical-services-depression-suicide/10422174. Also: https://justice.nt.gov.au/__data/assets/pdf_file/0006/614994/D01362017-Di-Lembo.pdf

28. Dharmawardene V and Menkes DB (2018) Responding to the UN Special Rapporteur's anti-psychiatry bias. *Australian and New Zealand Journal of Psychiatry*. https://doi.org/10.1177/0004867418818359 (epub 10.12.18) Accessed 21.12.18.

29. McLaren N. Criticising psychiatry is not 'antipsychiatry.' *Australian and New Zealand Journal of Psychiatry*. https://doi.org/10.1177/0004867419835944 (March 2019)

Appendices:

Appendix A:

McLaren N (2018). Electroconvulsive Therapy: A Critical Perspective. *Ethical Human Psychology and Psychiatry* 19: 91-104

Appendix B:

Commentary sent to Dr J Allan, Chief Psychiatrist, Qld MHS, July 2014.

Appendix C:

Submission to HREOC Enquiry into implementation of Optional Protocol to the Convention Against Torture (OPCAT). Also available at: http://www.humanrights.gov.au/submissions-opcat-australia-consultation-2017.

Appendix A:

McLaren N (2018). Electroconvulsive Therapy: A Critical Perspective. *Ethical Human Psychology and* Psychiatry 19: 91-104

ECT is widely used in the Anglophone world but very much less in the rest of the world. In some places, it is so severely restricted as to be a rarity; in others, it is banned. Comparative data indicate there is no scientific justification for this discrepancy. Instead, there is a prima facie case to say that the major impetus behind ECT usage lies in the financial rewards it generates for psychiatrists.

Keywords: ECT, psychiatry, models of mental disorder; psychiatric mortality.

INTRODUCTION

The official position of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) on electroconvulsive treatment (ECT) is given in their Position Statement on ECT, dated March 2014:

> 1. ECT... has efficacy in treating clinical depression, mania and psychosis... Its primary purpose is to quickly and significantly alleviate psychiatric symptoms.
> 5.6: The use of evidence based pharmacotherapy and other strategies to prevent relapse after improvement from ECT is essential for obtaining a lasting improvement.
> 7.2: ...ECT remains a useful and essential treatment option that should be available to all patients in whom its use is clinically indicated...

Further elaboration is given in the RANZCP submission (2011, pp1-2) to the US Food and Drug Administration's (FDA) hearing to reclassify ECT machines from Class III to Class II medical devices, i.e. requiring a *lower* level of proof of efficacy and safety (see Note 1):

> The RANZCP strongly supports the use of ECT as an established and valuable treatment for patients suffering severe mental disorder... The RANZCP is strongly of the view that ECT remains an important and necessary treatment for various serious psychiatric conditions, most commonly severe depression ...
> ...the RANCZP believes very firmly that it would be an injustice for ECT to be unavailable ... ECT is irreplaceable...
> There is further evidence that ECT does not cause brain damage or personality change, and a lack of evidence or rational reason to suggest or expect any long term ill-effects...
> The high morbidity and mortality associated with the conditions as detailed above, and the high prevalence of medication resistant depression, leaves ECT as the only alternative treatment for a significant number of patients...
> It is recognised that ECT raises anxiety and fearfulness in the community, however much of the opposition to ECT is based on fear and irrational thinking, not science.

ECT is held to be "useful," "essential," "irreplaceable," "effective," "valuable," "clinically indicated," "important and necessary," and harmless, while opposition to it is "irrational," out-dated and not scientific. These are very strong claims. Because ECT evokes strong reactions, they need the highest level of proof. In this brief review, I wish to question these claims, and will present evidence to show that they are not supported in the literature.

Is ECT useful in psychiatric practice?

This claim is not scientific. "Useful" is entirely a subjective decision; at most, it may be said that some practitioners find it useful, but that would be a matter for research, not fiat. In fact, not all psychiatrists find it useful, as Jonathon Phillips, a former president of the RANZCP, commented:

> ...it is very easy to order ECT treatment. I would not like to think that it is being used just because it's easy.... I do hope it is not the start of the slippery slope. Are we going back to an era where we resort to ECT rather than talking to people and using the art of psychiatry?.... In two years in a very busy practice, I have only referred one patient for ECT... (O'Brien, 2011).

In his enquiries, O'Brien noted an unusual discrepancy:

> The Medicare figures show that last year, New South Wales men aged under 24 were given (ECT) at three times the rate of men in that age group in Victoria.

It seems highly unlikely that, on clinical grounds, patients in neighboring states could differ so dramatically; clearly, the perception of "useful" does.

Is ECT essential to psychiatric practice?

This claim is more reliable, as the word 'essential' has a precise and objective meaning:

> Essential *adj*. 1. vitally important; absolutely necessary. 2. basic; fundamental.... 7. something fundamental or indispensable.

If it can be shown that it is possible to practice psychiatry without or rarely using ECT, then it cannot be considered "essential." This is in fact the case. Worldwide, there are very substantial variations in ECT usage internationally, intranationally and even from one locality to the next, as detailed in a lengthy review (Leinkes et al, 2012). These authors use the statistic "treated patient rate" (TPR), meaning the numbers of people who receive ECT per 10,000 population per year.

In the US, the TPR is 5.2 people per 10,000 pa, although there are enormous local variations. Australian rates vary from 2.2 to 4.4 (Victoria) while New Zealand gives it to just 0.75 people in every 10,000, one sixth of the maximum Australian rate. Other nations use it far less. In Spain, the TPR is 0.41, Germany 0.26 (western Laender averaged 0.36 while in the former eastern zone, it was only 0.15) and Poland uses it on only 0.11 people per 10,000 pa. In France, only half of approved psychiatric facilities reported using ECT, while in Poland, that figure was one in three. Japan, Finland, Italy and other countries hardly use it, while it is banned in Slovenia and some cantons of Switzerland.

Following the intense restrictions on ECT in Italy in 1978 and again in 1999, in which private ECT was banned, Abrams (2000) predicted disaster:

> (In Italy, ECT) may now be administered only as an emergency procedure in government hospitals after other treatments have failed and if the patient is in a “life-threatening” situation. Because of politically based conflicts, the use of ECT in Italy was already among the lowest in the European community; the new regulations now threaten the very existence of this truly indispensable treatment in the land of its birth.

In 2014, 91 centres in Italy were licenced to give ECT; only fourteen (15%) did, meaning about 53million people did not have access to ECT. Abrams' claim that it is "truly indispensable" has been contradicted by the passage of time. An impassioned plea for increased use of ECT in Italy by Buccelli et al (2016) omitted to mention that, in nearly twenty years since it was effectively banned, the mental health of Italians has not declined.

In the US, TPRs vary from 5.7 for women to 3.6 for men, a pattern which was also seen in England: female rates there were 2.56 per 10,000 while male rates were only 1.12. In Scotland in the 1990s, rates for people aged 65 and over were about five times those for people 18-65, but all rates in that jurisdiction dropped by over 50% during this decade. No explanation was offered. In practically all countries where the information was available, rates of ECT utilisation were higher in urban than in rural regions, ranging from 50-500% higher.

Commenting on an earlier survey of the US, Eranti and McLoughlin (2003) said:

> No ECT use was reported in just over one-third of the 317 metropolitan areas in the 1988-1989 APA survey and, in the remaining areas, annual rates ranged from 4 to 812 patients per 100,000 population.

That is, they found TPR ranged from 0.4 to 81.2 per 10,000, or 20,000% difference in the same country.

In the England-Wales division of the UK NHS, ECT use has declined precipitously over the past thirty years, from a total 137,940 episodes in 1985, to 105,466 by 1991, then to an estimated 65 930 in 1999. The decline has continued apace, down to about 22,500 in 2014-15, or barely one sixth as much as a generation before (Davis and Duncan 2017). As the population has increased by over 20% in this time, the relative decline is even greater.

In this context, my own figures are apposite. 2017 marks forty years of highly diverse practice, in public and in private, in hospitals, prisons and community clinics, in urban areas and remote, including six years as the world's most isolated psychiatrist (McLaren 1995). At present, I operate a solo, bulk-billing private practice in a working class area with high levels of unemployment, of broken families, immigrants and pensioners, as well as high levels of crime, school absenteeism, drug and alcohol abuse, etc. (all patients are eligible for national health insurance). Having worked for years in public services, I am satisfied that the patient profile I see now is the same as would be seen in any public service in the country. In four decades, I estimate I have personally assessed and managed, or been directly responsible for, well in excess of 12,000 patients. These are consecutive, unselected public patients, including about one thousand serving members of defence forces and perhaps two thousand veterans. In forty years, not one of those many thousands of patients has been given ECT.

Twice in that time, I was head of department of 30 bed units in general hospitals (Veterans' Affairs, RGH Hollywood, Perth, for five years, and Royal Darwin Hospital, NT, for three years). In each of those hospitals, ECT had been in use for years prior to my appointment. It stopped for the duration of my stay and was resumed some time later. During my tenure, the admission rate in each hospital dropped, the mean duration of stay dropped and the bed occupancy rate dropped to about half. Following my departure, when ECT resumed, these statistics returned to their previous means. That is to say, psychiatrists seeing exactly the same patient profile and, in some cases, even the same patients, were electing to use ECT in just the circumstances where I had not.

These figures indicate that many psychiatrists and many centres around the world feel able to practice psychiatry using ECT rarely or never. They do not support the claim that ECT is essential, i.e. "vitally important, absolutely necessary, indispensable."

Can ECT be "clinically indicated"?

A "clinical indication" is just what the prevailing medical standards say it is. It is an attempt to impose some sort of order on daily practice, as in: "If conditions A, B and C prevail then, all things being equal, current mainstream opinion is that treatment K should be followed." Most emphatically, it does not shift the decision to use a treatment from the practitioner to the clinical picture, which is the impression the expression gives: ultimately, the practitioner is responsible. Needless to say, two psychiatrists can look at the same patient and come to radically different conclusions about the best form of management. ECT, like all other forms of treatment, is indicated just when the psychiatrist says it is. In practice, Point 7.2 of the Position Statement now reads:

> ECT ... should be available to all patients *if the psychiatrist decides to use it*...

This imparts quite a different significance.

If the notion of "clinical indication" has any objective standing, it is difficult to explain how there could be such enormous variation between, say, rural areas in Belgium and their main cities (TPR respectively 2.0 and 10.0), or the American figures quoted by Eranti and McLoughlin (2003). More pertinently, it is necessary to explain New Zealand's relatively low rate compared to Australia. Since the populations are so similar on all genetic, socio-economic and cultural parameters, and psychiatrists in both countries are trained to the same curriculum, it is not possible to say that "clinical indication" can account for the 600% difference in utilisation of ECT. A potential explanation is buried in the paper by Leiknes et al: in New Zealand, ECT is not given in private facilities.

In practice, it is the psychiatrist's decision whether or not to use ECT but this has immediate impact on the concept of informed consent. Ideally, all patients advised to have ECT should be told that while their psychiatrist advises it, other psychiatrists in the same town would not while, in some countries, it is so severely restricted that the question would not arise. As will be shown later, the clinical outcome of ECT vs. no ECT is about the same so, whether patients get ECT or not is not a matter of science, it is a matter of the psychiatrist's personal predilection, i.e. chance.

There are further grounds to suspect the value of attributing ECT to "clinical indications." In Australia, use of ECT in private settings increased very dramatically in the decade from 2007, as shown by Medicare rebates for ECT in the private sector:

State	2007	2016	Increase %
New South Wales	4936	8039	63
Victoria	4895	8639	76
Queensland	4852	9274	91
South Australia	1163	2487	114
Western Australia	1457	4242	191
National totals	18183	33641	85

Nationally, the "clinically-indicated" use of ECT in private practice increased nearly six times faster than population growth in that decade (15%). The dramatic rise of 190% in Western Australia cannot be explained on any reasonable clinical grounds. In Queensland (population 4.8million), ECT usage in both public and private sectors jumped from 16,602 episodes in 2013-14, to 19,365 episodes the following year, i.e. 16.5% increase. By way of comparison, Davis and Duncan (2017) noted that in 2015-16 in England (population 53million), NHS trusts reported about 22,500 episodes of ECT, meaning Queensland uses ECT approximately 1000% more than England.

A similar pattern is seen in the US, where ECT is largely reserved to the private sector:

> A typical ECT patient in the United States was said to be an elderly white female paying for treatment with insurance or private funds (Leiknes et al, 2012).

Sackeim (2007) reached the same conclusion:

> ...ECT recipients are older, more often white, more likely to have private insurance, and more likely to live in more affluent areas. Contrary to its portrayal as a treatment inflicted on the poor or destitute, ECT is disproportionately administered to those more well-off.

After a most extensive review, Read and Arnold (2017) commented:

> We should, meanwhile, remain cognizant of the fact that the archetypal ECT recipient remains, as it has for decades, a distressed woman more than 50 years old.

This raises another question, the allocation of ECT.

Is ECT properly allocated by clinical indications?

Using figures taken from the website of the Australian National Depression Initiative (Beyond Blue.org), in any year, about one million Australians will suffer a depressive episode. Some, of course, will suffer several, so the total figure is quite a lot higher. In 2015, 3027 deaths by suicide were recorded, of which a certain proportion were not associated with depression, say one quarter. This yields 2270 suicides among one million plus cases of depression, where the risk for men is 3.4 times greater than for women.

Accepting Beyond Blue's figures that two thirds of cases of depression are female, the annual risk of suicide among depressed women is approximately 545 deaths in 670,000 cases p.a., or 81 suicides per 100,000 cases per annum (one suicide per 1,234 cases of depression). The equivalent risk for men is 525 per 100,000 cases of depression (one death per 190 cases of depression), 650% greater, but women get 80% of the ECT in this country. Clearly, this constitutes a grave misallocation of resources. Equally clearly, it would not be feasible to try to prevent all suicides by admitting all depressed people to hospital and giving them ECT.

Is ECT "irreplaceable"?

To paraphrase the RANZCP submission to the FDA, ECT is absolutely essential as an emergency measure to treat severe mental disorders and their associated morbidity and mortality. This applies especially to severe depression, which is becoming more problematic due to the rise of "treatment resistant depression." In a recent review of ECT, Kolar (2017) stated:

> ...acute ECT has an essential role when the urgency of the clinical situation (an increased risk of suicide, treatment resistant catatonia, malnutrition, etc) demands a treatment with a rapid onset of therapeutic action.

However, in Norway, ECT is restricted and it is reported (Leinkes et al, 2012) that, at centres authorised to use ECT, waiting lists of up to eight weeks are not uncommon. In Italy, 91 centres are authorised to use ECT but, in 2014, only fourteen did so. That is, about 85% of the population of some 63million did not have access to ECT. There is no evidence that they were any worse off. There is no doubt that, if there were a discrepancy in suicide rates between areas where ECT is available and those where it is not, advocates of ECT would seize upon it eagerly. There is no such evidence.

Despite the recent rapid increase in use of ECT in Australia, the suicide rate has recently peaked at 12.6 per 100,000 p.a. (ABS 2016) For men, the figure is 19.2, about 340% of the rate for women, but since most patients receiving ECT in Australia are female, it is clear that ECT is misallocated:

> ...100 female psychiatrists performed 109 ECTs with equal numbers of male and female patients, but 100 male psychiatrists performed 345 ECTs and there were four females for every male patient. These results are reflected in the national data. Male psychiatrists perform 93.5% of ECTs... (Quadrio 2001).

Those patients who receive ECT, essentially meaning older white women who can afford to be managed in private hospitals, are among the least likely to attempt suicide. The population at gravest risk of suicide is younger, male, unemployed, often with drug and alcohol problems, possible criminal history, recent major losses etc. That is, they show exactly the profile of my own practice. Needless to say, this group cannot afford private hospitals, and would be unlikely to cooperate in any event. It would not be unfair to conclude that the allocation of ECT in Australia is determined by some factor other than "the urgency of the clinical situation." ECT therefore appears to be very replaceable, dependent entirely on the patient's socio-demographic factors, otherwise known as finances.

A psychiatrist who says to a depressed patient "You must have ECT, it is irreplaceable in your case," is saying only one of three things:

> 1. "I am firmly committed to the concept of depression as a genetically-determined, biological disease of the brain and, as such, I believe that physical methods of management are irreplaceable."

If so, that psychiatrist is adopting a position which has been shown to be ideological, not scientific, and which is probably wrong anyway (McLaren 2013).

> 2. "I have tried everything I can but I have reached the limit of my skill set. I don't know what else to do."

That psychiatrist should request a second opinion from a colleague who is able to practice without ECT, or hardly uses it.

> 3. "It pays well."

There are other, doctrinaire positions but they are outside the scope of this paper.

ECT is never irreplaceable, but people who use it routinely will never discover that. It is only when it is *not* available that valid alternatives become obvious. Essentially, the decision to use ECT should be taken from individual psychiatrists and handed to an impartial committee, including critics of ECT. In order to remove the financial incentive as a confounding factor, it would be reasonable to argue that all ECT should be given in public facilities, as in Norway, or that private psychiatrists can give it but cannot charge.

Who believes ECT is best?

From the RANZCP Submission to the FDA:

> The RANZCP strongly supports the use of ECT ... The RANZCP is strongly of the view that ECT remains ... the RANCZP believes very firmly...

This is a category error (Ryle 1949). The organisation known as RANZCP is not the type of entity that can hold beliefs or opinions, etc, nor can it "strongly support" anything because it doesn't have mental properties. Its members do, but that is a different matter. As it stands, the submission is highly misleading. It should have said something like this:

> A small proportion of the membership of the RANZCP, all of whom use ECT, strongly support the use of ECT, etc., but they didn't survey the full membership, nor did they include critics of ECT in their deliberations.

Is ECT harmless?

From the RANZCP Submission to the FDA:

> There is further evidence that ECT does not cause brain damage or personality change, and a lack of evidence or rational reason to suggest or expect any long term ill-effects... much of the opposition to ECT is based on fear and irrational thinking, not science.

Historically, convulsive techniques were developed, initially by Ladislas Meduna in the 1920s, explicitly for the purpose of inducing diffuse, low-grade brain damage as evidenced by gliosis. There is now a substantial body of literature showing that ECT can cause long-lasting damage to memory, to other cognitive functions, and to the sense of self. For example, the American Psychiatric Association (APA) committee on ECT (2001) left no room for doubt:

> In some patients the recovery from retrograde amnesia will be incomplete, and evidence has shown that ECT can result in persistent or permanent memory loss.

A few years later, Rose and colleagues (2003) were perfectly blunt:

> The current statement for patients from the Royal College of Psychiatrists that over 80% of patients are satisfied with electroconvulsive therapy and that memory loss is not clinically important is unfounded.

Similarly, in a well-planned, multi-centre study of 347 patients receiving ECT, Sackeim et al (2007) concluded:

> ...this study provides the first evidence in a large, prospective sample that adverse cognitive effects can persist for an extended period, and that they characterize routine treatment with ECT in community settings.

MacQueen et al (2007) conducted a detailed neuropsychological study of post-ECT patients and found:

> Compared with healthy subjects, patients had verbal learning and memory deficits. Subjects who had received remote ECT had further impairment on a variety of learning and memory tests when compared with patients with no past ECT. This degree of impairment could not be accounted for by illness state at the time of assessment or by differential past illness burden between patient groups.

Similarly, after an extensive review, Read and Bentall (2010) concluded:

> Given the strong evidence of persistent and, for some, permanent brain dysfunction, primarily evidenced in the form of retrograde and anterograde amnesia, and the evidence of a slight but significant increased risk of death, the cost-benefit analysis for ECT is so poor that its use cannot be scientifically justified.

More recently, the Royal College of Psychiatrists appears to have had second thoughts, as their current patient leaflet explains:

> Memory problems can be a longer-term side effect (of ECT). Surveys conducted by doctors and clinical staff usually find a low level of severe side-effects, maybe around 1 in 10.* Patient-led surveys have found much more, maybe in half of those having ECT.... Some memory problems are probably present in everyone receiving ECT. ... some people do complain that their memory has been permanently affected, that their memories never come back. ...It is not clear how much of this is due to the ECT, and how much is due to the depressive illness or other factors.** Some people have complained of more distressing experiences, such as feeling that their personalities have changed, that they have lost skills or that they are no longer the person they were before ECT. They say that they have never got over the experience and feel permanently harmed. What seems to be generally agreed is that the more ECT someone is given, the more it is likely to affect their

> memory.... Between 30% and 50% of patients complained of difficulties with memory after ECT (RCPsych, undated)

* A 10% rate of "severe" side effects is hardly "low level."
** This isn't clear, as they had already said the depression had resolved; now they are saying persisting memory defects must be due to persisting depression, for which the treatment, presumably, is more ECT. In any event, since it isn't clear how much is due to ECT and how much to "other factors," and since alternative treatments are available, it would be reasonable to stop using ECT.

In a presentation to the US FDA enquiry on the reclassification of ECT machines, and speaking as a member of the FDA's research and assessment staff, Como (2011) stated:

> ....self-reported memory loss tends to be more persistent than the deficits that can be measured on formal neuropsychological testing. However, for those patients who do experience memory or cognitive impairment, they consider this to be a considerable source of distress for themselves and their families.

Breggin (2010) prepared a review for the same FDA enquiry, concluding:

> Electroconvulsive therapy (ECT) and the machines that deliver it have never been tested for safety and efficacy in order to receive approval from the FDA. The APA and ECT advocates protested when the FDA took steps to classify the machines as posing “an unreasonable risk of illness or injury”, which would have required their testing before approval. Without requiring this testing, the FDA is now preparing to classify the treatment and the machines as safe... ECT is very harmful to the brain and mind... the FDA should demand the usual testing, starting with animals, that is required before psychiatric treatments and machines are approved for marketing and use.

Breggin (2017) maintains a website with over 150 citations, dating from 1942-2012, showing that ECT can cause lasting damage. It is worth noting that medical attitudes to cognitive impairment have changed over the years. For example, a detailed research paper from 1951 found considerable levels of impairment of memory, but this was seen as evidence for the efficacy of ECT as "...facilitat(ing) the selective forgetting or repression of emotionally disturbing material" (Janis and Astrachan 1951). This view is generally not shared by patients. The amnestic effects of ECT are addressed poignantly in a widely-cited, first-person account by Donahue (2000) and in another by Ian McPhee, a Sydney anaesthetist (2009). In a section entitled *The Disaster of ECT,* McPhee said:

> The consequences (of ECT) were dire. Retrograde memory loss was profound. I was devastated and searched for answers where my treating doctors could give none.... I was left then to claw back a life only half remembered.

The Nobel Prize-winning author, Ernest Hemingway, committed suicide shortly after completing a course of 20 ECT. Just before he shot himself, Hemingway said bitterly:

> What these shock doctors don't know is about writers...and what they do to them...What is the sense of ruining my head and erasing my memory, which is my capital, and putting me out of business? It was a brilliant cure but we lost the patient.

However, the question of the risks of ECT is not the point: if it is unnecessary, then questions of safety do not arise. As for the suggestion that opponents of ECT are necessarily "irrational, antiscientific," the burden of proof rests with those who use it. As it happens, ECT has no rational basis in an articulated model of mental disorder (McLaren 2013). It should be recalled that in the debate over Italy's Basaglia Law (1978), which severely restricted ECT to the point where it is hardly used today, psychiatrists aimed just these criticisms at proponents of the law. They were shown to be wrong: the mental health of Italians did not deteriorate measurably and, forty years later, they appear to be coping admirably without it.

Is ECT effective?

ECT is widely held to be highly effective for treating depression and other major mental disorders. In fact, it is less effective than its supporters claim. In a study of 290 patients, Sackeim's group found that only 159 remitted (55%). Moreover, the remission is generally not maintained:

> Our study indicates that without active treatment, virtually all remitted patients relapse within 6 months of stopping ECT (Sackeim 2001).

That is, ECT is at best a temporary alleviation of symptoms, not a cure. Similarly, a study of 531 patients as part of the Consortium for Research on ECT revealed a remission rate of just 64% (Kellner 2007). This is not much better than most drug trials claim. The RANZCP Position statement explicitly acknowledges this:

> 5.6: The use of evidence based pharmacotherapy and other strategies to prevent relapse after improvement from ECT is essential for obtaining a lasting improvement.

Indeed, the very notion of "maintenance ECT" indicates clearly that any benefit is likely to be transient. Read and Arnold (2017) were equally skeptical:

> By 2010, there had only been ten such studies (placebo-controlled randomized trials) for ECT and depression, and none since 1985. Those ten had produced minimal evidence of some temporary benefits, for a minority, during the treatment period, and no evidence at all of benefits beyond the end of the treatment period.

Does ECT require special skills?

In public practice in many countries, it is normal for ECT to be administered by the most junior hospital doctors. In Norway, 6% of ECT is administered by nurses (Leiknes et al 2012) while I have seen it administered by medical students. In the UK and in the Netherlands, ECT is now being given by GPs and by geriatricians. Their view is that they can diagnose depression sufficiently reliably to prescribe antidepressants, and ECT is just another minor procedure to them. There are reports that ECT is now being administered to treat Parkinson's syndrome, and in early dementia. These are not psychiatric diagnoses and are therefore outside the scope of this paper, but I doubt the physicians regard ECT as demanding special skills only possessed by psychiatrists.

Is ECT cost-effective?

As noted several times above, ECT is more likely to be given to people who can afford it. Despite any claims to the contrary, ECT is an expensive form of management. In Australia, the current Medicare rebate for ECT, MBS Item 14224, is $70.35. In 1974-6, while in training in Perth, WA, assisted by an anaesthetist, I routinely gave four to six modified ECT per hour (55 minutes of which was spent standing around watching). The bulk-billing fee for a one hour consultation for the purpose of treatment, Item 306, is $156.15. Bearing in mind that very few private psychiatrists charge the base fee for ECT, more likely double or treble, it is clear that giving ECT to a severely depressed patient is much more profitable and requires very much less effort than psychotherapy with the same patient. Moreover, in Australia, private office psychotherapy funded by Medicare is capped at fifty sessions per year, which is not a lot for a seriously-disturbed patient, whereas for a patient admitted to hospital, there are no restrictions. A psychiatrist could administer ECT three times a week and see the patient every other day and still charge full fees.

Assume a day in a dedicated private psychiatric bed costs something of the order of $1500, plus the psychiatric and other fees. ECT will cost of the order $500 per episode, roughly one third to each of the psychiatrist, the anaesthetist and the hospital's theatre fees (in Brisbane, the actual figure is quite a lot higher). The cost of a five week admission to hospital for twelve ECT will start at about $58,500.00. Ten weeks of psychotherapy which, in qualified hands, will produce about the same result, will cost at most $1600.00, 97% less, more likely about half that (psychotherapy does not include CBT, DBT, Mindfulness, ACT etc).

CONCLUSION.

The claims made on behalf of ECT are that it is "useful," "essential," "irreplaceable," "effective," "valuable," "clinically indicated," "important and necessary," and harmless, while opposition to it is "irrational," out-dated and not scientific. This brief survey shows that these claims are not sustainable. ECT is most certainly not essential; it is not irreplaceable as alternatives are readily available; it is not based in a model of mind or of mental disorder so it has no rational or scientific basis; it is expensive; it carries significant risks which psychiatrists usually don't ask about; and it is effective in the short-term only. Suggestions that it is "useful, valuable and clinically-indicated" are personal judgements only, devoid of any empirical content.

By international standards, Australia uses ECT at a grossly excessive rate (e.g. 600% more than New Zealand, 4400% more than Poland), yet its use is increasing far more rapidly than any demographic factors can justify. It is thus reasonable to conclude that a major impetus for its use in this country is the perverse financial incentive built into the Medical Benefits Schedule of the national Health Insurance Commission. Bearing in mind that the remission rates of ECT-treated depression are quite poor, and that relapse is common, "...the cost-benefit analysis for ECT is so poor that its use cannot be scientifically justified" (Read and Bentall 2010). However, psychiatrists who use it, and their closely-associated private hospitals, represent an enormously influential lobby which governments show no signs of resisting. c.f. Upton Sinclair:

> It's difficult to get a man to understand something when his salary depends on his not understanding it.

Remarkably, insurers show practically no signs of interest in the notion that we can dispense with ECT and get the same results at a tiny fraction of the cost of ECT.

Note 1: The RANZCP made a submission to a foreign government agency because "...any decision by the FDA that leads to a restriction in the availability of ECT devices will have an impact on Australia and New Zealand as countries reliant on US manufacturers." ECT devices were in Class III but, for historical reasons, they had never been tested properly. When the FDA asked manufacturers to meet the standards of that class, they demurred on the basis of cost. They then asked to have the devices regraded to Class II so that they did not have to comply, which led to the hearings.

REFERENCES:

Abrams R (2000). Letter: Use of ECT in Italy. *American Journal of Psychiatry*. 157: 840.
APA Committee on ECT (2001). Washington, DC: American Psychiatric Publishing. ISBN 978-0-89042-206-9.
ABS. Australian Bureau of Statistics (2016). 3303.0 Causes of Death, Australia, 2015. Available at http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/bySubject/3303.0~2015~MainFeatures~Intentionalself-harm:keycharacteristics~8. Accessed Sept 8th 2017.
Basaglia Law (1978). https://en.wikipedia.org/wiki/Basaglia_Law. Accessed Sept 8th 2017.
Beyond Blue.org. https://www.beyondblue.org.au/. Accessed September 4th 2017.
Breggin P. (2010) The FDA should test the safety of ECT machines. *International Journal of Risk & Safety in Medicine*. **22**: 89–92 DOI 10.3233/JRS-2010-0491
Breggin P. www.ectresources.org. Accessed Sept 8th 2017.
Buccelli et al (2106). Electroconvulsive Therapy in Italy: Will Public Controversies Ever Stop? *Journal of ECT*. 32: 207-211. doi: 10.1097/YCT.0000000000000301
Como P; FDA (2011). Research Findings on Memory and Cognitive Impairment in ECT. Summary presentation to FDA, Jan 27, 2011. Accessed April 26th 2017, available at: https://psychcentral.com/lib/research-findings-on-memory-and-cognitive-impairment-in-ect/
Davis N, Duncan P (2017). ECT on the rise again in England. *The Guardian* 17.04.17. Accessed April 28th 2017: https://www.theguardian.com/society/2017/apr/17/electroconvulsive-therapy-on-rise-england-ect-nhs
Donahue AB (2000) Electroconvulsive therapy and memory loss: a personal journey. *Journal of ECT* **16**: 133-43. Available at: http://retina.anatomy.upenn.edu/pdfiles/5524.pdf
Eranti SV, McLoughlin DM (2003). Editorial: Electroconvulsive therapy — state of the art. *British Journal of Psychiatry* 182 :8-9. DOI: 10.1192/bjp.182.1.8
Janis IL, Astrachan M (1951). The effects of electroconvulsive treatments on memory efficiency. *Journal of Abnormal and Social Psycholofy*. **46**:501-510.
Kellner CH et al. (2006). Continuation electroconvulsive therapy vs pharmacotherapy for relapse prevention in major depression. A multisite study from the Consortium for Research in Electroconvulsive Therapy (CORE). *Archives of General Psychiatry*. **63**:1337-44.
Kolar D (2017). Current status of electroconvulsive therapy for mood disorders: a clinical review. *Evidence-Based Mental Health*. doi:10.1136/eb-2016-102498
Leiknes KA, von Schweder LJ, Hoie B (2012). Contemporary use and practice of electroconvulsive therapy worldwide. *Brain and Behavior*. **2**(3): 283–344. doi: 10.1002/brb3.37
McLaren N (1995). Shrinking the Kimberley: Isolated psychiatry in Australia. *Australian and New Zealand Journal of Psychiatry*; **29**:199-206.
McLaren N (2013). Psychiatry as Ideology. *Ethical Human Psychology and Psychiatry* **15**: 7-18.
McPhee I (2009). When doctors get sick. Radius *(Sydney University), Autumn 2009: 10-13. At: http://sydney.edu.au/medicine/news/pubs/radiuscontents/2009/March/22_1_coverstory.pdf*
*MacQueen G et al (2007). The long-term impact of treatment with electroconvulsive therapy on discrete memory systems in patients with bipolar disorder. Journal of Psychiatry and Neuroscience. **32** (4): 241–249.*
O'Brien N (2011). Electric shock therapy on the rise for young. *Sydney Morning Herald*, June 26 2011. Available at: http://www.smh.com.au/lifestyle/diet-and-fitness/electric-shock-therapy-on-the-rise-for-young-20110625-1gklc.html
Quadrio C (2001). *Women Working and Training in Australian Psychiatry*. Glebe, NSW: Bookhouse.
RANZCP Position Statement on ECT; No. 74, issued March 2014. Available at ranzcp.org.au.
RANZCP Submission to US FDA: *Reclassification of ECT Devices.* May, 2011. Available at ranzcp.org.au. Accessed Sept. 8th 2017.
RCPsych (undated). *Information about ECT* (patient pamphlet). Available at:

http://www.rcpsych.ac.uk/healthadvice/treatmentswellbeing/ect.aspx. Accessed Sept. 8th 2017.
Read J, Arnold C (2017). Is Electroconvulsive Therapy for Depression More Effective Than Placebo? A Systematic Review of Studies Since 2009. *Ethical Human Psychology and Psychiatry* **19**: 5-23.
Read J, Bentall R (2010). The effectiveness of electroconvulsive therapy: A literature review. *Epidemiologia e Psichiatria Sociale,* **19**: 333-347 doi:10.1017/S1121189X00000671
Rose D et al (2003). *Patients' perspectives on electroconvulsive therapy: systematic review. British Medical Journal **326**:1363 doi: https://doi.org/10.1136/bmj.326.7403.1363*
Ryle G (1949). *The Concept of Mind*. Chicago: University Press.
Sackeim HA, et al. (2001). Continuation pharmacotherapy in the prevention of relapse following electroconvulsive therapy: a randomized controlled trial. *Journal of the American Medical Association*. 285(10):1299-307.
Sackeim HA et al (2007). The Cognitive Effects of Electroconvulsive Therapy in Community Settings. *Neuropsychopharmacology*. **32**: 244–254. doi:10.1038/sj.npp.1301180.

Appendix B:

NOTES ON STATE OF MHS IPSWICH-WEST MORETON.

Qld MHS spends approximately $1.1billion per year on about 85,000 patients, or about $13,000 per patient per annum. The range of expenditure is enormous, from as little as $50.00 for some patients to perhaps $500,000 for others.

1. Administrative demands drive the entire service, on two levels, the Mental Health Act (MHA) and the public service.

(a) MHA is almost exclusively custodial/judicial/administrative in nature. ITOs are used excessively and for far longer than is clinically necessary. Forensic orders are punitive in nature, much stricter than probation orders and are normally prolonged far beyond any reasonable clinical indication.

(b) Mental Health Review Tribunal (MHRT) is almost exclusively a branch of the custodial state. At a cost of c. $10mln a year, it adds nothing to the management of the patients nor to their or the community's safety. Clinical reports and submissions are formulated on the basis of "what the MHRT will accept," not on what the patient needs. Medical staff not infrequently spend more time writing reports for MHRT hearings than they do seeing the patient.

(c) The Department is a bizarre combination of an excessively centralised, hierarchical bureaucracy and a fragmented regional service. Directly contravening modern management principles, there are too many layers of bureaucracy which remove responsibility for management from clinical staff to distant officials with no knowledge of the cases. At The Park, there is a committee to decide which patients will get leave, and another committee to decide which applications will be put to the first committee. In Ipswich, a team of seven clinicians has a full-time administrator on about $75,000 per annum but, in real terms, the administrator does nothing.

(d) Staff spend the majority of their time on administrative tasks which are designed to minimise administrative embarrassment but which add nothing to, and generally detract from, patient management. Administrative errors (eg patient returns late from leave, patient uses alcohol etc) are seen as vastly more serious than clinical errors (eg wrong diagnosis, failure to take a proper history, failure to change medication, inappropriate use of ECT, etc).

(e) Meetings consume time with no thought for their real value. In secure units, 8-12 staff routinely spend 4-5hrs per week discussing the same dozen patients, week after week all year, but nothing changes. Clinical staff in the out-patient units spend considerable time driving patients to and from appointments. The outdated computer system reduces productivity by its endless inefficiency: staff normally spend more time hunched over computers than they do talking to patients. Nobody ever checks on what they are doing.

(f) The Department's regional structure means ITOs are assigned to a region rather than to the state as a whole, making transfers very difficult. Even within districts, transferring patients is a major administrative feat. Transferring a patient from the medium secure unit at The Park to the high secure unit took eight days and numerous meetings of up to half a dozen people – for a distance of 150m. Swapping a patient at the medium secure unit at The Park for a patient in Robina Hospital took ten days and consumed something like 50hrs of staff time, not counting staff time for the actual transfers. This was for an agreed swap where both patients were keen to move and staff had no objections. A patient in Caboolture Hospital had been in the secure area for a year, during which time he had punched some fifty people, including staff, other patients and visitors. Eight staff had taken sick leave for injuries. Following transfer and a reduction in medication, his behaviour improved dramatically and there were no further assault in the next eight weeks. Key staff at the medium secure unit had known of the requests from the staff at Caboolture Hospital, who were at their wits end, but had resisted the transfer as the patient had been living in that region when he was admitted. In fact, he came from Ipswich and was well-known to West Moreton region but had been visiting relatives in Caboolture at the time he was admitted. A request to transfer a patient that, anywhere else in the country, would take a four minute phone call takes at the very least a visit to the outlying hospital by a group of staff to "assess" the patient, as though staff in the outlying centre were not capable of doing such a thing themselves. This may have something to do with the fact that once the patient is admitted to the secure units, he will be almost impossible to move.

(h) The medical records are a topic in their own right. As a source of knowledge of the case, they are largely worthless. My review of approximately 200 files did not reveal one in which there was a useful case history.

2. Clinical needs are secondary to custodial/administrative needs.

(a) The overwhelming impression is the total absence of what may be called clinical leadership. The biggest problem seems to be the widespread notion that psychiatry is easy, just a matter of asking a few questions then prescribing drugs under compulsion or referring the patient elsewhere. Because of the legal/custodial nature of the Department, senior staff spend the great bulk of their time administratively, with very little time allocated to clinical duties. Clinical duties devolve to the lowest level of the hierarchy but junior staff are frequently bewildered and resort either to a punitive/contemptuous attitude toward patients or rely on drugs to solve everything.

(b) One of the most striking organisational features of West Moreton MHS is the fractured structure of the service whose structure is driven wholly by administrative needs, not for patient convenience. Patients entering the service are seen by a variety of different staff then handed over to another team, and then to another, with the whole process starting again at each handover. Continuity of care almost does not exist, something patients hate and constantly complain about. Incoming patients are bounced around while staff have meetings and discussions, so that patients may wait 4-6wks before being seen, during which time the Department spends up to $1000 on administrative needs. Patients arriving for their first full out-patient assessment may already have 25-30 pages of notes, all of it useless (text messages and even failed telephone calls are logged word for word). Because of the long and unnecessary delays, general practitioners (GPs) in the area are in the habit of sending patients to the Emergency Dept. of Ipswich Hospital which clogs the system and further reduces efficiency. A new patient living just 200m from Goodna MHS centre must go 16km to Ipswich Plaza to be seen.

(c) Medical staff are largely sidelined, not least by their own despair, and are very largely de-skilled. Case histories do not follow a standard procedure and are, in the main, breathtakingly incompetent, but nobody ever checks them. Erroneous material that enters the record is never checked or corrected but forms part of the mythology of the patient. Necessarily, diagnoses are frequently misconstrued if not frankly and alarmingly wrong, so treatment is bound to fail. However, where treatment is unsuccessful, nobody ever questions the diagnosis. Instead, the patient is blamed and is given more medication. Patients who get angry over the way they are treated are punished.

The combination of an insecure and demoralised medical staff lacking basic skills, in an administrative setting that is seen as punitive, if not hostile, leads to excessive admissions to hospital, excessive use of involuntary treatment orders, and excessive use of medication and ECT to solve what are very often problems of living.

(d) Nursing staff in the inpatient units are the most despairing and demoralised I have seen in forty years in psychiatry. Nursing staff in the outpatient units have a level of authority greatly exceeding their capabilities. A new patient can be seen in the ED by a nurse, referred to the Acute Care Team (ACT) where his case is reviewed without medical supervision and major decisions made, such as not accepting the case into the service. Quite often, the morning meetings in Ipswich Plaza ACT have no medical staff present but, when present, they usually have very little to say. Nursing staff are generally very resentful of intrusions into what they regard as their area ("case management").

(e) Among other staff, psychologists exist in a world of their own. In the main, they are resentful/overtly hostile toward anything they see as an attempt to intrude into their practice. Social workers and the increasingly rare occupational therapists are now generic mental health staff and are not easily distinguished from nursing staff.

(f) Staff live in fear of making administrative errors. This stultifies initiative and leads to the situation where staff will do nothing through preference as the consequences of not acting are less severe than of making a mistake.

3. Productivity. Nobody knows what this word means.

(a) Outpatient services are grossly inefficient:

Brief comparison of performance of Ipswich-West Moreton MHS, May 2014.

	Ipswich ACT	Ipswich CCT	Goodna CCT
Psychiatrists	1.5FTE	0.75FTE	0.6FTE
Other clinicians	10	10	12
F/T manager	1	1	1
Clerical	3	3	2
Open service episodes	126	247	202
Closed service episodes	57	15	12
Consumer participated episodes of service	399	521	656

Normal booked occasion of service in MHS: 30mins.

Using figures supplied in MHS Discussion Document (Cost of Developing S238 Reports), the approximate cost per occasion of service (defined as direct, face-to-face contact with the nominated patient for purposes of assessment, treatment or review) **$275.00**

Item 302 (15-30mins) Medicare bulk-billed rebate for specialist psychiatrist: **$73.50.**

The majority of staff in the out-patient units spend the majority of their time either sitting at computers or engaged in essentially idle talk. The morning clinical meetings are astounding in that the bulk of staff present are not involved in the cases but sit and listen without contributing in any way to the management.

Six or eight people sit around while one person reads some notes then some sort of decision is reached. Assessments are usually grossly inadequate and staff are mostly making decisions for which they are not qualified. The types of decisions made at these meetings would take a suitably experienced psychiatrist about 15 seconds.

(b) In-patient services consist of the general unit at Ipswich Hospital and the secure units at The Park Centre, Wacol. Of the mental health unit at IGH, the overwhelming impression, beside the forbidding setting, is that the great bulk of nursing staff spend the great bulk of their time in the nurses' station, attending to a myriad of administrative matters, mostly trivial. Generally, they speak to patients through a small sliding window with no pretence of privacy. The unit is locked at all times, a breach of the national mental health policy, and patients are not allowed to smoke on hospital premises. This means that periodically, groups of patients are let out to smoke. They mill around on the footpath outside, with no supervision, often sitting on the curb with their feet barely a metre from passing traffic.

(c) Patients in the **medium secure unit** at The Park spend their days pacing or watching TV, or demanding to get out for a cigarette or to see a doctor. Some basic gym equipment is largely unused. Arguments are common. I estimated it cost $1200 a day to keep a patient there although nursing staff said it was more like $1500. However, the most prominent feature is the inordinate lengths of stay for patients. Patients on forensic orders are simply parked there with almost no effort to discharge them. Indeed, any move to discharge a patient results in a flurry of anxiety as staff find reasons as to why he cannot possibly be allowed to go:

(i) 31yo man on a forensic order has been there four years. His offence was trivial and drug-related. Throughout his fourteen year history, all his mental symptoms have been drug-related. He is a very mild-mannered person who is not and never has been a danger, although he has been a nuisance to his family because of drug use. There is nothing in the eleven volumes of his file that would constitute an adequate history, no rehabilitation program and no discharge plan. He is allowed to come and go from the unit as he pleases. If he were not on a forensic order, he would not be in hospital but he would never be in a secure unit anywhere else in the country. His admission has achieved nothing and nothing further is planned. Total cost so far: somewhere from $1,750,000 – 2,200,000.

(ii) 56yo man has a history of chronic psychosis and brain damage. He has been in and out of hospitals for decades and has been in the medium secure unit for perhaps 8yrs. His behaviour is difficult, uncooperative and occasionally threatening although he is too unsteady on his feet to do much more than swear and bluster. His monthly medication bill is in excess of $300. He has been assessed for admission by a number of nursing homes but is considered too difficult for even a dementia unit. By changing his medication to standard treatment for irritable elderly people with brain damage, at a cost of about $10.00 per month, his behaviour improves dramatically and he becomes cheerful and cooperative. The process of discharging him to a suitable unit starts again but is handicapped by his largely undeserved reputation for being unmanageable. Total cost of admission to date – in excess of $4,000,000.

(iii)46yo man has been in hospitals for many years. He is not considered a danger to anybody. Seven days a week, he leaves the secure unit at 8.00am and returns at 6.00pm and has done this as long as anybody can remember. He takes medication but gets no other form of treatment or rehabilitation whatsoever. He simply sleeps in the unit, at a cost of $1200-1500 per day.

4 Rehabilitation: Apart from a small kitchen, the medium secure unit at The Park has no occupational therapy facilities at all. In 1969, Graylands Hospital, the main MHS hospital in Perth, had the following occupational and rehabilitation facilities:

(i) A new, free-standing building housing an art therapy unit called Creative Expression Unit which was managed by an artist. Facilities included a large studio for painting, a pottery room, woodwork area and an outside area where welding was taught.

(ii) A new suburban house, run by the CWA, which was used to teach (mostly male) patients how to cook and look after themselves in a flat.

(iii) An opportunity shop, managed by Friends of Graylands but staffed by patients, which sold good quality second hand clothing and shoes, books, electrical equipment such as radios etc, games, drinks and snacks and so on.

(iv) A garden and nursery area.

(v) A large, purpose built industrial rehabilitation unit consisting of nine separate sections, such as mechanical shop (supervised by a mechanic), panel beating shop, a unit that manufactured hospital glassware, clothing store, sewing room with twenty industrial machines making hospital curtains etc, a large canteen, and others. At least 300 people attended this unit each day.

Forty-five years later, The Park has nothing even though patients are there for long to very long periods of time.

5 Accountability

Because patients are handed from one section to another and constantly change staff, there is no continuity of care and hence no accountability. In Perth years ago, detaining a person under the Mental Health Act took about two minutes. The forms were signed by one medical practitioner who was fully responsible for the order. If the practitioner didn't make proper enquiries or made any mistakes, he was fully liable. Here, nobody is responsible for anything but it takes forever. Responsibility is diffused through a labyrinthine quasi-judicial system and patients very often don't have any idea who signed the orders or why, or when they will expire. This causes intense antipathy but “the system” is entirely unresponsive. The justice examination orders would be comical if they did not have such a devastating effect on people's lives.

Appendix C:

Submission to HREOC Enquiry into implementation of Optional Protocol to the Convention Against Torture (OPCAT). Also available at: http://www.humanrights.gov.au/submissions-opcat-australia-consultation-2017

July 16th 2017

HUMAN RIGHTS COMMISSION ENQUIRY INTO IMPLEMENTATION OF OPCAT.

Submission pursuant to HRC Consultation Paper (May 2017)

1. Introduction;

My submission concerns my specialty, psychiatry. I submit that I am suitably qualified and experienced to speak as an expert in the field of general adult psychiatry, with particular emphasis on post-traumatic states, isolated psychiatry, and in the application of the philosophy of science to psychiatry. By way of background, I graduated in medicine in 1971 and in psychiatry in 1977. Since then, I have worked in prisons, in veterans' hospitals, in security wards in general hospitals, in private practice and in community practice; in cities, suburbs and in Western Australia's Kimberley region, one of the most isolated parts of the Anglophone world. I have extensive experience in military and forensic psychiatry, isolated and Aboriginal psychiatry, and in the mental health of immigrants, refugees and injured workers. Throughout this time, I have published extensively, including five books, mainly theoretical works on the application of the philosophy of science to psychiatry.

Today, in Brisbane, I operate two bulk-billing practices, one in a middle class area with a surprisingly high rate of struggling younger families, the other in a Housing Commission suburb with many unemployed people, pensioners, immigrants and refugees. My offices are situated in busy shop-front general practices, which provide most of my referrals. Thus, I see the sorts of patients who would normally have to attend public services. Some of them have previously attended public services and are keen to change but are unable to as they cannot afford private rates for private psychiatrists (200-300% higher than Medicare rebates).

In short, I have always worked at the tough end of psychiatry, including six years as the world's most isolated psychiatrist [1; references begin on P12]. In four decades, I have had one complaint against me and two notifications of disputed decisions, all of which were fully investigated and dismissed.

A brief CV and publications list are appended.

2. In respect of the definition in Item 52 of the Consultation Paper, public and some private psychiatric hospitals in Australia qualify as places where people are deprived of their liberty. All mental health acts (MHA) in this country authorise...

> ...detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order of any judicial, administrative or other authority.

My intention in this submission is to show that standard methods of apprehension, detention and management in psychiatric hospitals in this country regularly breaches the prohibitions against "cruel, inhuman and degrading treatment."

3. In psychiatry, the following beliefs are accepted as axioms:

a) mental disorder constitutes a danger to the individual and to society;
b) psychiatric patients "lack insight" and cannot be trusted to decide for themselves;
c) everything psychiatry does is necessarily for the good of the patients;
d) enforced treatment is always better than no treatment; and
e) the end justifies the means.

Because of the belief that they are incapable of making rational decisions, under state MHAs, mentally-disturbed people are are deprived of their right to decide whether they want treatment or not. As a result, they can be forcibly detained, deprived of their liberty and forcibly drugged and/or given electroconvulsive therapy (ECT), with or without restraint and seclusion.

Detention and deprivation of liberty can only be justified if it can be shown that the risks of doing nothing will, on balance, greatly outweigh the risks of enforcing treatment and the human and social costs of deprivation of liberty. I am not aware if this has ever been done in the history of psychiatry. These beliefs are simply accepted as given by the entirety of the psychiatric establishment, the rest of the mental health industry, and the political establishment. Questioning them inevitably provokes a hostile response from psychiatrists. In the rest of my submission, I will show that enforced treatment is often unjustified and qualifies as "torture."

4. In Qld, it is even the case that all voluntary wards in public psychiatric hospitals are locked. Voluntary patients may not leave the premises without the express permission of the staff, who open the doors at their convenience. Patients very quickly learn not to be demanding. Any voluntary patient who insists on leaving runs the very real risk of being detained under the Act, forcibly restrained, injected with powerful drugs and conveyed by any means necessary to be locked incommunicado in a 'seclusion' room. Very often, patients are stripped and left naked on the pretext of preventing suicide attempts. This is done on the undefined notion of "duty of care."

5. There is a quasi-judicial process involved in detaining a psychiatric patient but, as the recent debacle over the Mental Health Tribunal (MHRT) in Qld showed, it is hardly fool-proof. More to the point, there is an inherent bias built into the MHRT, in that psychiatrists sitting on the panels are trained in the same system as the hospital psychiatrists. They and the hospital psychiatrists are all firmly convinced that all mental disorder is biological; that patients cannot know their own minds; that enforced treatment is always better than no treatment and that the hospital psychiatrists, whom they mostly know, and the hospitals, where most of them trained, are never wrong [2]. The chances of a psychiatrist appointed to sit on the MHRT taking an independent or neutral position are vanishingly small.
The direct costs of MHRT in Qld are of the order $11million a year. In addition, there are substantial indirect costs which would approximately double this sum. 97% of applications by hospitals are approved exactly as requested. Of the remainder, a few are dismissed while the rest are granted with strengthened conditions. Only 4% of patients have legal representation in these hearings, which can lead to practically all their human rights being extinguished in the very long term.
The outcome of applications to MHRT is so predictable that a significant proportion of patients don't even bother attending. After the event, many or even most have no idea what the conditions are. They simply believe, and with very good reason, that, under threat of forcible readmission to hospital, they must do precisely as they are told by any and all MHS staff with no possibility of refusal.

Before mental health became "legalised," it was the case that one medical practitioner signed the detention forms and was fully liable for any mistakes or omissions. Since then, detaining a patient necessitates long delays and, above all, ensures the dilution of responsibility among many people so that ultimately, nobody is responsible. While large numbers of people are now profiting from this bureaucratic intrusion, there is no evidence whatsoever to show that it has benefited sufferers.

The insertion of semi-judicial panels into the decision-making process has not led to any measurable improvement in the lives of the mentally-disturbed. These hearings are intimidating to the mentally-disturbed and their relatives, and generally make things far more difficult for people who wish to retain a degree of self-control over their lives, to the point where many people simply give up.

6. While patients can obtain second opinions from a psychiatrist of their choice, very few actually know this. Far fewer would know how to do it and practically no public patients would be able to afford it. A typical medicolegal report in Qld costs of the order $2000-3000 or more, plus travelling time. The new MHS in Qld allows for the hospital to pay for reports but this has not been tested and the hospital itself probably chooses the psychiatrist [3]. My experience is that when a dissenting second opinion is presented to the MHRT, the hospital is likely to request an adjournment while it gets more, and more, opinions. Inevitably, these are from psychiatrists who will support the hospital's request. Equally inevitably, the presiding member of the tribunal, a lawyer, will feel obliged to "go with the weight of opinion," because that is how lawyers think. When the hospital has unlimited time and funds to gain the opinions it wants, it is all but impossible for a patient's wishes to prevail. While most state mental health acts state that the patient's and his relatives' wishes must be taken into account, I have never seen this happen. Relatives who object too strenuously or effectively are likely to be barred from the process and from the hospital itself.

7. It is the case, and I can produce patients whose records confirm, that people can be taken from their homes by police and mental health staff, entirely without warning, to a psychiatric hospital where they will be detained and forcibly treated with psychiatric drugs. They are unable to see the warrants; cannot know who gave the evidence; and therefore cannot cross-examine the complainant; and will not be permitted to see their records later. At present, under Qld law, a psychiatric patient in a public hospital who asks to see his record will be compelled to wait 25 days. If he is given permission, the files are likely to be redacted, and/or in such a jumble that an ordinary patient would not know where to start. If the files are needed for a hearing, there is little prospect of gaining an adjournment on the basis of inadequate information.

8. As far as government and mainstream psychiatric services in this country are concerned, all mental disorder is necessarily a form of physical brain disease, for which physical forms of treatment are de riguer. A patient detained under MHA will be compelled to take powerful psychiatric drugs regardless of his or her wishes. Public services are not equipped to assess people for psychologically-determined mental disorders but, in any event, they don't believe there is such a thing. A very few patients will be offered the simplified form of moral treatment known as Cognitive-Behavioural Treatment (CBT) but the overwhelming majority will simply be drugged with as many as seven different psychiatric drugs. There is no evidence that polypharmacy does anything but cause severe and often dangerous side effects. For the record, there is ample evidence that psychiatric drugs are toxic and have major, long-term side effects [5]. Psychiatric drugs meet all standard definitions of "highly addictive substances." Drug manufacturers have actively suppressed evidence of serious side effects in their products. Australian adults who take psychiatric drugs in the long term die, on average, 19yrs younger than their undrugged peers. In the US, where larger doses and polypharmacy are the norm, that figure is 25yrs. That is, in order to "save an unfortunate's life," the treatment is highly likely to shorten his life dramatically.

In women, the risk of suicide in untreated depression is about one in 700 cases while in men, it is about one in 400 cases. The mere fact of being depressed is taken as sufficient grounds to detain someone and treat him against his will but the treatment is likely to shorten his life. See Note 1, P6.

In particular, a person who refuses electroconvulsive treatment (ECT, 'shock treatment') is highly likely to be detained and given it on the basis of "unreasonably refusing treatment." There is no definition or standard of "reasonably refusing treatment." The efficacy of ECT is outlined in Note 2, P6, while its risks are given in Note 3, P7.

For the record, I have practiced public psychiatry for just on four decades, in a wide variety of settings. In that time I have personally assessed and treated well in excess of 12,000 unselected, consecutive patients. Not one of them has been given ECT. There has been one suicide among my patients in about the past ten years. (As of Sept. 3, 2017, that figure is four deaths in twenty-one years).

9. The prevailing narrative is that psychiatric drugs are benign, effective, safe, non-addictive and have minimal side effects. The accepted principle is that, for all conditions and in all people at all times, it is indubitably safer to prescribe psychiatric drugs than to withhold them. This is all completely false and is the product, not of dispassionate science, but of an overwhelmingly successful marketing exercise. For example, there are now many people in the community who have been taking antidepressants for 25 or more years, yet all the original research studies on which these drugs were approved studied them for periods of weeks to a few months at the most. In the English division of the British NHS between 2000-15, the number of antidepressant prescriptions doubled from from 30 to 60million. Community surveys show no change in the incidence of depression, so that means many people taking them are not depressed. This fits the notion that the drugs are addictive and that cessation is fraught.

As it happens, there is a large and rapidly-growing data base to show that psychiatric drugs are non-specific psychoactive chemicals (i.e. they are not 'antipsychotic,' 'antidepressant' or 'mood stabilisers' in any reliable sense of the expressions). Worse, in the longer term, they are little better than placebo (bear in mind that practically all psychiatric drugs are given in the very long-term). In addition to being highly addictive, they have a vast range of highly unpleasant and often dangerous side effects; they are far more expensive than alternative treatments; and they add to but do not reduce the burden of illness in the community, not least by shortening the life span of those who are compelled to consume them. Above all, patients have no choice whatsoever in their management. If they decline to take tablets, their drugs will be administered by monthly injections of depot preparations. These guarantee high levels of side effects. It is inhumane to force people to take drugs knowing full well, for example, that the drugs severely inhibit sexual function. Similarly, practically all psychiatric drugs cause massive weight gain, of 30, 50 or even 80%. For a sensitive person, this is an exquisite form of torture.

As the consumption of psychiatric drugs rises in this country, the numbers of people on Disability Support Pensions for mental disorder rises in lock-step.

10. One particular side effect of psychiatric drugs which is seriously underestimated, and almost certainly deliberately so, is known as akathisia (Greek for "I can't sit down"). It consists of a debilitating, terrifying and/or infuriating sense of inner restlessness which compels the patient to keep moving.

This side effect is very common: about half of all antidepressants induce it, and practically all antipsychotics. It is particularly a problem when the drug is started or when the dose is changed, either up or down, but there is also a form known as 'tardive akathisia,' which comes on months or even years after the drug is stopped. Apart from more drugs, there is no treatment for akathisia. Patients routinely describe akathisia as "torture."

For descriptions of akathisia as "torture," see Note 4.

It is now widely believed that akathisia is the causative mechanism of the sudden, unexpected suicides and/or homicides which are known to cluster at times of increase or reduction of psychotropic drugs. For example, all major mass murderers in the US in the past 25yrs have been taking psychiatric drugs at the time of their offence. In all known cases of criminal homicide among US troops in the current wars, the offenders were consuming psychiatric drugs at the time.

As mentioned, patients who have developed akathisia describe it as "torture." After years of observation, I believe this to be a valid description and not an exaggeration. In the former USSR, these drugs were used on dissidents who had been incarcerated in mental hospitals on the spurious grounds of having a condition called "sluggish schizophrenia." The symptoms of this condition were entirely restricted to opposing the Soviet Government. The reason psychiatric drugs were used is because they disabled and silenced dissidents who, after a few months, were mostly unwilling to risk further punishment.

In the mid-1970s, this practice was strongly criticised by the World Psychiatric Association and the World Health Organisation. The Soviet government eventually stopped it although it is still used in China. At about the same time, prison hospitals in California were using depot antipsychotic drugs, especially fluphenazine, which is a powerful cause of akathisia, to "treat" homosexuality among prisoners. Survivors described the effects as "torture" (neither the WPA nor WHO complained about this practice).

It is the case that, given the choice, most patients would choose a drug that minimised these side effects but, under state MHAs, they have no choice. Mental health staff almost invariably believe that patients who object about the drugs are either obstreperous or more seriously disturbed than previously suspected. Either way, the patients are highly likely, if not certain, to get more of the drugs that they describe as "torture."

11. Orthodox psychiatry will argue that, by detaining and forcibly administering drugs to unwilling patients, they are performing a life-saving procedure as patients are inevitably worse off by not being so treated. They will argue that their drugs are safe, reliable, predictable, non-addictive, non-toxic, cheaper than the alternatives, pleasant and, critically, *effective*. None of this is true. It is a narrative carefully constructed upon the most fastidiously cherry-picked evidence, one that serves the purposes of psychiatrists, mental health bureaucracies and drug manufacturers far better than it serves the mentally-disturbed. Even when very much safer, cheaper, more effective, more humane and less terrifying alternatives are available, psychiatry insists on using methods and procedures that patients themselves regard as "imprisonment" and "torture."

12. Conclusion:

To return to the axioms given above:

a) mental disorder constitutes a danger to the individual and to society;
b) psychiatric patients "lack insight" and cannot be trusted to decide for themselves;
c) everything psychiatry does is necessarily for the good of the patients;
d) enforced treatment is always better than no treatment; and
e) the end justifies the means.

I submit that the risks to the individual and to the community of "untreated" mental disorder are seriously overstated. It is the case that the great majority of violence is not committed by mentally-disturbed people, and the great majority of mentally-disturbed people are not violent. Newspapers typically "beat up" offences committed by the mentally-disturbed.

It is a matter of historical fact that psychiatry has, in the past, committed the most serious abuses of mentally disturbed people [4]. There is ample reason to believe that forms of treatment offered by modern psychiatry are much more dangerous than is supposed, and that the public perception has been carefully manipulated by drug manufacturers and their well-paid supporters in academic psychiatry [5, 6].

It is false to claim that enforced treatment is always better than no treatment. There is no evidence in the psychiatric literature to support this, and plenty to show it is empirically false. The various 'epidemics' of psychiatric disorders are growing at almost exactly the same rate as the consumption of drugs to treat them.

Whether the end justifies the means is a matter for the community to decide. Having seen many, many lives ruined by compulsory admission to mental hospitals and enforced treatment which, in other contexts, is accepted as amounting to torture, I am not convinced that, in the field of mental disorder, the fancied end justifies the brutal means.

Note 1: Risks of suicide:

We are told that one million Australian adults will suffer depression each year, including about 700,000 women. Prescription rates for antidepressants doubled between 2000-15, yet the suicide rate rose to its highest for many years, 12.6 per 100,000 population. At 19.3 per 100,000, male rates are generally three times those of females yet, as Quadrio [7] showed, women in private hospitals get the lion's share of ECT.

All suicide statistics indicate that depressed women are probably not going to commit suicide (at most one in 700 cases each year), and that most men who commit suicide haven't seen a psychiatrist, so this represents a very serious misallocation of resources. If ECT is so remarkably effective in "relieving severe depression" as its advocates claim, should we not do more to reach out to depressed men and offer them admission and ECT? That wouldn't work as most men who commit suicide don't have private health insurance. Thus, we end up giving ECT to the people who can afford it, who won't object too strenuously and who don't actually need it, not to the people who allegedly need it but can't afford it and are likely to object.

Note 2: Is ECT effective?

A review by Antunes et al [8] found that between 50-80% of depressed people responded to ECT but relapse rates within six months are of the order 40-60%; within 12 months up to 85% relapse; while recurrence rates within six years (generally from small studies) are of the order 45-60%:

> Studies show that the relapse rate after six to 12 months of ECT is approximately 50% in patients who underwent ECT due to refractory depression.... Sackeim et al. demonstrated that 64% of the patients who received adequate pre-ECT antidepressant treatment relapsed in the first post-ECT year.

They quoted the irrepressible Charles Kellner, of Mt Sinai Hospital in New York, who found that maintenance ECT (one, two or four per month, indefinitely) actually gave worse results (37% relapse rate in six months) than people who received conventional treatment (32%).

These outcomes are hardly convincing of the claim that ECT is effective. A new treatment in physical medicine or surgery that yielded these figures would not be approved. However, that's not the point. If ECT were the only form of management available, these doleful figures could perhaps be tolerated, but it isn't. My figures show that *not* using ECT gives at least the same outcome, if not better, at a tiny fraction of the cost, with no risk of side-effects and none of the inconvenience.

Proponents of ECT routinely exaggerate the risks of "untreated" depression. According to a group called Mental Health America, which is heavily sponsored by the drug and private psychiatry industries, 6.7% of American adults (16million) will suffer depression each year. Manifestly, all those people can't go to hospital and most of them get over it. There were 43,000 suicides in the US in 2014, 13.26 per 100,000 or 0.013% of the population. Suicide is a significant cause of death but only 0.27% of all cases of depression end that way (about one in four hundred cases). Bear in mind that not all suicides are depressed; that the US figures show male suicide rates are 350% of female, while "women experience depression at approximately twice the rate of men" (MHA site), and it becomes clear that the claim that ECT is necessary to prevent suicide is empirically false:

> ...adjusted for age, the annual U.S. suicide rate increased 24% over the 15 previous years (1999 to 2014), from 10.5 to 13.0 suicides per 100,000 people, the highest rate recorded in 28 years... (Wikipedia, Suicide in the US).

In that time, the consumption of antidepressants in the US nearly doubled; i.e. as the drugs go up, so too does the suicide rate. The claim that aggressive and widespread prescription of antidepressant treatment is both necessary for treating depression and effective in preventing suicide is baseless (These figures need to be accepted with some degree of caution. One report says 13% of the US adult population, about 32million people, take antidepressants, meaning there are twice as many people taking the drugs as there are reported cases of depression. If, however, the drugs are addictive, this is not implausible).

Note 3: The Risks of ECT.

The literature is crystal clear: ECT causes significant memory and other cognitive impairments, and these adverse reactions effects are wholly due to the physical effects induced by the treatment itself (i.e. the memory impairment is not psychological in nature). Let there be no mistake that from the outset, mild, diffuse and non-specific brain damage was the precise reason convulsive treatments were developed.

In the late 1920s, the Hungarian neuropathologist, Ladislav Joseph Meduna, found that the brains of people who died of epilepsy showed a surfeit of gliosis, the marker of neuronal death. At the same time, he found that people dying with schizophrenia showed much lower counts of gliosis. It had long been known that epilepsy and schizophrenia were in some way inimical, that people with schizophrenia who had fits showed an improvement in their psychotic state. He therefore reasoned that inducing seizures with the direct intention of causing neuronal death should be clinically beneficial. He experimented with camphor, leading to the IV drug, pentylenetetrazol (Metrazol, 1934), which reliably induced seizures almost immediately (its history is much worse than that, see references).

A few years later, after watching pigs being stunned in a slaughterhouse, the Italian neurolopathologist, Ugo Cerletti, and his associate, the psychiatrist Lucio Bini, developed electroconvulsive machines which quickly took over as quicker, safer and less unpleasant. Initially, ECT was used mainly in schizophrenia but by 1941, it was being used more and more in depression. There was, however, never the slightest doubt that its clinical effect was mediated by physical damage to the brain. In the era when actual physical destruction of the brain by "lobotomy" was widely used and praised as modern and merciful, this was seen as non-contentious. It was only when the idea of deliberately causing brain damage on unwilling patients fell into serious disrepute that psychiatrists started to claim that ECT didn't cause brain damage.

The literature, however, belies this. In 2001, the APA committee on ECT [9] left no room for doubt:

> In some patients the recovery from retrograde amnesia will be incomplete, and evidence has shown that ECT can result in persistent or permanent memory loss.

A few years later, Rose and colleagues [10] were equally blunt:

> The current statement for patients from the Royal College of Psychiatrists, that over 80% of patients are satisfied with electroconvulsive therapy and that memory loss is not clinically important, is unfounded.

Similarly, in a well-planned, multi-centre study of 347 patients receiving ECT, Sackeim et al [11] concluded:

> ...this study provides the first evidence in a large, prospective sample that adverse cognitive effects can persist for an extended period, and that they characterize routine treatment with ECT in community settings.

MacQueen et al [12] studied post-ECT patients and found:

> Compared with healthy subjects, patients had verbal learning and memory deficits. Subjects who had received remote ECT had further impairment on a variety of learning and memory tests when compared with patients with no past ECT. This degree of impairment could not be accounted for by illness state at the time of assessment or by differential past illness burden between patient groups.

After an extensive review, Read and Bentall [13] concluded:

> Given the strong evidence of persistent and, for some, permanent brain dysfunction, primarily evidenced in the form of retrograde and anterograde amnesia, and the evidence of a slight but significant increased risk of death, the cost-benefit analysis for ECT is so poor that its use cannot be scientifically justified.

6.6. More recently, the Royal College of Psychiatrists [14] appears to have had second thoughts, as their current patient leaflet explains:

> Memory problems can be a longer-term side effect (of ECT). Surveys conducted by doctors and clinical staff usually find a low level of severe side-effects, maybe around 1 in 10.* Patient-led surveys have found much more, maybe in half of those having ECT....
>
> Some memory problems are probably present in everyone receiving ECT. ... some people do complain that their memory has been permanently affected, that their memories never come back. ...It is not clear how much of this is due to the ECT, and how much is due to the depressive illness or other factors.**
>
> Some people have complained of more distressing experiences, such as feeling that their personalities have changed, that they have lost skills or that they are no longer the person they were before ECT. They say that they have never got over the experience and feel permanently harmed. What seems to be generally agreed is that the more ECT someone is given, the more it is likely to affect their memory.... Between 30% and 50% of patients complained of difficulties with memory after ECT.

* A 10% rate of "severe" side effects is hardly "low level."

** This isn't clear, as they had already said the depression resolves with ECT; now they are saying persisting memory defects must be due to persisting depression, for which the treatment, presumably, is more ECT. In any event, since it isn't clear how much is due to ECT and how much to "other factors," and since alternative treatments are available, surely the answer would be to stop using ECT.

In a presentation to the US FDA enquiry on the reclassification of ECT machines, and speaking as a member of the FDA's research and assessment staff, Como [15] stated:

> ....self-reported memory loss tends to be more persistent than the deficits that can be measured on formal neuropsychological testing. However, for those patients who do experience memory or cognitive impairment, they consider this to be a considerable source of distress for themselves and their families.

Breggin [16] prepared a review for the same FDA enquiry, concluding:

> Electroconvulsive therapy (ECT) and the machines that deliver it have never been tested for safety and efficacy in order to receive approval from the FDA. The American Psychiatric Association and ECT advocates protested when the FDA took steps to classify the machines as posing “an unreasonable risk of illness or injury”, which would have required their testing before approval. Without requiring this testing, the FDA is now preparing to classify the treatment and the machines as safe... ECT is very harmful to the brain and mind... the FDA should demand the usual testing, starting with animals, that is required before psychiatric treatments and machines are approved for marketing and use.

His website, ectresources.org [17], includes a list of some 150 citations extending from 1942 to the present. This evidence leaves no doubt that, quite apart from unexpected catastrophes including anaesthetic deaths, brain damage follows ECT in a dose-related fashion.

In a more recent study, Kirov et al [18] found:

> Repeated courses of ECT do not lead to cumulative cognitive deficits.

This appears to be so completely at variance with patients' accounts and with majority opinion that it cannot be taken as settling the matter. It is an easy matter to find accounts which completely contradict this group's findings (e.g. Grant [19]: "ECT completely wipes out 30yrs of memory"). Note that Kirov's group did not cite the results of Sackeim's group's prospective study. This is very typical in the psychiatric literature: adverse results are simply ignored.

However, the most recent review available, by Kolar [20], contradicts Kirov's group's findings:

> Cognitive side effects of ECT are sometimes underestimated and may last much longer after completed treatment than it is usually expected. These cognitive impairments associated with ECT may cause significant functional difficulties and prevent patients returning to work.

Two things were quite clear in this review. Firstly, in view of their own figures, the expression "sometimes underestimated" is excessively cautious (they are actually routinely underestimated). Second, the reason cognitive side effects are "sometimes underestimated" is because the great majority of studies are inadequate to the task (i.e. substandard):

> Neuropsychological assessment should be an essential part of a good clinical practice in ECT services.... Cognitive assessment during ECT treatment is usually not comprehensive enough and is limited to bedside assessment. A more proactive approach to careful neuro-psychological assessment (is) essential.

A possible explanation of the "outlying" figures in Kirov et al [18] is that patient surveys invariably find much higher incidences of memory and cognitive dysfunctions than researchers do. This is addressed poignantly in a widely-cited, first-person account by Anne Donahue [21] and in another by Ian McPhee, a Sydney anaesthetist [22]. In a section entitled *The Disaster of ECT*, McPhee commented:

> The consequences (of ECT) were dire. Retrograde memory loss was profound. I was devastated and searched for answers where my treating doctors could give none.... I was left then to claw back a life only half remembered.

The author Ernest Hemingway shot himself a few days after a course of 20 ECT. Just before he died, he said bitterly:

> What these shock doctors don't know is about writers...and what they do to them... What is the sense of ruining my head and erasing my memory, which is my capital, and putting me out of business? It was a brilliant cure but we lost the patient.

In the past two years, I have managed a number of patients complaining of major memory loss after ECT. One, for example, a professional writer, had had only three episodes of ECT but has complained for the eighteen months since of memory effects. Another was taking anticonvulsants at the time of the ECT and initially did not develop seizures. He was therefore given much more powerful shocks, then bilateral ECT, so this may be a little unusual but it is still ECT.

This brief survey indicates that ECT can have severe and long-lasting, if not permanent, effects on memory and cognitive function, and that this damage is physical in nature. Anybody who claims that ECT has no significant side effects should try it himself.

When this information is so readily available, why do most psychiatrists not know this? The answer is that psychiatrists are not trained to think critically. As trainees, they are given approved reading lists and, as graduates, they simply follow the pattern of reading whatever reinforces their opinions. It is exceedingly rare for a mainstream psychiatrist to read outside his narrow interests.

Note 4: Akathisia.

This side effect consists of an intensely unpleasant sense of inner restlessness or itching agitation in the limbs, which drives people completely mad. This is how patients describe it:

> Akathesia for me was an anxiety so intense and deep seated I thought I was losing my mind. I also had an inner restlessness that made me want to keep moving, keep moving...
>
> I was just extraordinarily restless. Not in the sense that I had to get up and go do something, but in the sense that it was distressing to stay still in the same position too long. You know how if you sit in the same position for too long, after a while your joints/muscles/whatever get uncomfortable and you have to get up and stretch or walk around or at least change positions? It was like that, only a million times worse, and it happened every 30 seconds. I had to keep moving, or my brain and body just would not shut up about how it was not OK to stay still.
>
> It's like the worst "bugs under your skin" feeling ever. I hate it...
>
> ...the most severe anxiety-kinda feeling EVER. Panic attacks are bad - that feeling is worse. Nobody ever called it akathisia when I experienced it on *Effexor* (venlafaxine, antidepressant). It got chalked up to anxiety and "histrionic behaviour"... bugs-under-your-skin is a good description. I could not stop moving, I felt like if I did my body would explode.
>
> For me it also comes with a feeling of rage - I needed to scream almost as much as I need to move. I think it's just a product of the desperation I felt, though - at times I would also cry uncontrollably (but did not feel sad).

> (Akathisia was) like I HAD to move, but the *Abilify* (aripiprazole, antipsychotic) had made me fatigued as well so I was in this horrible in-between state that was driving me insane. My doc said that people have actually killed themselves over it because they couldn't describe what was going on with them and get so upset and frustrated they kill themselves. I could NOT get comfortable anywhere, no matter what. I had trouble sleeping, I couldn't stop moving, I needed to move.
>
> I am just coming down off severe akathesia from *Remeron* (mirtazepine, antidepressant). I was pacing back and forth and up and down stairs from 5am to midnight two days ago. It felt like I'd had 18 shots of espresso. Worst experience of my life. Emotionally, I flipped back and forth from extreme anxiety (just want to die because the world is ending and you're losing your mind simultaneously) to a giddy, silly, hypomanic-type mood.
>
> When I had it the first time, it was mainly physical. I had no idea what it was and my psychiatrist said it was mania. It wasn't though. It was sit down, stand up, try to lie down, pop back up, pace, sit etc. Once I shoved myself around the living room on an office chair with loud music on. I recommend that. That would have been *Seroquel* or *Abilify* or both (quetiapine and aripiprazole, antipsychotics). Next time it was *Abilify* withdrawal/ discontinuation and it was more mental, as in dread, grim, doom, and the the constant refrain in my head "I can't take this another minute." By then I knew what it was, not that it helped anyway.

Agitation caused by psychiatric drugs is not recognised for what it is. Inevitably, the patient will be seen as "seriously agitated" or "psychotically disturbed" or "aggressively rejecting treatment" or "suicidally depressed" and will be given more drugs, thus compounding the problem. As noted above, the psychiatrist is never wrong, the patient is never right. People who say they are being poisoned or damaged by the drugs are regarded as deluded, and are inevitably given more.

For the record, the Diagnostic and Statistical Manual of the American Psychiatric Association, Firth Edition (DSM-5) states (pages 124-125) that anybody who develops such a state of agitation during treatment with an antidepressant or during ECT is not suffering a side-effect of the treatment but is manifesting a true manic or hypomanic attack and is therefore properly diagnosed as suffering bipolar affective disorder type I, for which long-term treatment is required. The treatment will almost certainly include antidepressants which, with equal certainly, caused the agitation in the first place. Similarly, a person taking antipsychotics for any reason (e.g. drug-induced psychosis, psychogenic psychosis etc) will be rediagnosed as having an affective disorder and given more drugs, thereby converting a transient psychotic reaction into a permanent psychotic state.

Also for the record, I see approximately two hundred new case a year. Only two or three of those patients will be prescribed antidepressants, and then only in the short term. My figures for recovery, return to work etc are at least as good as, if not better than, those patients who are prescribed antidepressants and/or admitted to hospital for ECT. The average cost of treatment of my patients is a very small percentage of the costs of patients in conventional mental health systems, either private or public. The suicide rate among my patients is about one in 1600 patients or better, which is considerably better than the figures quoted in Note 2 above.

References:

1. McLaren N (1995). Shrinking the Kimberley: Isolated psychiatry in Australia. *Aust NZ J Psychiat*

29:199-206.

2. McLaren N (2013). Psychiatry as Ideology. *Ethical Hum Psychol Psychiat.* 15: 7-18.

3.https://www.health.qld.gov.au/__data/assets/pdf_file/0032/465188/cpp-request-second-opinion.pdf

4. Whitaker R (2002). *Mad in America: Bad Science, Bad Medicine and the Enduring Mistreatment of the Mentally Ill*. New York: Perseus Books.

5. Gotzsche Peter (2015). Deadly Psychiatry and Organised Denial. London: Artpeople.

6. Whitaker R, Cosgrove L (2015). *Psychiatry Under the Influence: Institutional Corruption, Social Injury, and Prescriptions for Reform.* New York: Palgrave MacMillan.

7. Quadrio C (2001). *Women Working and Training in Australian Psychiatry*. Glebe, NSW: Bookhouse Press.

8. Antunes PB et al (2009). Electroconvulsive therapy in major depression: current aspects. *Rev. Bras. Psiquiatr.* 31: suppl.1 May 2009. doi.org/10.1590/S1516-44462009000500005

9. APA Committee on ECT (2001). Washington, DC: American Psychiatric Publishing.
ISBN 978-0-89042-206-9.

10. Rose D et al (2003). Patients' perspectives on electroconvulsive therapy: systematic review.
Brit Med J 326:1363 doi: https://doi.org/10.1136/bmj.326.7403.1363

11. Sackeim HA et al (2007). The Cognitive Effects of Electroconvulsive Therapy in Community Settings. *Neuropsychopharmacol* **32**: 244–254. doi:10.1038/sj.npp.1301180.

12. MacQueen G et al (2007). The long-term impact of treatment with electroconvulsive therapy on discrete memory systems in patients with bipolar disorder. *J Psychiatry Neurosci*. **32** (4): 241–249.

13. Read J, Bentall R (2010). The effectiveness of electroconvulsive therapy: A literature review. *Epidem Psichiat Soc*, 19: 333-347 doi:10.1017/S1121189X00000671

14. Royal College of Psychiatrists (undated) Information leaflet on ECT. Available at http://www.rcpsych.ac.uk/expertadvice/treatmentswellbeing/ect.aspx. Accessed April 25th 2017.

15. Como P; FDA (2011). Research Findings on Memory and Cognitive Impairment in ECT. Summary presentation to FDA, Jan 27, 2011. Accessed April 26th 2017, available at: https://psychcentral.com/lib/research-findings-on-memory-and-cognitive-impairment-in-ect/

16. Breggin P. (2010) The FDA should test the safety of ECT machines. *Int J Risk & Safety Med*. **22**: 89–92 DOI 10.3233/JRS-2010-0491

17. Breggin P. List of over 150 references showing brain damage caused by ECT, from 1942-2011. Available at: www.ectresources.org.

18. Kirov GG et al (2016). Evaluation of cumulative cognitive defects from ECT. *Brit J Psychiat* 208: 266–270. doi: 10.1192/bjp.bp.114.158261

19. Grant JE (2006). ECT completely wipes out 30yrs of memory. *Curr Psychiat*. **5** (8):84-86. Available at: http://www.mdedge.com/currentpsychiatry/article/62301/ect-wipes-out-30-years-memories.

20. Kolar D (2017). Current status of electroconvulsive therapy for mood disorders: a clinical review. *Evidence-Based Mental Health*. doi:10.1136/eb-2016-102498.

21. Donahue AB (2000) Electroconvulsive therapy and memory loss: a personal journey. *J ECT* **16**: 133-43. Available at: http://retina.anatomy.upenn.edu/pdfiles/5524.pdf

22. McPhee I (2009). When doctors get sick. Radius (Sydney University), Autumn 2009: 10-13. At: http://sydney.edu.au/medicine/news/pubs/radiuscontents/2009/March/22_1_coverstory.pdf