Australian Government, Productivity Commission, Inquiry into Mental Health

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Reasons to Doubt Psychiatrists Are Mental Health/Disability Experts!

Commission Terms of Reference Addressed:
Scope:
"Examine the effectiveness of current programs and Initiatives across all jurisdictions to improve mental health, suicide prevention and participation, including by governments, employers and professional groups";

Suicide Prevention and Comorbidities
"What changes do you recommend to healthcare to address the specific issues of suicides and comorbidities among people with a mental illness? What evidence is there to support your suggested actions and what types of improvements would you expect in terms of population mental health, participation and productivity?"

ABSTRACT

The crisis of confidence in Psychiatry is a major concern.. A notion shared even among psychiatrists themselves. Psychiatry has a checkered history and its alliance with the pharmaceutical industry, aka Big-Pharma, reinforces a need for healthy skepticism. Why? An over-reliance on the so-called expertise and authority afforded psychiatry as the specialists of mental health. The checks and balances are failing miserably. In this submission, I contend that the authority of psychiatry, in its various forms, is misplaced and harmful. Since the criteria required to justify and satisfy psychiatric expertise is not warranted, essentially so, when substantiated by compelling reasons to rethink its authority as a reliable profession in its current form. Psychiatric expertise is not particularly scientific and this is especially dangerous in a sector that prescribes mind-altering drugs. There are a number of identified criteria that would otherwise substantiate psychiatric expertise and whilst partially existent, are nonetheless deficient. These major yet deficient aspects of psychiatric practice concern diagnostic problems – reliability and verification of diagnoses and testable validity of diagnoses - mainly due to an absence of underlying biomarkers ordinarily related to disease or biological conditions. Discernibly some psychiatrists fail to distinguish between reactive-depression and endogenous-depression; with that the general problem regarding reliably distinguishing between conditions constitutive of 'trait' and that of 'state' (e.g. reactive depression; adverse effects from medication, etc.). In practice too many psychiatrists underplay the significance of the placebo effect, realised more so when associated with concerns regarding appropriate prescribed dosages. Rather damaging is the persistent under-reporting of adverse effects which is a disturbing omission of responsibility in psychiatric health care, though a problem afflicting medicine across the landscape. Pertinently, psychiatrist instead, generally regard and treat adverse effects as comorbidities, involving polypharmacy, thus amplifying dangerous adverse effects, in particular, suicidality (suicide ideation).

Keywords: expert-expertise, psychiatry, diagnosis, reliability, verification, pharmacogenetics, validity, drug-induced-deaths, medication-adverse-effects, suicide-ideation.

INTRODUCTION

The crisis of confidence regarding Psychiatry looms large. It is a notion shared even among psychiatrists themselves. Psychiatry has a checkered history and its alliance with the pharmaceutical industry, aka Big-Pharma, reinforces a need for healthy skepticism. Why? An over-reliance on the so-called expertise and authority afforded psychiatry as the specialists of mental health. Psychiatrists, in many ways, not only determine what mental illness is but also what and how treatment is administered to those deemed afflicted. The recognition that this authority, based on expertise, can have profound effects on people requires detailed attention. Psychiatrists can enforce the Mental Health Act and compel hospital admissions, and if so determined, seclusion and restraint within hospital; an authority which extends to private care-residency facilities, and more often than not, to the administration of psychoactive drugs. Psychiatrists, generally, are sought after to offer opinions concerning people's capacities to rationally make financial and medical decisions, moreover to provide opinions regarding whether someone requires hospitalisation or prison (Badre, Barnes, Lehman & Steingard, 2019, pp. 155-156). On close examination however psychiatric expertise is imprecise, broadly at variance among its own rank and file, too often unreliable, marred by methodological diagnostic deficiencies; thus arguably, justified concern symptomatic of its own reliance on what appears to be its poor empirical methodological framework. Indeed, there is no universally accepted or standardised empirical theory of mind/consciousness. So, it begs the question: Why is psychiatry regarded as a specialist profession that wields medical authority, which has become increasingly relied upon for its so-called expertise in both mental health and disability service sectors? Is psychiatry anything more than a control mechanism? Considering that a number of anti-psychiatry associations exist in the world today, in addition to several psychiatry survival groups world-wide which operate to bring people together to share their experiences and to educate others. Over the last twenty-five years there has been a proliferation of work that continues to emerge that questions the underpinning assumptions of psychiatric knowledge and practice. "This work, appearing as academic papers, magazine articles, books, and chapters in books, has not been written by academics, sociologists or cultural theorists. It has emerged from the pens and practice of a group of British psychiatrists" (Thomas, 2013). In fact, the movement has increasingly grown to incorporate psychiatrists and associated clinicians and researchers in America, Australia and New Zealand.

People with lived-experience tell a different story to that found in the literature funded by the pharmaceutical industry. Moreover, the literature regarding research studies investigating the long-term effects of psychiatric drugs, identifying the scale and range of adverse effects (iatrogenic damage) from antipsychotics (neuroleptics) and antidepressants, provide cautionary and often contrary accounts to that found in psychiatric journals (Dorozenko and Martin, 2017).

A qualification is required here by being mindful that many people benefit from psychiatric services and from the administration of psychiatric drugs particularly when the condition being treated is in fact endogenous. One should not doubt that for some individuals there is an interplay of environmental and psychological factors and biochemical dysfunction amplified by the combination of stressors or even, if at times, these may occur in isolation (Preston & Johnson, 2019). The real benefit, however, is gained more so on the short-term basis, in most instances. Longitudinal studies show that long-term use of antipsychotics and antidepressants produces more damage than benefit for the consumer both financially and at the expense of genuine good health (Breggin, 2013; Davies, 2013; Gøtzsche 2013; Moncrieff, 2008; Szasz, 2010; Whitaker, 2015). It seems clear that there are inherent problems associated with the professional and clinical education psychiatrists are receiving. Mental health should be considered along a continuum such that practitioners need to be qualifying to what extent a disorder comes about by psychological factors or whether there is some biochemical disturbance at play (Preston & Johnson, 2019).

Accordingly, in this submission I contend that the authority of psychiatry, whether related to those that fall within biological psychiatry or to those that fall within psychologically oriented psychiatry, is equally misplaced and harmful. Since the criteria required to justify and satisfy psychiatric expertise is not warranted essentially so when substantiated by compelling reasons to rethink its authority as a reliable profession in its current forms. Psychiatric expertise is not particularly scientific and this is especially dangerous in a sector that prescribes mind-altering drugs. There are a number of identified criteria that would otherwise substantiate psychiatric expertise and whilst partially existent, are nonetheless deficient. These major yet deficient aspects of psychiatric practice concern diagnostic problems – reliability and verification of diagnoses and testable validity of diagnoses - mainly due to an absence of underlying biomarkers ordinarily related to disease or biological conditions. Moreover, psychiatrists in general, often fail to distinguish between reactive-depression and endogenous-depression. In other words, indicating typical competency failure of psychiatrist to establish the etiology and appropriate treatment of major mental disorders, by too often failing to distinguish between psychological disruption and biological disruption. Hence not reliably distinguishing between

conditions constitutive of ‘trait’ and that of ‘state’ (e.g. reactive depression; adverse effects from medication, etc.). In practice psychiatrists underplay the significance of the placebo effect, realised more so when associated with concerns regarding appropriate prescribed dosages. A concern that extends beyond psychiatry to medicine in general. Rather damaging to psychiatry is the persistent under-reporting of adverse effects (not uncommon in medicine) which is a disturbing omission of responsibility in medical health care; pointedly regarding psychiatrists who instead too often regard and treat adverse effects as comorbidities, involving polypharmacy, thus amplifying dangerous adverse effects, in particular, suicidality.

This submission is aligned to the two issues listed above from the Productivity Commission Terms of Reference, focusing on the profession of psychiatry relative to the constitutive development of expertise, as understood as the subject of psychological investigation, examined through a comparative analysis with medicine in general. The methodology employed is a critical examination of the historical literature of psychiatry, of expertise, of relevant medical advances, and of contemporary studies into the practice of psychiatry of both mentioned streams. The process unfolds through an examination of the criteria required to establish subject or profession related expertise to then consider the reliance on psychiatric expertise and the identifiable implications of such reliance as it plays out in society and interrelated institutions and services. The ethical perspective underpinning the research for this submission is the Common Theory of Morality as articulated by Beauchamp and Childress (2009). From this there are four main principles that operate in health care: principle of respect for autonomy; principle of non-maleficence; principle of beneficence, and; the principle of justice. Psychiatric coercion breaches the principle of respect for autonomy and the principle of non-maleficence and the justification for doing so is often shrouded in psychiatric jargon and implied authority. The recommendations and relative rationale are listed at the end of this submission.

SUICIDE STATISTICS

I chose to do this research for several reasons largely related to my son who lives with autism and from having encountered so many baffling errors made by the psychiatrists that have prognosticated over his life, imposing their own debilitating mixture of psychotropic drugs and electroconvulsive therapy on him. Also spurred on by a broadcast I heard from mental health

ambassador, Wayne Schwass, during an interview with Fiona Bollen from the 'Daily Telegraph' October 7, 2017, who said:

> "I talk about eight suicides a day (six of which are men); it's estimated there are another 65,000 attempts every year. The evidence for this tragic account emerge from "[s]tatistics released by the Australia Bureau of Statistics for 2016 which revealed there were 2,866 deaths by suicide in Australia in 2016 (7.8 per day). Of those, 2,151 were men (5.9 per day)" (Bollen 2017).

The interview does not include the high rate of suicides in 2016 involving antipsychotic medication. A common adverse effect of antipsychotic therapeutic drugs is suicidal ideation – therapeutic? Figure 1 below illustrates the types of mortalities as they occurred in 2016. The Australian Bureau of Statistics (2018) '3303.0 Causes of Death, Australia, 2016' Report released 15 May 2018 provides a summation:

> Drug misuse is linked to a number of adverse social and health factors, with Australia's Health Report 2016 (AIHW, 2017a) reporting that unemployment, living in a lower socioeconomic area and suffering high emotional distress are all associated with higher illicit drug use. Of note, 669 people (37.0%) who died of a drug induced death in 2016 had a mental health condition (including depression, schizophrenia and anxiety disorders) coded as a contributory factor to the death event. … Composition of Drug Induced Deaths: The majority of drug induced deaths in 2016 were due to acute accidental overdoses (71.3%), followed by suicidal overdoses (22.7%) (ABS, 2018).

Fig. 1. Causes of Death, Australia, 2016', Australian Bureau of Statistics, Released 15/05/2018.

Fig. 1

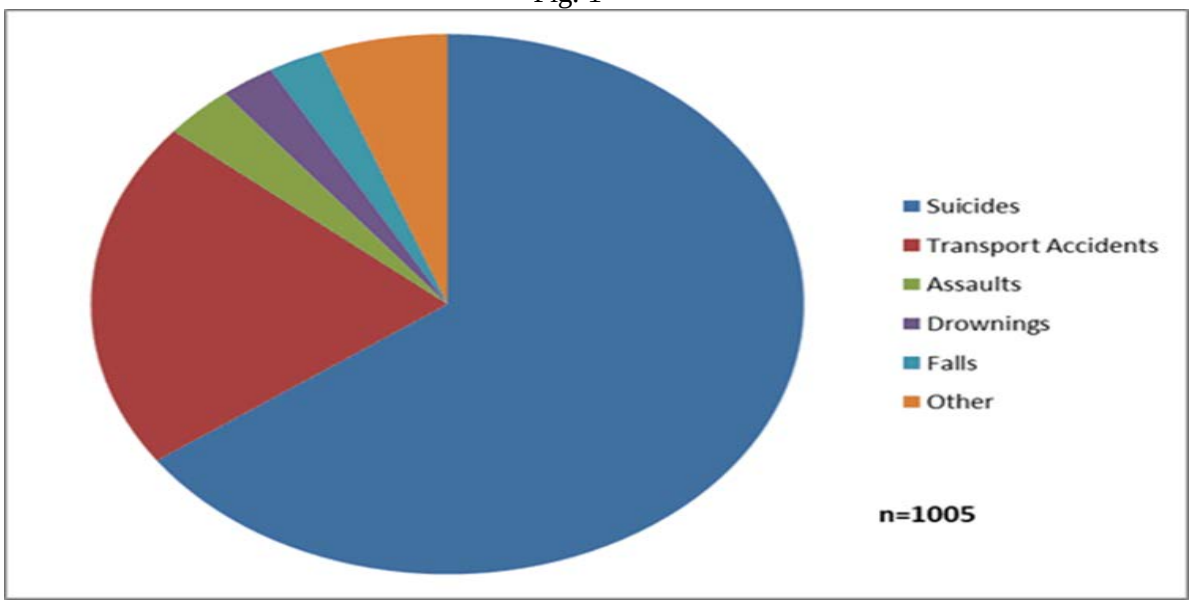
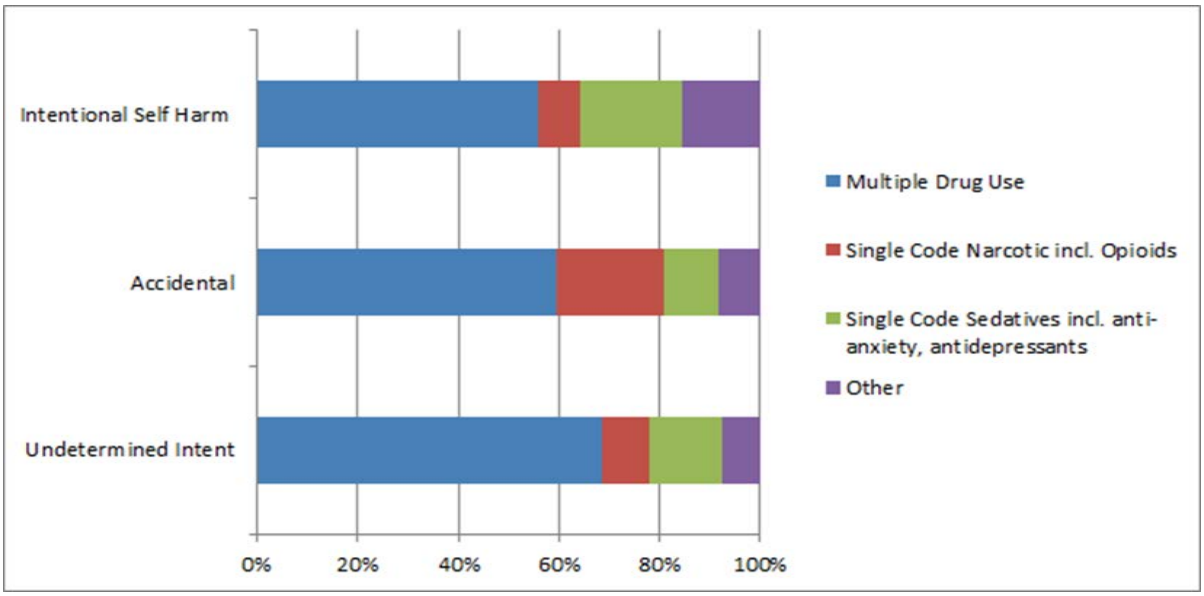


Figure 2 has the number of drug-induced-deaths as one thousand, eight hundred and eight, as registered in Australia in the year 2016. At a glance Figure 2 maps the classification of intent behind death events (ABS, 2018).

Fig. 2.



The following is a breakdown of those deaths involving single drug use:

> When analysed by single drug type, benzodiazepines were the most common substance present in drug induced deaths in 2016, being identified in 663 (36.7%) deaths. Benzodiazepines are drugs prescribed for the treatment of anxiety and insomnia, and are prone to tolerance and addiction. Benzodiazepines are associated with both accidental and intentional overdoses and were the most common drug in both unintentional and suicidal drug deaths in 2016. Although benzodiazepines were still present, they were the third most common substance present in deaths amongst this cohort. In 1999, psychostimulants were present in 54 deaths of males (0.6 deaths per 100,000) **compared with 274 deaths in 2016** (2.4 deaths per 100,000). (ABS, 2018). (Emphasis added)

In the year 2017 the number of deaths from 'Intentional Self Harm' (ISH) increased to three-thousand, one hundred and twenty-eight. That is, an additional two hundred and sixty-two lives lost to suicide (ABS, 2018) that following year, despite the services provided by suicide-prevention agencies. These statistics are disturbing and highlight ethically challenging prescribing practices around Australia. Loved ones of the deceased are left irate about the lack of accountability regarding not just psychiatrists but all prescribing clinicians.

These concerns are amplified by the release of the Pharmaceutical Society of Australia (PSA) January 2019 Report titled *PSA Medicine Safety: Take Care* which details the scope of harms in Australia resulting from medicine use. "The report reveals that 250,000 Australians are hospitalised each year, with another 400,000 presenting to emergency departments, as a result of medication errors, inappropriate use, misadventure and interactions". Half of these were preventable. "…the report calculates the annual cost of medication-related problems in Australia at nearly $1.4 billion – equivalent to 15 per cent of total PBS expenditure" (PSA, 2019). Making matters worse, the number of hospital presentations included in the *PSA*

Medicine Safety: Take Care report does not include Mental Health or Disability services numbers. Accordingly, of serious concern then, though not featured in the ABS suicide statistics, is the extent of adverse effects and associated harm suffered by individuals administered psychiatric drugs. The use of both chemical restraint and physical restrictive practices in health care and residential institutions for Aged Care, Mental Health and Disability Services adds deepening concern to what is now publicly recognised as a crisis in Aged Care, Mental Health and Disability Service sectors.

In the next section the concept of human agency is examined to consider and establish the extent to which medical authority and expertise legitimately emerges.

EXPERTISE & AUTHORITY

The term 'expert' implies the notion of authority, which contains two main senses: 'expertise', and 'the right to rule'. To have authority pertaining to belief (to be 'an authority') is to have:

> ...theoretical authority; to have authority over action (to be 'in authority') is to have practical authority. Both senses involve the subordination of an individual's judgment or will to that of another person in a way that is binding, independent of the particular content of what that person says or requires. If a person's authority is recognized then it is effective or de facto authority; if it is justified then it is de jure authority. The latter is the primary notion, for de jure authority is what de facto authorities claim and what they are believed to have. Authority thus differs from effective power, but also from justified power, which may involve no subordination of judgment. In many cases, however, practical authority is justified only if it is also effective (Green 1998).

In virtue of these two senses and in particular, that practical authority is justified only when effective, one may critically ask: is the authority of psychiatry justified? Expert authority is not just relational to its specific field or practice because in many instances it is mutually inclusive of the exercise of power across several fields. But with psychiatry especially related to the authority of expert witness in Courts of Law; Mental Health Tribunals; State Administration Tribunals, Office of the Public Advocate, etc.. One of the most common problems with the expert-witness, is reliability. By what standards or criteria should the term expert be assigned in this context when reliability within a given field of practice, as with psychiatry, is not sustainably established? Reliability is an operational requirement in medicine. Success, as well, in any practice, is often a good measure or criteria as a guide to what constitutes expertise. Psychiatric success measured by patient-maintenance as a form of reliability may be no more significant however than the benefits rendered by placebo in many cases. Unfortunately, in many others, the adverse effects can be so devastating individuals succumb to aggravated harm

or suicidal ideation. Not all psychiatrist practice the same way but for too many their modus operandi is a reliance on the prescription pad.

The role of authority is thus pertinent to this examination regarding psychiatric expertise. Hence it is important to consider human agency in the expression and execution of authority. For the purposes of the examination of authority I turn to a psychologist to gain insight. In 1961, psychologist Stanley Milgram conducted a series of social-behavior experiments regarding obedience to authority-figures which sparked an interest in 'white-lab-coat' phenomenon. The impetus for Milgram's experiments arose after the World War II, Nuremberg War Criminal trials in response to the excuses offered by those accused for the acts of genocide. A common defence was based on 'obedience' (or diminished responsibility) that the accused testified were following orders from their superiors. In the experiment Milgram used two groups: group-one – consisted of actors, and group-two – consisted of people from differing socio-economic backgrounds. Milgram's group-one actors played the role of learners. Those in group-two were to participate in the experiment as teacher paired to learner. The teachers were *not* informed that the learners were actors. The process of role selection appeared to the teachers as randomized. From the outset the teachers were informed that the experiment was being conducted to test how punishment affected learning. During the setup stage the teachers were told how the experiment was to be conducted and were shown the electric-shock generator situated in one room and how the learner, in another adjoining room, was to be strapped into a chair and his/her arms hooked up with electrodes. The teachers agreed to administer electric shocks to the learners at increasing voltages every time the learner gave the wrong answer to a series of multiple-choice association questions. The generator voltages ranged from 45 volts up to lethal doses of 450 volts as illustrated on the generator monitor. Surprisingly, the results of this experiment were alarming. More than sixty percent of the teachers exceeded expectations and administered lethal doses. Concerned by the results Milgram then set up varied experiments. After eighteen variations of this experiment he concluded that people will simply follow orders if instructed by someone of authority i.e. in this case, man in a white-lab-coat, to the point of death (McLeod, 2017).

Criticisms of the Milgram experiments have uncovered some interesting findings. One in particular, that 'order-like prompts' were ineffective compared with appeals to science, supporting the idea that people are not blindly obedient to authority but believe they are contributing to a 'worthy cause'. Though this criticism and other criticisms including cultural difference, need for income paid for participating in the experiment, are valid reasons, the problem remains, in that this type of experiment has been repeated, under more scientific

rigorous conditions all around the world with differing cultures, across all socio-economic backgrounds, and the results are nonetheless very similar to Milgram's original experiments (McLeod, 2017). Interestingly, Milgram provided an explanation under the title of 'Agency Theory', for the behaviour of his participants by theorising that people are not in every set of circumstances consistent, more specifically, that people have two states of behavior when they are in a social situation:

1) The autonomous state – people direct their own actions, and they take responsibility for the results of those actions.

2) The agentic state – people allow others to direct their actions and then pass off the responsibility for the consequences to the person giving the orders. In other words, they act as agents for another person's will (McLeod, 2017).

Milgram suggested that two things must be in place for a person to enter the agentic state:

a) The person giving the orders is perceived as being qualified to direct other people's behavior. That is, they are seen as legitimate.

b) The person being ordered about is able to believe that the authority will accept responsibility for what happens (McLeod, 2017).

Milgram's 'Agency Theory' indicates that people will obey an authority if they believe that the authority will take responsibility for the consequences of their actions (McLeod, 2017). Support for this notion is rendered by aspects of Milgram's evidence. What is not doubted is that belief informs conduct. Ordinarily, people seek advice from those perceived to be authorities in the area to which advice is sought. When sick, see a doctor. The benefits from just visiting a doctor can be therapeutic. Significant yes, but no need to rehearse here the placebo effect since it has been greatly realised in medical experiments and drug testing trials over many decades now.

Similarly, regarding individual-psychology, in terms of decision-making and performance on attention-related tasks, can also be influenced by priming (suggestion) and by other external factors as shown by experimenters at Northwestern University (2012). The authors, Hajo Adam and Adam Galinsky coined the term "enclothed cognition" to describe the co-occurrence of two factors – "the symbolic meaning of clothes *and* the physical experience of wearing them" (2012, p. 1). The research explored the effects of wearing a lab-coat in one experiment (E1) and in subsequent testing the coat was referred to either as a doctor's coat (E2), or a painter's coat (E3). The focus of the experiment was on 'attentiveness and carefulness'. In the experiment when participants wore the coat called the 'doctor's coat' (E2) the result achieved was an increased sustained attention compared to (E1) and even more so when participants

wore the lab-coat called a painter's coat (E3) (2012, p. 1). One's belief and attitude towards any task makes a world of difference to outcome because belief informs behaviour. Whatever success psychiatry has enjoyed might well be borne out of perceived clinical authority? In the following section I present textbook research regarding diagnostic medicine to establish the foundations for the development of expertise in medicine and to set the stage for a comparative analysis with psychiatry as a medical practice.

DIAGNOSTIC MEDICINE

Authors, Geoff Norman, Kevin Eva, Lee Brooks, and Stan Hamstra of *Expertise in Medicine and Surgery* (2006) published in *The Cambridge Handbook of Expertise and Expert Performance,* provide insight into understanding the development of expertise:

> Expertise in medicine requires mastery of a diversity of knowledge and skills – motor, cognitive, and interpersonal – which makes it unlike many other fields of expertise, such as chess, bridge, computer programming, or gymnastics. Although some specialties such as pathology or surgery may emphasize one kind of skill or another, most clinicians must be skilled in all domains and must also master an enormous knowledge base drawn from areas as diverse as molecular biology, ethics, and psychology (Norman *et.al.* 2006, p. 339).

As a domain of expertise medicine is unique not only because of the required formal knowledge base which is extensive, but medicine is also dynamic. Advances in our biological understanding, inclusive of the social and environmental influences, aided by advances in our technologies, render approaches to therapy subject to constant change. With the advent of new drugs and commercial influences, keeping abreast of this continually changing landscape, is a significant hurdle for practitioners. Consider what this means in terms of diagnosis:

> The interplay between the formal knowledge of medicine and experiential knowledge has emerged as a central issue in understanding medical expertise. Not all of the domains of medicine are equally represented in the literature on medical expertise. Indeed, much of what we call medical expertise is really closer to medical diagnostic expertise, and, of this, much is confined to the diagnosis of problems in internal medicine (Norman et al. 2006, p. 340).

Pointedly, we glean the understanding that medical expertise is closer to medical diagnostic expertise. Norman, et al., (2006) identify three distinguishable yet broad approaches to understanding medical diagnostic expertise as prevalent throughout its history. Earlier understanding predicated on process-oriented studies held that diagnosis was a general skill acquired by practitioners contemporaneously with medical knowledge, "but distinct from knowledge (2006, p. 340). They report a paradigm shift occurred in the 1980's and that the old process-oriented model was replaced by a new model recognising the central role of

knowledge, relative to its extent and organisation. In sum, incorporating a time line of which further investigation found that medical expertise involves coordination among several kinds of knowledge. Thus, three broad types of knowledge were identified and investigated: *causal knowledge* (understanding basic mechanisms and interactions), *analytical knowledge* (formal relation between diagnoses and features – signs/symptoms/conditions), and *experiential knowledge* (accumulation or experiential-repository of prior cases based on previous experience) (2006, p. 340).

Psychiatry in general, is largely practice-based and primarily trades on symptom-based diagnosis even though variability among humans is vast, despite the similarity of symptoms co-occurring across disparate and broad range of disorders. So, not without contention, psychiatry's symptom-based experiential method of diagnosis somehow provides the legitimacy it enjoys for its role as a practice. To examine experiential knowledge in this context requires understanding the role of exemplars so pivotal within the domains of mental health and disability healthcare. Experiential knowledge, utilised for diagnostic purposes, is commensurate to recognising suitable exemplars. In order to understand the underlying philosophy involved in the psychiatrists' diagnostic tool kit requires examining 'exemplar theory'. Psychological examination of the role of prior examples in everyday concept formation is what led to "exemplar theory". In brief, every learned category contains a number of examples acquired through experience. The examples acquired through experience that are to a high extent dependent on experience, are said to be individually retrievable. The sum of these examples provide support for the categorisation of any new cases, based on some kind of similarity to at least one prior example (Norman, *et al*. 2006, p. 340).

Exemplar theory shares similarities to *Inference to the Best Explanation* (IBE) which is a form of inductive reasoning employed in abductive arguments derived from C.S. Peirce. Abductive arguments lead to an explanatory hypothesis often used in medicine. A typical medical example runs like this: a) patient presents with slight fever and red spots over body; b) an explanation would be patient has measles (hypothesis); c) patient having measles is the best explanation for why there occurs slight fever and red spots over body; therefore, probably, this patient has measles (Govier, 2010, p. 298). Because measles is a testable disease, that primarily makes this line of reasoning quite typical of symptom-based diagnosis. Yet these same symptoms, 'slight fever and red spots' can be confused with other illnesses it should be noted. Problematically, as such, psychiatric disorders are not in the same ontological category on grounds of verification. Hence, the serious concerns regarding variability between individuals and variability between presentations of symptoms loom large. For where there is

great and broad variation between examples the weaker the capacity to diagnose efficiently and reliably (Norman, et al. 2006, p. 341). Other concerns add complexity to establishing reliable and verifiable psychiatric diagnoses (Preston & Johnson, 2019).

To examine these, I assess other measures employed to evaluate and track development to understand the structure of expertise. According to Phillip Ackerman and Margaret Beier, authors of *Methods for Studying the Structure of Expertise: Psychometric Approaches* (2006), we understand psychometrics, as the scientific discipline formed by the combination of psychological inquiry and quantitative measurement. Considering psychometric approaches to expertise the most general revolve around 'measurement and prediction' of individual differences and group differences (e.g. age, gender) and more specifically, to the 'level of proficiency' and 'expert performance' (Ackerman & Beier, 2006, p. 147). These refer more to the acquisition of skills and to the measurement of the individual's development. However, psychometric considerations provide a further insight relating to the identification of symptoms and probable causes of error which links to 'causal knowledge' as described above in the Norman *et al* research.

To elaborate requires first considering psychometric use of psychological terms and to provide a brief explanation pertinent to the study of expertise in relation to psychiatric symptomatology and to diagnostic medicine. One important distinction of relevance is between 'traits' and 'states'. 'Traits' refer to "broad and stable dispositions" regarded in two ways: as "either 'physical properties', such as visual acuity, strength, agility, etc. or 'psychological properties', such as intelligence". 'States', in contrast, are regarded as temporary qualities characterised by changeable moods, and understandably, by definition is quite broad, generally involving emotional stressors, for example, being happy, then "sad, or angry, sleepy and the like" (Ackerman & Beier, 2006. P. 147). Pertinently, and more extensively what constitutes a state includes anything that induces or disrupts one's mood, such as, a disruption caused by the ingestion of some causal agent, like psychiatric drugs.

An example of a medication-induced state causing delirium, or psychosis and violent behaviour, is medication-induced akathisia (Greek meaning: 'can't sit down'). "Akathisia is a dangerous adverse effect of antidepressants, antipsychotics and some other drugs that cross the blood-brain barrier" (Eikelenboom-Schieveld, Lucire and Fogleman, 2016, p. 65). Prescribed medicines can increase blood levels "towards toxicity because of genetically determined metabolizing capacities, high doses and interactions with co-prescribed CYP450 inhibitors and synergies" that often-times produce erratic and disruptive behaviour. Pharmacogenetics includes the "genetics of the cytochrome P450 (CYP450) system which are the otherwise

invisible factor that can correlate with catastrophic behavioural disturbances" (Eikelenboom-Schieveld, Lucire and Fogleman, 2016, p. 65; Breggin, 2013, pp. 40-41).

Severe akathisia-related effects causing violence and suicidality will "abate when medication is decreased, changed or slowly stopped. Suicidality and violence tends to get worse if the dose is not tapered slowly" (Eikelenboom-Schieveld, Lucire and Fogleman, 2016, p. 65; Lucire, & Crotty, 2011; Breggin, 2013, p. 41). The evidence is both genetically and behaviourally clear (Moncrieff 2008; Bentall 2010) yet many psychiatrists deny psychotropic drugs produce adverse effects. Much worse, too many psychiatrists are even convinced that "it is not an adverse effect of the drug but a positive sign that the drug starts working" (Bielefeldt, Danborg, and Gøtzsche, 2016, p. 385). What is not common knowledge even among psychiatrists is that "the CYP450 enzymes can be induced or inhibited by many drugs and substances resulting in drug interactions in which one drug enhances the toxicity or reduces the therapeutic effect of another drug" (Le, 2016, p. 1). The liver's capacity for metabolism through the CYP450 enzyme system with age "is reduced by ≥ 30% because hepatic volume and blood flow are decreased" (Le, 2016, p. 1). Consequently, over time maintaining or stabilizing a patient with treatment proposed to be recovery oriented is virtually impossible, particularly when the psychiatrist's reliance is to an ill-guided treatment option that very often turns out to be an unsuitable patient-drug treatment.

Psychometric approaches to the inquiry of expertise formalise other predictors but two aspects of measurement move beyond psychology and scientific enquiries, referring to 'reliability' and 'validity'. Any measurement requires reliability as a basis to establish validity. Any form of assessment within the realm of psychometrics considered reliable occurs when a "group of individuals can be consistently rank-ordered over multiple measuring occasions" (Ackerman & Beier, 2006, p. 148). Reliability of anything being measured extends to the measuring devices and tests employed among a broad range of phenomenon which can be measured. A typical example is measuring running speed by using a timing device. Alternatively, measuring reliability of a surgeon one might measure the surgeon's minimisation of unintended laceration and her procedural success. Measuring reliability between individual performances during athlete running tests, for example, is replete with variation between the individual's states at the time of measuring. So multiple testing would be required to establish an average (test-retest reliability). A simple example in everyday clinical settings is testing a patient's blood pressure, test-retest reliability has become standard practice because of the white-lab-coat phenomenon. Yet, problems arise in relation to 'memory and performance' both at the level of predictors and at the level of criteria. That is, will involve: aptitude, ability, skill

assessment, context of task, expression of perceptual-motor-skills, and tasks involving cognitive/intellectual expertise associated with learning (Ackerman & Beier, 2006, p. 149).

Historically, one way around this that has some merit in other disciplines regarding reliability, which is relevant to this study of psychiatric expertise, is 'inter-observer reliability'. Broadly, this refers to an 'index of agreement' between different individuals who act as judges. An application of this method occurs when an individual performance cannot be objectively evaluated (e.g. music composition, gymnastic tournament, diving competition, art submission, etc.). When agreement between judges in rank-ordering of individuals is high that corresponds to high inter-observer reliability; where there is "little agreement, reliability of the judgements is low" (Ackerman & Beier, 2006, p. 148). But the problem encountered in mental health and disability sectors is reliability and verification of diagnosis. This kind of modelling when used in case conferences, for example, between groups of psychiatrists, even if inadvertently, often incorporates biases perpetuating misunderstood patient symptoms and the consequent errant diagnoses. Hence, a significant indication of internal problems for psychiatry as a profession relates to misdiagnoses involving mistaking 'state' for 'trait'. By misdiagnosing symptoms, for example, mistaking tardive dyskinesia for catatonia or akathisia for hyperactivity or attention deficit disorder, or mood disorder for reactive-depression, trauma for a whole range of so-called psychiatric disorders, etc. that will ultimately lead to mismanagement and inappropriate treatment options (Kolk, 2014, pp. 37-38; Preston & Johnson, 2019 pp. 2-19; Whitaker, 2015, p. 212;). This is a common occurrence and not an exception to the rule of practice. The current drug-based psychiatric paradigm of treatment progresses through a trial and error prescriptive process as realised by changing medication in exploratory practice to find a suitable so-called medication-to-client fit, too often at great cost and adverse harm to child/patient/client. Particularly concerning, when verifiable and reliable scientific methods are available through pharmacogenetics, as mentioned above.

Furthermore, misdiagnoses involving psychiatrists mistaking 'state' for 'trait' generates additional repercussions that impact patient welfare rather significantly, that of which involves the under-reporting of adverse events. Though this problem is generally recognised as a central problem in medicine *per se* it is by degrees intensified in psychiatry. However, overall it is estimated that only about five-percent of adverse events are reported by practitioners, nationally. The Minister for Health the Hon. Greg Hunt in a letter dated 20 August 2018 to the Chair, Standing Committee on Petitions, acknowledged that under-reporting of adverse events is a global issue (author sighted letter). Furthermore, Robertson and Newby (2013) in *Low Awareness of Adverse Drug Reaction Reporting Systems: a consumer survey*, identify a

massive gap in psychiatric drug related adverse effects being reported. Most often consumers report adverse-effects to their prescribing clinicians yet all too often the adverse effects are rationalized away by the clinician. To reiterate most consumers readily report adverse effects to their clinicians, as generally understood, but relying on practitioners to report such adverse events is evidently a very poor or unreliable pathway to register such adverse drug-events. Indeed, interrogating why there is such low numbers of reported adverse events, can arguably be understood as a conceptual and attitudinal concern about how psychiatrists, in particular, play down adverse effects and quite commonly define them as comorbidities (Breggin, 2013; Davies, 2013; Hari, 2018; Steingard, 2019; Whitaker, 2015). Unfortunately, many patients, are subsequently prescribed by their psychiatrists, additional medication to treat the adverse-effect or insist the patient requires Electro-Convulsive-Therapy (ECT) (Moore, 2018) when otherwise, as is not uncommon, the psychiatrist characterizes the patient as 'medication resistant' etc.. (Breggin 2013; Davies 2013; Gøtzsche 2013; Moncrieff, 2008).

The chief error in psychiatry is overstatement and though its aim is plausible its success exaggerated. This, in effect on a grand scale, is to commit the 'fallacy of misplaced concreteness' as coined by Alfred North Whitehead (1978, p.7):

> This fallacy consists in neglecting the degree of abstractness involved when an actual entity is considered merely so far as it exemplifies certain categories of thought. There are aspects of actualities which are simply ignored so long as we restrict thought to these categories.

Errantly diagnosing adverse effects as comorbidities and mistaking psychological problems not helped by medication treatment but still treating a patient with psychiatric medication, to say the least about the practice of psychiatry, is to recognise the fatal error often committed by psychiatrists as the 'fallacy of misplaced concreteness'. The following section draws upon the literature on biological psychiatry and comparative practices to highlight the significant deficits bedeviling psychiatry in general.

PSYCHIATRY: MISSING BIOMARKERS, NAME THE SYMPTOMS

Problems associated with psychiatric disorders emerge from a failure to establish identifiable 'biomarkers' that would otherwise provide verification and diagnostic reliability for the many disorders described by psychiatry as defined within its five iterations of the Diagnostic Statistical Manual (DSM). The term "biomarker", short for "biological marker", refers to a subcategory of medical signs; in other words, these are objective indications of medical states generally observed from outside the patient. Importantly, biomarkers are the indicators that can be "measured accurately and reproducibly". The use of medical signs in clinical practice has a

long history and biomarkers serve as the “most objective, quantifiable medical signs modern laboratory science allows us to measure reproducibly” (Strimbu and Tavel, 2011, p. 463).

For psychiatry two concerns are manifestly evident: firstly, identifiable biomarkers are absent that would otherwise provide verification for assumed disorders and, secondly, it suffers from a lack of sophisticated diagnostic tools (Davies 2013; Moncrieff, 2008). Both constitutional foundational pillars to a successful and reliable clinical practice. Lacking these fundamental foundational pillars arguably, as necessary conditions for expertise and medical authority, raises questions about psychiatry as a domain of expert practice, and therefore its individual practitioners not clinically, at least not empirically, warranted the title of expert, even more so, not specialist. Particularly when further examining the concept of ‘validity’, the second aspect of psychometric measuring and beyond that adds another necessary condition warranting the ascription of expert.

Validity is a long-standing evaluative term of logic which refers to the evaluation and structure of deductive arguments. Validity, refers to a formal characteristic that applies to deductive arguments only, as distinguished from truth, which applies to propositions employed in an argument as the elements forming the composition of the argument. The term ‘validity’ as employed in psychometrics is described as “a property of an instrument that refers to whether it measures what it sets out to measure” (Ackerman & Beier, 2006, p.149). Examining the use of validity in psychometrics requires understanding that there are three distinctive aspects of a test in evaluating its validity: ‘content validity’, ‘construct validity’, and ‘criterion-related validity’.

‘Content validity’ refers to the underlying content of the trait under consideration e.g. Australian Rules Football performance traits would be those related to the football: kicking, handballing, and bouncing, including other aspects such as tackling, blocking and on-field conduct, etc. Content validity is understood in relation to the subject-matter based on expert judgements but it is not something that is directly assessed quantitatively. ‘Construct validity’ is a relational concept referring to the relationship between a measure of a trait or state and the underlying theoretical concept or construct (Ackerman & Beier, 2006, p. 149). In terms of predictability construct validity requires well established theoretical and substantive measurable and verifiable markers. In terms of psychiatry with the controversy surrounding constructed disorders, no identifiable or verifiable biomarkers, renders this form of testing validity unsustainable or dubious at best. Perhaps the most important application of psychometric measures is the criterion-related validity. Central to the criterion-related measure of validity is ‘prediction’. Characteristically described as the degree to which the measure can

predict individual differences relative to some criterion measure. Most common example is the intelligence test that equates frequency of scores on the intelligence test that correlate with the criterion of academic performance (Ackerman & Beier, 2006, p. 149). This, in the context of psychiatry, has some merit in terms of potential but it is nonetheless shrouded by diagnostic incompleteness and broad variability relative to etiological or environmental and social influences associated with the onset of many so-called disorders. Complicated more so when dealing with cognitive disabilities, or brain-injured child, and hence, too often fails as a reliable validity measure for successful diagnosis (Doman, 2005). Unfortunately, and rather condemningly, this also provides rationale for psychiatrist to insist upon lengthy unnecessary and debilitating pharmacological treatment regimens. Psychiatrists by and large are not taught how to taper medication. This is a gross oversight in terms of a psychiatrist's formal education that needs serious attention to remedy. It also raises a whole series of other ethical questions related to professional integrity, responsibility, and duty of care to minimise harm under the principle of non-maleficence.

Very telling for this examination of psychiatry expertise is Glenn Doman's (2005) detailed account of his life's experience as a practitioner dealing with brain-injured children and adults. During a discussion regarding the reliability of standard intelligence tests used in the United States for testing the intelligence of a well child his consideration is that they achieve what they are meant to achieve, 'but nothing more'. Using the same tests on brain-injured children does provide a good result of the brain-injured child's disabilities. What is insightful about this account is that "disability is not to be confused with inability, which is an inherent lack of ability to perform an action; disability, on the other hand, arises from a deprivation or loss of the ability to perform an action" (Doman, 2005, p. 130). Testing abilities is standard practice and testing disability is acceptable as well but Doman adamantly indicates, only with one massive proviso:

> Providing that when we are testing abilities we know we are testing abilities, and providing that when we are testing disabilities we know we are testing disabilities. But when we test disability and believe we are testing ability, only devastating results can follow, and that is precisely what occurs every single time we apply such tests to a brain-injured child. Yet the tests continue to be given and, worse, the ratings that result are often accepted as a basis for action. **Brain-injured children by the hundreds of thousands have been 'put away' in institutions for life on such evidence** (Doman, 2005, p. 130) (Emphasis added).

What a tragedy! The problem generally understood for Doman and his colleagues was finding alternatives to these tests which they realized simply did not work. Because a brain-injured child who is being intelligence tested is tested comparatively through expected stages of life to the well child's abilities at respective stages of life, but in doing so incorporates a myriad of

underlying assumptions not hitherto recognised. These assumptions and consequent problems are discussed at length to explain the salient draw backs inherent in these forms of testing and the alternative way Doman's team came to realise and develop new approaches established after many years of research and practice (Doman, 2005, pp. 129-146).

Beyond this is the disconcerting fact that criticism of psychiatry is rife and increasingly so for good reason. Recently, scholars and clinicians, collaborated to produce a rich and varied scholarly and clinical view of the central concept of validity culminating in the publication of *Alternative Perspectives on Psychiatric Validation: DSM, ICD, RDoC, and Beyond* (2015). This collective work seeks to address the 'crisis of confidence in psychiatric diagnostic concepts' inviting an appreciation for the complexity associated with the claim that diagnostic criteria, however they may differ, 'define a valid psychiatric disorder'. Psychiatrists themselves have identified many problems and inconsistencies in the DSM, that indeed a "crisis of confidence has become widespread … inside the field. The problems with the current diagnostic paradigm, some psychiatrists believe, has become so great that a significant paradigm shift may be required" (Zachar & Jablensky, 2015, p. 9).

Other complications emerge as echoed by Johann Hari's research published in 2018 *Lost Connections: Uncovering the Real Causes of Depression and the Unexpected Solutions.* Hari draws upon empirical research and presents these findings in an accessible manner. Interestingly, when it comes to depression psychiatrists do understand that the causes can be wide and varied. Some people experience depression due to environmental, social and psychological concerns, as such are classified as "reactive depression". Others, experience depression for reasons due to internal physical concerns, as such are classified as "endogenous depression" (Hari, 2018, p. 52). Hari describes a clinical trial that involved a comparative analysis of the two groups: group diagnosed with 'reactive depression' and group diagnosed with 'endogenous depression', evidently, the result was: 'no difference between them'. There was however one common factor discovered between the two defined groupings. The common factor was 'trauma' and the "generalisation of hopelessness" featured as a distinctive variable. Repeated clinical trials, as Hari reports, undertaken some years later to investigate the causes of depression in places radically different as rural Zimbabwe and rural Spain, produced the same findings. In sum, where there exist strong community ties, like rural Spain, depression is very low, consistent with people who have less traumatic experiences and, in such community's, this acts to protect people against depression. In contrast, in areas where trauma is high, community ties withered, as then rural Zimbabwe, it was found that these factors were

driving depression (Hari, 2018, p. 52). Question raising observations that lead us into the next section to consider recent advances in medical science and psychiatric woes.

PSYCHIATRY: MEASURES AND REPERCUSSIONS

Our focus shifts to the extreme sense, where the power relation can, and regularly extends, to the subjugation of patient by medical expert, more so by the so-called psychiatric expert, in both mental health and disability service facilities. The emergence of medical authority bestowed on psychiatry in historical context is traceable. Since by its own admission and actions "psychiatric institutions have sought to become more socially accepted and less stigmatized, more central to everyday life and in dialogue with other institutions" (Behague, 2008, p. 142; Moncrieff & Steingard, 2019, pp. 1-15). Yet through the biomedicalisation of psychiatric practice, the rapid infiltration of pharmaceutical regimes from the 1970's, has seen significant increases in interventions for less severe disorders, such as mild depression, experienced by "average" citizens (Behague, 2008, p. 142; Bentall, 2010; Whitaker, 2015). Many psychiatrists during the late twentieth century committed to population health sought to increase attention to what they perceived, aided by their distorted narrative of the now highly controversial notion of 'chemical imbalance', suggested high prevalence rates of 'common mental disorders'. However, in doing so demonstrating very little regard for cultural sensitivity nor proper understanding of "cultural contexts" (Behague, 2008, p. 142; similarly, Hari, 2018). These and similar concerns are prevalent around the world and many mental health practitioners call for reform and suggest that better empirical training is required for psychiatrists regarding methods of diagnosis and treatment to keep abreast with the advances in genomics and neuroscience (Insel and Quirion, 2014).

Advancing these same concerns in resounding fashion is psychiatrist Bessel Van der Kolk whose life-long work, published under the title *The Body Keeps the Score: Mind, Brain and Body in the Transformation of Trauma* (2014) provides insight and evidence grounded in empirical longitudinal studies. The work includes the presentation of studies conducted in several treatment centres across the globe drawn from a range of health and social disciplines. The increasing understanding of trauma, situates it, as is now recognised, as one of the most serious public health concerns and its manifestation and effect rather extensive. Kolk is understandably critical of standard approaches to trauma and extended problems dealt with by practitioners, even those within his own field. Kolk argues that too many psychiatrists and other clinicians fail to recognise the symptoms of trauma, and as a consequence misdiagnose, then

mismanage their patients, however inadvertently, in effect aiding the generation of so-called comorbidities.

In turn Kolk's work was inspired by Stephen Porges' foundational development of the Polyvagal Theory that emerged from the "study of the evolution of the vertebrate autonomic nervous system (Porges, 2011, p. 263). One main insight drawn from the theory is that many of our social behaviours and vulnerabilities to emotional disorders are "hard wired" into our nervous system" (Porges, 2011, p. 263). The theory provides ways of thinking about certain aspects of mental health, to develop 'treatment techniques' that enable people greater means of communicating and 'relating better to others'. The referent for the term polyvagal is the vagus nerve ('poly' means 'many' and 'vagal' points to the vagus nerve). The vagus nerve is an integral component of the Autonomic Nervous System (ANS). The vagus nerve extends from the brainstem to its interconnected branches to regulate several organs, not least the heart. According to the theory, there are two branches of the vagus that "are related to different behavioral strategies, one related to social interactions in safe environments and the other related to adaptive responses to life threat" (Porges, 2011, p. 263).

The historical understanding of the ANS interprets two opposing components, one the sympathetic and the other parasympathetic. This understanding, dates back to the 1800's and took the form of an antagonism model. As Porges explains, the model characterised the function of the ANS as a continuous battle between the two components. On one side, the sympathetic nervous system taken to be associated with fight-or-flight behavioural responses and the other side, the parasympathetic nervous system taken to be associated with "growth, health, and restoration". Since most of the organs of the body, for example, the heart, the lungs, and the gut, have "innervations from both sympathetic and parasympathetic components, the paired antagonism model evolved into "balance theories"" (Porges, 2011, p. 264). What Porges describes is very significant and testament to the paucity of understanding in which several medical schools of thought reliant upon an understanding of physiology fall behind, not keeping pace with new developments. None more so evident than in psychiatry whose claim to operating from a scientific evidence-based practice is therefore exposed as quite wanting:

> Balance theories attempted to link tonic imbalances to both physical and mental health. For example, a sympathetic dominance might be related to symptoms of anxiety, hyperactivity, or impulsivity, while a parasympathetic dominance might be related to symptoms of depression or lethargy. In addition to the tonic features of autonomic state, the paired-antagonism model also assumed to explain the reactive features of the autonomic nervous system. This dependence on the construct of "autonomic balance" is still prevalent in textbooks, although there has been an intervening century in which neurophysiology has documented a second vagal pathway involved in regulating autonomic function. Unfortunately, this new knowledge of the second vagal pathway has

> not permeated the teaching of physiology, which still is dominated by descriptions of the paired antagonism between the sympathetic and parasympathetic components of the autonomic nervous system (Porges, 2011, p. 264).

This failure to keep pace with the emerging and new knowledge of physiology is what allows the myth of 'chemical imbalance' to persist. The myth of chemical imbalance that forms part of the narrative emanating from the ranks of pharmaceutical industry-influenced research and their spokespersons, is what otherwise is meant to be the source underpinning mental health problems (Bentall 2010; Davies 2013; Moncrieff, 2008; Whitaker 2015). It is not that people do not experience some kinds of chemical imbalance at times but not exploring the true causes (nutrition, stress, chemical assaults on our brains, vitamin deficiencies, maturation, interpersonal problems, childhood trauma, etc.) and distorting the diagnosis such that consumers are led to believe that the only cure is through psychiatric drugs, is arguably unethical. It is extremely questionable conduct, effecting the lives of so many around the world and should more seriously be considered ethically abhorrent practice, not least for its ignorance, but worst for its deceit in perpetuating and profiteering from the myth. Compliance towards professional practice would require duty of care and due diligence to keep abreast of up to date knowledge of one's clinical practice, particularly so on the part of the prescribing psychiatrist, when the drugs administered to patients can be, and are, very dangerous. The clinical literature on the dangers of psychiatric drugs is vast, and ignorance is no excuse. Accordingly, in practice knowingly administering medication which produces debilitating adverse effects greater than the intended benefit for recipients from medications/drugs, is negligent and is a breach of the professional and ethical principle of Non-Maleficence or 'Do No Harm' to say the least. Current psychiatric practice exposes a fundamental lack of critical thinking and reflection in practice on the part of its practitioners and this suggests that the education psychiatrists receive is drastically deficient and in effect, and in no small way, compromises the safety and well-being of many clients/consumers. A revolution in psychiatric training is required and greater accountability assigned to its practitioners under the principle of justice, given the influence they exercise in the construction of Public Health Policies.

In this submission I argued that the misplaced authority of psychiatry is harmful. Because the criteria required to justify and satisfy psychiatric expertise is not warranted as provided by compelling reason to rethink its authority as a reliable profession. The identified criteria required to substantiate psychiatric expertise were found to be deficient. The main concerns dealt with related to diagnostic problems – reliability and verification of diagnoses and testable validity of diagnoses. In part due to the absence of underlying biomarkers ordinarily related to

disease or biological conditions that psychiatry continues to face verification, reliability and validity of diagnoses problems. In addition, a problem psychiatrist's face is distinguishing between reactive-depression and endogenous-depression; with that the general problem of reliably distinguishing between conditions constitutive of 'trait' and that of 'state' (e.g. reactive depression; adverse-effects from medication, etc.). Psychiatrists underplay the significance of the placebo effect which is linked to additional concerns regarding appropriate prescribed dosages. Considerable concern is directed at the persistent under-reporting of adverse effects which is a disturbing omission of responsibility in psychiatric health care. Disconcertingly, practitioners instead regard and treat adverse effects as comorbidities, consequently, involving polypharmacy and thus amplifying dangerous adverse effects, in particular, suicidality. Psychiatrists are not gods nor real experts of mind. Therefore, we need better informed checks and balances, more robust regulatory frameworks and better informed investigative bodies to safeguard us against the largely self-determining agency of psychiatry and pharmaceutical industry.

RECOMMENDATIONS

1. Promote greater awareness of the serious adverse effects of psychiatric drugs.
2. Promote, respect, and value the voices of individuals, their loved ones, and supporters, impacted by psychiatric drugs.
3. Advocate for greater investment in a wide range of approaches to, and understanding of, the causes of mental distress, which are not medication based.
4. Encourage and facilitate improved literacy around treatment options, including alternatives to psychiatric drugs.
5. Establish National Tapering (withdrawal) Guidelines (Guidelines informed by Pharmacogenetics). Tapering must be supported under appropriate medical supervision.
6. Greater involvement of pharmacists to oversee current poor prescription practices.
7. Review and enhance clinical education for psychiatrists. Education to promote an understanding of the dangers of polypharmacy, dosage administration, drug-drug synergy, drug-to-drug reactions (effects pharmacokinetics). Education to promote recognition to readily distinguish medication-induced psychiatric symptoms (adverse-effects) so that they are not regarded and treated as comorbidities.
8. Education for psychiatrists should incorporate critical and reflective thinking skills to enhance decision-making capacities to improve diagnostic considerations.

9. Greater oversight and compliance measures be established particularly when any drug administered to patient has a therapeutic range and toxicity range close together. For example, treatment with lithium should only be initiated after necessary lab tests are conducted. With high dosages side effects are more common and compliance is much poorer (Preston and Johnson, 2019, p.24).
10. Promote the use of pharmacogenetic testing to establish patient-drug suitability as an empirical protective measure to minimise the onset of drug-induced psychiatric conditions. Suggested inclusion in the Pharmaceutical Benefit Scheme.
11. Clinicians, before psychiatric medication is prescribed must ensure psychosocial stressors are not the cause of mental distress, and if so refer for psychotherapy.
12. Increase the onus of responsibility for clinicians to report adverse-effects (we learn more when we can establish a clearer picture of the range and scope of adverse-effects).
13. Establish whistle-blowers register and protection mechanisms to promote increased compliance to reporting psychiatric drug-induced adverse-effects.
14. Clinician awareness of the importance of reporting adverse-effects is low. This has to change! Measures are required to improve awareness and of its significance to medicine and so mechanisms that encourage this based on information gathering be promoted rather than focusing on punitive consequences. Punitive measures should be enforced when errors are repeated and the clinician's standard of practice is not accordingly modified.
15. Rethink current Health Care Standards. Standards better informed by Polypharmacy concerns, Restrictive practices concerns, Chemical restraint concerns, and Drug-induced adverse-effects. Safeguard against the onset of psychiatric conditions regarded and treated as comorbidities.
16. Establish protective safeguards in order to monitor and review residences, those provided by service providers that accommodate people living with disabilities and for people with mental health concerns, to protect against restrictive practices and safeguard against chemical restraint, poor and abusive care.
17. Support-worker education standards enhanced. Education and level of competence should be subject to type of duties and responsibilities, particularly more robust controls established for when drug administration such as PRN's may be required.
18. This submission provides reason to rethink the clinical authority bestowed on psychiatry and reason to revaluate current governance and investigatory standards.

19. Prescription of psychiatric drugs should not be considered a permanent, lifelong solution. A plan for discontinuation of psychiatric medication should be based on shared decision-making principles negotiated between the service user, their supporters and the clinical team.
20. Greater recognition and support be given to recovery oriented prescribing practices, which means the person's recovery goals and vision are central and privileged and clearly defined.
21. Therapy should be guided by the principle of prescribing at the lowest dose for the shortest length of time.

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