

Submission Regarding Mental Health Report Volumes 1 and 2 by the Australian Productivity Commission October 2019

Broad media gave this highly controversial report very scant exposure. Official closure for submissions was made 23 January 2020. The holiday season has curbed scope to protest. This very repetitive report is over 900 pages, and is appalling because:

- Its cost benefit analysis takes no account of detriment of taking money and resources off broader needs (e.g. tight budgets of many households and companies, plus urgently needed knee replacements and cancer treatments)
- It greatly lacks originality, especially in sourcing research and making statements independent of standard dogma of the mental health or psychiatric industry
- Mounting evidence and warnings over several decades indicate a rapacious multi-billion-dollar psychiatric *industry*, with a strong vested interest in *entrenching* mental illness under guise of Early Intervention in Australia (and abroad)
- Psychiatry is by far the least objective medical field in terms of diagnosis and treatment. This seriously calls into question alleged benefits of increased psychiatric interventions and partly explains wild variations in supposed economic costs and benefits of the recommendations (such as a 6-fold variation in assessed benefits of stepped-up suicide prevention programs)
- Along with over-reliance on research and materials sponsored by drug companies, the Commonwealth has allowed undue and vast influence to a single individual, Psychiatric Professor, Harvey Whiteford, who has largely driven the direction of our psychiatric industry for at least 3 decades (the Commonwealth Department of Health has in the past, paid \$1.2 million to Harvey Whiteford Medical Pty Ltd which has a strong vested interest in “reform” as a burgeoning psychiatric industry)
- Australia is already third globally in terms of psychiatric drugging per capita. There is mounting evidence of abuse and harmful outcomes due to a psychiatric industry out of control, including steep rise in electro convulsive therapy (ECT) following failed drugging
- Very shamefully, the report ignores repeated calls for royal commissions (national and state) into our psychiatric industry, made due to this mounting evidence and proceeds without it

- It fails to address contribution of Harm Minimization policies to Australia's high consumption of street drugs, and related addiction and mood/cognitive disturbance
- It advocates mandatory psychiatric screening of infants aged 0 to 3, if parents are on welfare, and ultimately plans such screening of all our infants
- It aims to make creches, educational institutions and even workplaces effectively psychiatric clinics, interfering with integrity, neutrality and operations of many vital services and activities.

Text below elaborates and notes some solutions. I write from viewpoints of history as a family carer, freelance researcher/journalist, human rights advocate and 20 years as an employer (with 40 staff). I use the term "patient". "Consumer" patronizes children and others not freely consenting. To cut repetition, some points made may not appear under all relevant headings. I have referenced as far as possible given time constraints.

Failure to Learn from History

In 1993, we were in the aftermath of a Royal Commission into psychiatric abuse in Chelmsford Private Hospital, which courts held cause of 48 deaths. Brian Burdekin, then Human Rights and Equal Opportunities Commissioner, opposed any increase in psychiatric treatments via de-institutionalization, as it did not address inhumane treatments, but hid them via Community Treatment Orders. Modern psychiatry is an autocracy pervading all key spheres. Australia now is more **in need of a basic separation of state from psychiatry than religion**.

In 2006, NSW MP, Sylvia Hale wrote to me "In situations of extreme social distress, individuals are sometimes inappropriately and forcibly brought for psychiatric assessment and given psychiatric drugs, when addressing the pressing social issues they face would be far more productive than taking what can be an effectively punitive approach".

Such cases have soared due to wider ranging powers and influence of the psychiatric industry across states and territories. **Too many people are tortured relentlessly by heavy handed treatment until they perish**. The more overwhelmed they already are, the less overwhelm they can take.

The Commonwealth, in appointing Harvey Whiteford as an Associate Commissioner, to guide the Australian Productivity Commission's report, has

pre-empted highly partial (not impartial and objective) outcomes. I also note the report copiously regurgitated prior aims by the psychiatric industry in earlier National Mental Health Strategy, such as aims to have mandatory psychiatric screening for infants of parents on welfare and then apply it on all Australian children.

Rightly, mandatory psychiatric screening of children from families on welfare was shouted down with outrage and dropped in 2015 (even the Australian Psychological Association opposed the mandatory screening). The National Mental Health Strategy itself reflects the psychiatric *industry* rather than being any reasonable independent investigation and conclusions about mental well-being.

Failures and Strained Budgets

On average, increased psychiatric intervention has had negative, not positive impacts. **During a period in which the number of Australians on psychiatric drugs rose seven-fold, those on pensions for psychiatric disability rose five-fold. Since 2011, ratio of suicides recorded as related to antidepressants has more than doubled.**

Despite a plethora of motions for more psychiatric intervention (on top of already greatly increased interventions) the report rightly noted: **“There is no evidence mental health treatment plans have improved mental health outcomes”** (pg. 21) and **“there has been no significant reduction in the death rate”** (suicides) pg. 14.

Suicide attempts by people on psychiatric drugs are more often violent and successful. Long term sexual dysfunction is a side effect contributing to suicide of young men.

In 1950 (right before widespread introduction of mind-bending drugs as a chemical straight jacket for psychosis and schizophrenia) rates of violent crime amongst schizophrenics was just below the national average. Now it is around ten times the national average (*Ref: National Mental Health, From Crisis to Community, 2006*). Both increased psychiatric drugs and street drugs in Australia are likely contributors.

Governments now largely regard mental stress and illness as a biochemical abnormality isolated from broader life. This has diverted much focus from improving social and economic conditions for the public (*Ref: Chapter 4,*

National Mental Health, From Crisis To Community, 2006). The Australian Productivity Commission's report grossly misses this point in **recommendations to facilitate job placements for the mentally ill, and housing, even for those who are not "housing ready"** and may rapidly destroy good housing stock.

These recommendations about housing would entail high end supervision and bureaucracy. They would also distract from broad preventative social supports outside the psychiatric system. A burgeoning psychiatric system has great scope to undermine government capacity to deliver the public broad preventative social supports.

Demand for a higher and higher ratio of psychiatric spending in the health system threatens to undermine Australia's basic system of universal health care (a point perhaps presciently outlined first in the *Public hearing Into Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder In Children and Adolescents, NSW MP David Clarke convened on 12 May 2009*).

Given the track record of the Medical Model of Mental Health in Australia, **recommendations for centrally co-ordinated treatment plans for the worst-off patients** are more likely to fix them in invasive treatments they will perish by than seamlessly integrate beneficial actions.

Recommendations to invent MBS items in which mental health professionals consult or indoctrinate family carers without consent and presence of the treated patient are unseemly. They would violate privacy and could distort value of centralized records.

In any case, as centralized records holding psychiatric diagnosis can invoke incumbent bias, and the psychiatric industry has such dirty hands, sharing of records between health and other professionals should only be at patient discretion.

The report urges **activity-based funding, not block funding to fit budgets**. Similarly, the **Rebuild Model of integrated funding** (pg. 46) is not justified on grounds of seamless integration of services between agencies and tiers of government. It is anti-democratic, being designed to restrain governments, including the newly elected, from changing entrenched funding to suit values of constituents.

Forced Treatments and Legal Disadvantage

Ironically, a **saving grace of the report** is indirect recognition that forced treatments harm, by noting the very common lack of legal representation greatly reduces the chances of legally overturning forced treatment (pg. 34).

Of all psychiatric treatments, forced treatments have the least positive outcomes. Yet, the mantra of Early Intervention by excessive diagnosis and drugging is a gateway into drug addiction and all too often, deteriorating long-term mental states that cause forced treatments.

This comment on forced treatments concerns NSW but largely reflects Australia:

“Involuntary patients are meant to receive minimal treatments but usually get far more. If a patient or their family protest, the patient is usually far too drugged for legal defense. The Mental health Tribunal is not a neutral court. It includes psych professionals. An ‘Authorized Person’ can even remove a patient’s right attend the tribunal and restrict them to video link-up, without any compelling reason. **Only around 3 patients in a 1,000 win a case”**

Ref: Serving Humanity, Interview with Rochelle Macredie, Human Rights Lawyer, The Subcontinent Voice October 2017.

Over 3 decades, Australian states and territories have kept changing mental health laws to give the psychiatric industry rising power at cost of patient’s rights. Since 1990, the ratio of Australians with post-traumatic stress and physical disability by invasive treatments (psychiatric detention, heavy drugs, ECT, etc.) has soared.

Mental patients contesting treatments no longer have equity under the law per the Universal Declaration on Human Rights. Unlike defendants to criminal charges, there are lower and lower standards of proof required for their forced treatment and detention (the trauma can be compared to that of jail and may be worse due to invasive treatments).

In some jurisdictions, it is enough that there is mere suspicion of mental illness, and increasingly, the judgement call is not by psychiatrists but by other personnel acting as mini psychiatrists on minimal training. In Victoria, two doctors can now have a child committed, without the consent of parents or court orders. Adolescents and families are being traumatized by Victoria’s policy to not routinely advise parents where children aged over 14 are held in

psychiatric detention. The secrecy also fosters abuse. Victoria has also side-stepped judicial scrutiny that the World Health Organization deems essential for electro convulsive therapy (ECT).

Further, since around 1990, gradual revamping of courts and tribunals to include psychiatrists and other mental health professionals sitting in judgement, permits conflicts of interests and violates a key legal principle of separating the judiciary and executive. It has cut neutrality of courts. The role of psychiatrists and other mental health professionals in legal decisions should be testimony only, not jurisprudence.

The [report proposed to shift scarce legal aid resources, to mental patients contesting treatments](#) (pg. 34). Restoration of reasonable equity under the law for mental patients across the states and territories, is a fundamental and preferred step.

The *UN Principles for Protection of Persons With mental Illness and the Improvement of Mental Health* prohibits forced treatments that can cause irreversible damage. Yet some 7,000 people (including minors) recently received ECT in NSW within a year, many without consent. The World Health Organization urges ECT be banned on minors.

We vigorously defend rights regarding gender and sexual orientation with great sensitivity, while rights of mental patients (a growing portion of our community) are flouted wholesale, with little protest. Arguably, given ferocity of most forced treatments, mental patients are now the group suffering the cruelest discrimination.

The UN Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatments presented a report advocating all nations “impose an absolute ban on all forced and non-consensual interventions against persons with disabilities, including the non-consensual administration of electroshock and mind-altering drugs, both for long and short-term application”.

There are now calls for a Royal Commission into suicides in the military. Correlating with broad introduction of psychiatric diagnosis and drugs into the military, [Australian soldiers, are now far more likely to die by suicide](#) than directly due to active duties.

The Penal System

Court verdicts around the world note a growing role of psychiatric drugs, especially antidepressants called SSRIs (Selective Serotonin Reuptake Inhibitors) in inducing violent outbursts and random murder sprees. They have cost lives of many, even students at their desks. The first trial for fluoxetine (Prozac) was aborted at South Carolina University. Two subjects, with no history of violence, went violently psychotic. Yet, the US and **Australian governments have ignored calls for a national data base of street and psychiatric drug histories in all cases of extremely violent crime.**

By increased impact of psychiatry on the justice system, a rising number of prisoners now receive SSRIs, with little thought about the synergy of giving these drugs to people who already have a violent background. I have been advised in confidence that doctors who would be whistle-blowers in privatized jails are threatened with sacking. So, **we have raised the odds of random violence against the public anywhere, at any time. Psychiatric drugs also increasingly accelerate domestic violence.**

Psychiatrists weakened legal protections for the public at large by lobbying to extend scope of persons who have committed criminal violence, to plead insanity. Deterrence is vital. Urge to act on a dark impulse can hang by a thread.

Psychiatrists/psychologists have not been shown more than other people, to be able to predict danger of people to self or others. For public safety, the scope to plead insanity should be reduced. Currently, the more horrendous the crime, the more likely an insanity plea. The perpetrator is then likely to be released into the community early by psychiatrists (as no minimum judicial sentence is set). Only they will be on psychiatric drugs, which at the very least are likely to cause or exacerbate an addiction problem. The drugs themselves can also cause or exacerbate further risk of violence.

If Mon Haron Manis (perpetrator of the Lindt Café siege, Sydney) had survived police storming of the café, it is likely lawyers would have advised he plead insanity. He was already a failed product of both our psychiatric and justice systems.

In stunning hypocrisy, Victoria called for set penalties for people who assault police and ambulance staff regardless of drugs or mental state (whilst regarding any other and horrendous crime excusable on accepted pleas of insanity).

Global studies show nutritional upgrades and supplements improve social behavior in jails far more than psychiatric drugs. The Criminon Program in Indonesia aims to restore personal pride, ethics and survival considerations. **It reduces recidivism well over 90 percent** (it was also very successful on child soldiers in Rwanda).

Psychiatric Diagnosis

A highly subjective Medical Model of Mental Health increasingly pathologizing human behavior, sets psychiatric diagnosis. It now seeks to pathologize even spiritual crisis and negative but normal reaction to social and economic stresses including injustice. Prof. Allen Francis, chief convener of American Psychiatric Association's Diagnostic and Statistical Manual IV, has slammed quantum leaps in version V as an extreme and ridiculous, diagnostic catch-all.

A century ago, psychiatrists deemed 1 to 2% of people mentally ill. Recent assumptions of 25% is far more likely to be from vested interests in a growing mental health **industry** with highly subjective and wide-ranging diagnostic labels than Mankind having just made great discovery in human nature (insanity and neurosis occurred in ancient times). Steven Sharfstein, former President of the American Psychiatric Association, conceded there is no definitive laboratory test for "chemical imbalances" allegedly linked to genetically based depression.

Collections of mental symptoms or behaviors are set as diseases by a process of voting of attendees at psychiatric conferences on the day, **not scientific analysis**. The process can be highly politicised. So, homosexuality was voted out of the DSM as a mental illness, but arguably over-representation of men on the day let premenstrual tension in. *Drug companies sponsor most voting psychiatrists*, then produce drugs to be paired with the new mental illnesses. Attendees at voting conferences have noted a very significant laziness and lack of professionalism.

Australian, like American doctors and psychiatrists mostly use the DSM. The United Nation's International Classification of Diseases (ICD) Version 11, contains some of the excesses of diagnosis typical to the interests of Big Pharma and Big Med but its assessment of deemed mental disorders is more sensible than the DSM.

The report advocates potential patients, psychiatric carers and a variety of health, social and law enforcement professionals be given increased psychiatric

dogma in training and online information/counselling. This is a gateway to more initiation and acceptance of dubious psychiatric diagnosis and drugging.

In terms of mental well-being, our professionals and bureaucrats have been looking at wrong sources, especially to the US, a declining nation.

The decline is in part due to the profound levels in which the US population has been progressively disabled over 4 decades by excessive navel-gazing, over-medication and acceptance of recreational drugs, not just forces of international competition. **Over-medication, including by psychiatric drugs, is now acknowledged as a factor in recent decline of at least 3 years in life expectancy of today's young white Americans** (after centuries of steady rise in lifespan). When America coughs, Australia sneezes.

Astroturf and Psychiatric PR

Lobbyists with major monetary ties to drug companies e.g. Psychiatric Professor, Patrick McGorry, form the "Independent" Mental Health Reform Group. It is anything but. Drug companies have sponsored his mental health youth program, Orygen.

To his credit Patrick McGorry has declared fatty acids in fish oil help mental well-being. But he was censured for endorsing neuroleptic drugs for adolescents on a basis of *anticipated* psychosis mostly not going to occur (*Ref New Dawn Magazine: The Brave New World of Pre-Drugging Kids: Patrick McGorry & Psychosis Risk Syndrome, by Jan Eastgate, President of Citizens Commission on Human Rights International*).

Australia's psychiatric industry has a "warm, fuzzy" image. It sponsors (largely funds and controls) "consumer" groups such as SANE and the Schizophrenia Fellowship as pseudo grassroots or "Astroturf". PR firms have technology to do thousands of letters and calls, convincing key politicians of wide public support for their angle. (*Ref: Pharmaceutical Industry Agenda Setting in Mental Health Policies by Richard Gosden and Sharon Bedder, Ethical Human Sciences and Services 3(3) Fall/Winter 2001*).

The system frequently hand picks patients propitiating to it, or families ignorant of the real or long-term side effects of psychiatric treatments, to be advocates.

Nobel prize winner, John Nash, slammed the pro psychiatric stance, in the film on his life, Beautiful Mind, saying that **not** taking drugs helped him recover from schizophrenia.

The Australian Productivity Commission's report has strongly relied on and quoted Astroturf rather than independent groups consistently promoting patients' rights. The relatively few such recent groups in Australia include Inside Out, Alternatives Melbourne, the Citizens' Commission on Human Rights and the Do No Harm Movement.

Acute Mental Symptoms

Psychiatric drugs (like street drugs) initially flatten symptoms of mental disorientation and distress by toxic brain function, the very mechanism that usually worsens prognosis long term. Like street drugs, they can also flatten empathy (relevant to drug induced killings) and often (paradoxically) flatten emotions integral to enjoying and finding meaning in life.

Antidepressants

Meta-analysis finished at the University of Pennsylvania in 2009 (involving all relevant published and unpublished trials) found **on average, antidepressants work no better than placebo**. For mildly depressed people (now the key market) results were distinctly negative.

SSRI antidepressants have Black Warning boxes, noting raised risk of suicide especially in children and teenagers. They also cause malnutrition and neurological damage. Professor of Psychiatry, David Healey (author of *Pharmageddon, and Let Them Eat Prozac*) found depressed people do not necessarily have low serotonin. But SSRI drugs eventually erode capacity of the brain to store it.

Adverse reactions reported to the Australian Therapeutic Goods Administration more than doubled in a 7-year period.

We now know intake of antidepressants in utero curbs foetal intake of oxygen plus foetal weight and development, while raising risk of autism. But, suddenly stopping anti-depressants can cause rebound effects of flu-like symptoms, nausea, headache, fatigue, intense anxiety and irritability.

Neuroleptic Drugs

Neuroleptics (often called anti-psychotic drugs) raise risk of breast cancer nine-fold. They cause osteoporosis, serious dental decay, liver damage and irreversible neurological damage. It involves an agonizing nervous irritation and resembles cerebral palsy. Neuroleptic tolerance causes symptoms indistinguishable from schizophrenia. Long-term intake strongly relates to persistent mental dysfunction (per papers the International Neuropsychological Association holds).

Side effects are so bad they cause suicide. Over 100,000 Americans have died of Neuroleptic Malignant Syndrome (it induces fever, rigidity and heart failure). Newer “atypical “ neuroleptics affect motor co-ordination less, but may be more dangerous overall, due to a steep rise in diabetes and marked propensity to blood clots, cardiac arrhythmia, seizures, hormonal disturbance, heat stroke, blindness, extreme anxiety or restlessness, etc in users, and birth defects in their children (it may be many decades before we know all long-term effects).

Elder Abuse

Increasingly, psychiatric drugs dumb down elderly patients, reducing reliance on personal care. Increasingly, natural ageing is deemed mental illness. **Half of all Australians over age 75 take psychotropic drugs.**

Some of the drugs cause neurological damage making swallowing hard and eating more difficult, unpleasant and risky for the elderly (by increasing aspiration of particles to lungs). Many of the drugs already cut appetite. Patients may begin to avoid eating, then loose immunities due to malnutrition, and so be prone to infection and slow healing. When aspiration of any food particles occurs with any further eating, pneumonia is more likely.

This slow, torturous form of “euthanasia” belies calls in the Australian Productivity Commission’s report for more psychiatric presence in nursing homes, especially given **recent Commonwealth refusal to release details of institutional abuse and neglect of elders.**

In 1993, Calare Nursing Home in Orange ditched all psychiatric drugs. Only one patient got allowed sleeping pills. Patient and staff morale surged. There were less fractures by falls. There’s growing evidence, including research by the Brain and Mind Centre of the University of Sydney, that art appreciation, music and dance reduces memory loss and social dysfunction of dementia.

Aluminium deposits in the brain is a factor in dementia. Health benefits would likely offset cost of banning aluminium as a cheap preservative in flu shots and other vaccines the elderly receive. We could also ban or restrict aluminium in cookware and deodorants.

Psychology

Even intense psychological counselling (without drugs) is sometimes suspect, due to introversion low self-esteem by formal evaluations and normal reactions being over pathologized (first noted in a large-scale Canadian study by Cunningham, 1957). Thousands of counselled children fared worse in maturity than a control group. A recent study found burns victims took longer to recover if counselled. A key schism exists between psychologists wary of psychiatric drugs that may follow a psychiatric or mental health diagnosis, and psychologists as a gateway for prescription of harmful and addictive psychiatric drugs.

Substance Abuse

Street drugs create fodder for the psychiatric industry. Injecting rooms give a wrong social message. Specific ingredients from cannabis may have limited and special medical applications that broadly exclude the tetra hydro cannabinols giving a "high". A cannabis *industry* is sponsoring its own studies and rhetoric as tobacco companies did in the 1950s.

Arguments about injecting rooms sending users to rehabilitation are hollow. It happens in few cases and most psychiatric "detoxifications" and treatments in Australia rely heavily on more drugs. Pouring Valium over the top is only a start. Methadone often prompts use of "speed" to overcome a "downer" effect. Methadone is usually harder to stop than heroin. The withdrawal phase is longer. Addicts may be on Methadone 20 or more years. Various other psychiatric drugs and cocktails are harder to stop than heroin.

Small scale trafficking ("Ant Trade") mushroomed by paltry penalties introduced across Australia in the 1990's for possessing a smallish but saleable quantity of cannabis plants. Stiffening penalties for use and possession would be better than having more and more youth in mental wards. Cannabis gives 3 to 4 times the risk of serious dependency or mental illness than alcohol and is a gateway to other street drugs. It must not be equated with alcohol (*Ref: Marijuana, An Australian Crisis, by Elaine Walters*).

We should review Australian public education on drugs. It largely white-washes serious long-term effects of street drugs and over describes signs of being doped or “high”. Sweden is much more successful than us, having a kind of Zero Tolerance policy with stiffer penalties, franker public education and more incentives for drug free rehabilitation. But Sweden struggles with the compromise of aiding syringe disposal. Our per capita use of street drugs exceeds theirs least three times (and our use of Ice is rising 30 percent pa).

Harm Minimization has become a cash cow for researchers and allied professionals absorbed in the growing complexities of drug addiction that aspects of Harm Minimization may fact contribute to.

Ironically, the Greens hold Portugal as an ideal, despite far more drug use than Sweden, and descent into economic and social backwaters. In the 1980’s Portugal made possession of all street drugs for usage up to 10 days quasi legal. The total drug related deaths and drug related sexual disease soared. In any case, Australia’s contemporary crisis in child protection is an aspect showing use of street drugs is very far from “victimless crime”.

Recent Harm Minimization in the US has escalated use of street drugs and related deaths and overdoses both rose by at least 30 percent in one year. Holland never fully legalized cannabis. Wary of today’s more potent plant breeds, is rapidly closing cannabis cafes.

We should broadly examine Narconon, the most successful global drug rehabilitation program. It is drug free after any initial scaling down of drugs. It uses tailored dietary supplements, and special processes to naturally extrovert from pain and disturbance of withdrawal. It then uses the world’s strongest detoxification regime, to drag drug residues from fat cells and break physical addiction (New York funded the detoxification stage for 9/11 firefighters, just to heal physical harm from fumes). Narconon is quite successful from Spain, Italy and Sweden to Nepal, etc. It radically changed Mexico’s Ensenada maximum security prison when used there.

American research shows a strong link between hard drinking and advertising. Australian youngsters receive double advertising of alcohol to a generation ago. Lock out laws restrict night life but surely aid health and public safety. More regulation of alcohol is in the public interest.

The report fails to recognize the role psychiatric drugs themselves play in addiction. Typically, tolerance and symptoms of withdrawal on stopping them

are deemed return or progression of underlying mental illness and result in increased dosages, adding or switching drugs. Patients can end up 8 or more psychotropic drugs despite interactions and toxicity.

Professional denial of the incidence and extent of the quality of addictiveness in psychiatric drugs is rampant. Historically, morphine and cocaine were “non-addictive” cures for opium, heroin was a “non-addictive” cure for morphine. Methadone was a “non-addictive” cure for heroin.

How wrong the good doctors were. Many psychiatrists and general practitioners today, don't even seem to read and advise patients of withdrawal symptoms of psychiatric drugs, clearly noted in Consumer Information Sheets.

Drugs, Mental Health and the Workplace

A difficulty with the report's **recommendations for more introduction of psychiatric practices into the workplace, including in health and safety**, is raising numbers of staff on psychiatric drugs and/or who are introverted or seek financial gain based on diagnostic labels. These staff may strain production lines and colleagues. Close to the ultimate horror was the Germanwings incident in which a pilot (despite or even due to antidepressants) plunged himself and over 200 travellers to their deaths.

Cannabis, other street drugs, and even psychiatric drugs themselves, can all pose a workplace health and safety issue by causing gradual and significant deterioration of personality, mood, perception and performance, not just by direct effects of acute intoxication. One aspect is the physical and psychological addiction.

Impacts of this deterioration on colleagues and supervisors sometimes constitutes a “work injury” per legal definitions. At the very least, it makes work unpleasant and difficult in today's highly competitive global economy, in which Australia is falling behind.

It is noted that over 300,000 people in the US now suffer permanent motor damage to the brain due to psychiatric drugs, which greatly effects quality of life and employability.

I once had to personally escort a disturbed employee off a work site as he spoke of suicide and said: “I'd like to take someone with me!” Calling police may have exacerbated the situation as he was paranoid about them. His medication and years of psychotherapy (apparently ordered by his

psychologist mother) was a failure. My company has also had staff not reporting intake of psychiatric drugs that impair use of heavy machinery and driving.

Separately, there is strong evidence mental illness is now used frequently as a cash cow and to “settle scores” in workplaces, a point experienced law firms note, including Pryor, Tzannes and Wallis (who have consulted for the Printing Industries Association).

Once one of my staff failed to give a medical certificate validating carer’s leave per company policy. On query, he said *“You know how important mental health is in the workplace now and I feel stressed so I’m going home”*.

Arguably, it was a spiteful try to milk the system. Increasingly I hear similar reports by other businesses. Such behavior insults staff who shoulder the work of non-performers and/or who have genuinely suffered work related trauma (physical and mental) e.g. in policing and firefighting.

Claims for work based mental illness due to “adverse reactions” related to discrimination on disability grounds (including original mental illness) and race etc, are growing at around 30 percent pa. It is clearly not sustainable, yet the **report further aims to increase burden on employers by higher workers’ compensation premiums** to allow yet more spending on leave and psychiatric treatment for work-based mental injury or illness.

There is also inherent unfairness in the current legal structure for compensation claims against employers based on these “adverse reactions” in that under state and federal anti-discrimination laws, **onus sits on employers to show their innocence**, even in those rare occasions where criminal sanctions apply! Arguably the reversal of onus is unconstitutional but testing it in the High Court of Australia may require millions of dollars.

Australian manufacturing is in crisis while retail and most other sectors perform poorly. The potential for further over regulation and restrictions on employers is to bury further businesses. especially small businesses (Australia’s main employers).

The optimistic note of the report’s proposed co-opting of workplaces for mental health purposes with assumed benefits to Australia and employers, is unjustified and contradicts the broad track record of psychiatric outcomes.

Undoubtedly employment boosts sense of mental well-being of the vast majority who can work. But, the rate of Australians now on psychiatric

disability pensions, introversion from psychiatric diagnoses and the known effects of long-term usage of psychiatric drugs firmly warns against the Australian Productivity Commission's broad approach.

Dodgy Approvals, Prescriptions and Monitoring

Prescribing psychiatric drugs outside guidelines for cohorts and conditions the Australian Therapeutic Goods Administration and drug manufacturers set, is called off-label prescription. Given potency of side effects of psychiatric drugs and psychiatry is the least objective branch of medicine, off-label prescription of psychiatric drugs should be banned outside proper clinical trials.

Currently, Australian children under 18 are being given anti-depressants, and Australian children under 6, stimulant drugs, in off-label medical prescription outside the officially accepted age groups. This off-label prescription has been linked to strokes and deaths in young children.

Drug induced psychosis and suicidal ideation due to use of anti-depressants is more prevalent in users under age 24, and especially under 18 (yet **some 5,000 scripts for anti-depressants were recently written this way for Australian children under 4 within a year**). Shamefully, rather than foster accountability, the Commonwealth Department of Health **is no longer releasing dedicated figures for off-label prescription of children under 6** since 2015.

Three-quarters of clinical trials on psychiatric drugs are not published. Overwhelmingly, these are ones with negative results. Trials of psychiatric drugs are typically sponsored by their manufacturers, not independent. They now involve as little as 6 weeks use on individuals.

The Australian Therapeutic Goods Administration (TGA) greatly tends to rubber stamp approvals of the US Food and Drug Administration though arguably that body is corrupted by fast tracking schemes and political donations by large drug companies. The TGA admits adverse reactions to psychiatric drugs in Australia may be seriously under reported and is not systematic. The vast majority, even of serious cases, is unreported.

There should be mandatory reporting to the TGA for adverse reactions to psychiatric drugs, especially when taken by vulnerable cohorts e.g. children (it is mandatory for health and allied professionals report possible sexual abuse of children).

Contemporary “reform” to prescription practices for psychiatric drugs means they are now routinely prescribed for at least 6 months even when originated to handle a specific crisis. This period is generally enough to ensure addiction and withdrawal symptoms.

Doctors and psychiatrists very commonly increase risks of toxicity and drug interactions by carelessly or unknowingly prescribing psychiatric drugs over the top of street drugs.

Children, And Attention Deficit (Hyperactivity) Disorder

Child diet has declined in terms of nutritional balance. Kaiser Permanente, largest managed healthcare provider of the US advocates people eat organically where possible and avoid GM foods totally.

We have largely ignored detailed findings of psychologist, Steve Biddulph that long hours of separation from primary carers in infancy is very detrimental to child mental states.

The recent four-fold rise in just 2 decades in the ratio of Australian children with allergies is a compelling evidence of our toxic environment, including record levels in medicating children. The ratio of children with other chronic health issues is also rising.

Especially since 1990, we have subjected children to a massive and failing pharmacological experiment. Prescriptions have risen and continue to rise dramatically. An example is the **34-fold rise in prescription of stimulant drugs for ADHD in children and adolescents between 1985 and 2000. Between 2007 and 2008, NSW still had a 79 percent increase** in such prescriptions. In 2017, **over 100,000 Australian children under age 17 took antidepressants.**

Many children can be spared inattentiveness and later drugging by exercises to strengthen neurological connections, restoring nutritional balances and even resuming strong focus on phonics in learning to read. I spared a daughter the indignity of recommended assessment for mental disorder, by getting a phonics tutor.

Children are being stressed and made dizzy by curricula too extensive and frequently lacking practical application to balance theory, along with enough time and focus to code break basic meanings of words and technical terms. The High School Certificate is deemed a Be All and End and End All of life, while our system of TAFE (practical colleges of Technical and Further Education) has

been largely dismantled, so dismantling the dream of many students for useful education, and jobs.

ADHD is at best a blanket term, at worst total fraud. The psychiatric industry falsely presents it as a concrete medical disorder as diabetes and Downs Syndrome are. ADHD is simply a construct of a set of behaviors undesired. They can signal underlying physical illnesses and even one high sugar meal can substantially alter test scores.

Very bright, socially non-conformist children are also disproportionately deemed ADHD. Australian author, John Marsden has noted it puts us at risk of losing many of our creatives such as actors, novelists, circus performers and scientists (Einstein was originally an inattentive student).

Subjective marking from scales of 1 to 10, occurs rather in the style by which teachers mark essays. The current American Psychiatric Association's Diagnostic and Statistical Manual (version V) dropped the number of arbitrary traits and level of test scores for diagnosis. **Children not "ADHD" 5 years ago now are.** It is psychiatric ambition not science.

There is a higher rate of female teachers in schools than decades ago. Even subjects such as physics have been "feminised" with essay tasks demanding language skills. Evidence suggests boys relate best to male teachers. Boys are deemed ADHD at 3-4 times the rate of girls, indicating inadequate tolerance of the nature of boys, who often need more "hands on" and less theoretical learning. If girls were diagnosed at 3-4 times the rate of boys, there would be cries of sexism. Studies note youngest children in classes are twice as likely to be diagnosed.

Rising diagnosis of "ADHD" partly relates to more tired children, fed fast food and rising obesity (obese children are diagnosed more often). Some families get home well after 6pm (especially in Sydney and Melbourne) causing late nights, rush for food and anxiety over homework (given in increasing amounts and often done by parents).

Once again, these aspects indicate physical and social determinants dismissing true scientific basis for ADHD. Calling red spots on a child's body Spotus Rubicus would not make them a real medical condition. The spots may exist due to causes ranging from insect bites and allergies to measles or skin painting. There is no consistent difference in brain scans in children deemed

ADHD, that allows for effects of underlying physical disease and medications on the brain.

Prescription can be a racket. In 2011, [a single psychiatrist in WA wrote 1,473 scripts for stimulants to treat ADHD](#). An enquiry in WA found 75 percent of children labelled ADHD either had nothing wrong or physical illness caused inattentiveness.

Draft National Clinical Practice Points for ADHD (2010) were not ratified due to controversy over subjectivity of ADHD and downplay of natural remedies along with rigid focus on drugs (yet natural remedies pose far less risk). These factors were attributed to conflicts of interests of key authors and researchers with ties to drug companies, and to an extent, exclusion of a balanced panel of practitioners with leaders in natural medicine (failure of the highly quoted US psychiatrist, Dr Joseph Biederman to disclose \$1.6 million US in drug company money received in one year, was a criminal offence under American law).

These inadequacies reflect [ongoing bias in the National Medical and Health Research Council of Australia. It sits very uneasily with recommendation of giving it statutory authority and a new role in data collection and evaluations in mental health.](#)

The Clinical Practice Points still conceded ADHD is “a description rather than an explanation” of behaviors for which there is no single known cause (pg. 10) and no long-term benefit is established for stimulant drugs in terms of academic, emotional, behavioural or social outcomes (pg. 11). The Clinical Practice Points also noted children deemed ADHD had twice the normal rate of physical disorders.

The related Draft National Guidelines specifically noted higher rates of diagnosis for ADHD in cases of prenatal exposure to liquor and nicotine, head or brain injury, obesity, low birth weight, thyroid deficiency and antenatal exposure to toxins such as lead, mercury, manganese and PCB compounds. They also noted children deemed ADHD far high rates of sleep disorders, kidney malfunction, epilepsy, hyperglycaemia and endocrine imbalance etc.

Some children are on ADHD drugs despite undetected distractions of asthma, allergies, poor sight, glue ear, color blindness, nutritional/dietary imbalances, allergies, excessive levels of aluminium and even ongoing sexual abuse. Cost to eliminate aluminium as a cheap preservative in vaccines would likely be

offset by prevention of leaky gut syndrome linked to aluminium, and which draws the ADHD label.

It is not new data that drugs for ADHD in children and adolescents is unfounded. Meta-analysis of 2287 studies of 16 ADHD drugs (virtually all trials done by 2005) found none had shown their benefit for social or academic results or curbing risky behavior (*ref: Evidence Based Practice Centre of Oregon Health and Science University, 2005*).

The Raine Study (WA) found effects of drugging children for “Attention Deficit Hyperactivity Disorder” are very substantially negative for physical health, mental well-being and academic and social outcomes. The largest single study ever on child given stimulants for “ADHD” found they stunted growth but gave no improvement in behavior or academic outcomes whatsoever long-term (*The Multi Modal Treatment Study For Children With ADHD, released January 2009*).

Ironically, **stimulants used for ADHD which should improve mental functioning cause brain atrophy if used long-term** (seen in some 40 studies) and arterio-sclerosis. Children are dying but we do not fully know ultimate effects on survivors in maturity. Some of the drugs cause psychosis in 10% of children. Many become permanent mental patients. (*Ref: The Real Crisis In Mental Health Today. Report And Recommendations On The lack of Science And Results Within The Mental Health Industry by Drs Julian Whitaker, Anthony Urbanek, Mary Jo pagel and Rohit Adi*).

Very shamefully, **soaring use of stimulants on children for “ADHD’ has continued even since 2005, when the United Nations censured Australia’s high use** despite “growing evidence of the damage these drugs cause” (*Ref: 40th Session, Australian Section, United Nations Committee on the Rights of the Child, 30 September 2005*).

The “Consumer Medicine Information” sheet on Ritalin says:

“Tell your doctor if you notice any of the following and they worry you: nausea (feeling sick) vomiting or stomach pain, loss of appetite, loss of weight and slower growth in children, feeling nervous and unable to sleep, dry mouth, headache, drowsiness, dizziness, mood changes such as depression or irritability, blurred vision or problems focusing your eyes, muscles cramps, hair loss”

“Tell your doctor immediately or go to the Accident and Emergency at your nearest hospital if you notice any of the following: signs of allergy such as swelling of the face, lips or tongue, shortness of breath, wheezing or troubled breathing. Rash, itching, red blotches, blisters or peeling of the skin. Sudden increase in body temperature, fast heart-beat, muscle stiffness and fluctuating blood pressure, which may lead to coma. Constant “flu-like” symptoms such as chills, fever, sore throats, swollen glands, aching muscles or joints. Unusual bleeding or bruising. Unusual tiredness, shortness of breath when exercising, dizziness, pale skin. Uncontrolled twitching, jerking or writhing movements. Seizures (fits) or unexplained fainting. Pain or tightness in the chest. Fast or irregular heart-beat. Changes in blood pressure. Yellow color to the skin or eyes, dark colored urine or light colored bowel motions. Confusion, delusions, or hallucinations (seeing or feeling things that are not really there). Excitement or overactivity and uninhibited behavior. New or worsening aggressive behavior. Severe or persistent headache. The above side effects may be serious. You may need urgent medical attention.”

Other amphetamine-style stimulants used for “ADHD” have similar chemical basis to Ritalin. Ironically, some newer drugs for ADHD are *depressants* such as Strattera (belying neat theories of chemical imbalance). Its Consumer Information Sheet warns of *these possible side effects “thought or talk of death or suicide; thoughts or talk of self-harm or harm to others; attempts to commit suicide”*.

I note details of *Consumer Information Sheets* for 3 drugs given for physical conditions. They are Diabex and Diamcron (for blood glucose) and Avapro for blood pressure. Avapro can *curb appetite* but these drugs do not cause *suicidal thoughts or attempts, anxiety and panic attacks, hostility and impulsiveness, insomnia, hallucinations, raised blood pressure, fits or nausea*. However, *all of the following drugs our children receive for ADHD or depression have 4 or more of the foregoing side effects noted in italics: Exefor-Xr, Lexapro, Prozac, Lovan, Ritalin LA, Strattera and Zoloft*. It is shocking given the prescription is based on subjective interpretations.

In Australia, a third of prescribed stimulants become street drugs, separate to patients experimenting (changing dosage to stimulate or sedate). Science writer, Robert Whitaker, notes “What we have after years of soaring use of psychotropic drugs is a crisis in mental health, an epidemic of mental illness among children. *Instead of seeing better mental health with ever more medicating, we see a worsening of mental health*” (the trend also endangers

children by preventing or delaying detection of real illnesses and social situations).

Certainly, my son in law attributes descent into amphetamines and heroin to originally tinkering his prescribed Ritalin. A parliamentary enquiry confirmed an exceptionally large cohort of children prescribed stimulants for ADHD in WA in the 1990's gave rise to Australia's first amphetamine epidemic.

One half of all Australian children in foster care are now on psychiatric drugs. We are behind Kazakhstan. It has banned psychiatric drugs for children in foster care unless ordered by court. Statistics also show our postcodes closely correlate with drugging for ADHD (**it can be 10 times more in some post codes**). Prescription is especially dramatic even after comparison with other phenomena linked to disadvantage, physical disease included.

Despite this already profound discrimination against our poorest children, the Australian Productivity Commission's report would accentuate it by having psychiatric screening added to the Healthy Kids Check for children aged 0 to 3 (a physical check mandatory for children of parents on welfare) on the basis of a single un-replicated study.

It has been seen everywhere from Eastern Europe to Chile that any broad psychiatric screening of children increases psychiatric diagnosis and dangerous drugging. Our poorest children would be the main targets. There are more drug free options for children from the wealthiest families.

For 2 years the NZ government denied mother and academic, Maria Bradshaw, medical data noting her son's anti-depressant probably caused his violent suicide. At the *Mental health in Crisis Australian and NZ Tour* (Sydney, 24 February 2018) she said "*The recent NZ Suicide Mortality Review found that in not one of some 1,300 cases was anyone granted equal collaboration with clinicians. If things weren't going well, clinicians did more of the same. They're killing our kids*". Guests and speakers included dissenting general practitioners, psychiatric nurses, psychologists, psychiatrists, patients and family carers. They noted similar rigidity in Australia's broad psychiatric approach. Maria has written various papers condemning the Medical Model of Mental Health.

Further, useful psychiatric diagnosis of children at the tender age from 0 to 3 is virtually impossible, and indistinguishable from disturbance caused by underlying physical illness. Infants agitated by underlying health issues are less able than adults to internalize emotions.

Risk of pathologizing normal behavior such as irregular feeding, not sleeping, sleeping with lights on, whining, crying, temper tantrums, and even shyness is very substantial. It will certainly facilitate child abuse unless national laws ban psychotropic drugging of children under 3. Such legislation is especially vital if there is to be no specific legislation to outlaw off-label prescription of such drugs to children.

Some states in the US have passed laws to restore schools as neutral places of education, without screening, “identification” and pressure to explore or accept psychiatric counselling, diagnosis and drugging. In Australia, the pressure largely relates to vested interest in extra funding given for children with mental illness as “disability”.

This corruption urgently requires general review of funding systems for education. It is also a substantial source of loss of morale and rising resignations amongst dissenting teachers (some of our very best).

Parents are also lured or pressured into accepting psychiatric diagnosis for ADHD and mental illness by increased welfare money when children have a label of psychiatric disability, and they hope it gets their children more personal attention in school and auxiliary services as their child is then “special needs”. But risk of dangerous drugs being given, and loss of a child’s self-esteem can outweigh benefits.

Yet the report (pg.16) **recommends increased incentivization of families and carers of those deemed mentally ill.** This is largely bribery given the highly subjective nature of most diagnosed mental illness. But it is true mental states can be more variable than some physical conditions, so give psychiatric carers uncertainty.

Even without **proposed wholesale introduction of teachers in schools and creches to monitor mental well-being and make psychiatric referrals** (at an estimate of up to \$660 million pa. in public schools and \$975 million in private) there is enough psychiatric interference in choices of educational styles and ethos parents are entitled to seek, that Australia now substantially violates the UN Convention on the Rights of The Child.

Freedom to seek spiritual paths and practice a set religion and freedom of conscience, may also be at risk under further proposed domination of the Medical Model of mental health. Reasonable autonomy of the Family is at grave risk. **It is simply unacceptable in democracy.**

Physical Conditions

There is a big silo due to psychiatrists lacking experience in practice of general physical medicine though they have starting qualifications as general medical practitioners. In any case, there is severe deficit in dietary/nutritional training in university curricula for medical practitioners. There is some evidence psychiatry is a preferred option for medical students who barely pass general medicine. When Latin was dropped in the 1960's as a requirement in medicine, it got harder to code crack and grasp terms in biology and chemistry.

Global studies show **around half of those in the psychiatric system simply should not be there**, as untreated, undetected illness is the root cause of their mental symptoms e.g. depression/psychosis from nutritional/dietary imbalances, thyroid collapse, cancer and early onset of diabetes.

Psychiatric intervention (including neuroleptic drugs and ECT) increasingly delays detection of serious or life-threatening illnesses, so can have tragic results. I have personally noted it in cases of tumors, hepatitis, and thyroid malfunction.

In one study, 83 percent of psychiatric patients had undetected physical ailments, e.g. diabetes, causing their mental state. Another study found it true in 42 percent of psychotics. Mental symptoms are the first sign in 76 percent of some cancers. *Ref: Dr David Sternberg, M.D., "Testing For Physical Illnesses in Psychiatric Patients", Journal of Clinical Psychiatry, Vol. 47, No. 1 Jan 1986, Supplement, pg 5: Dr Richard C. Hall, M.D. et al, "Physical Illness Presenting As Psychiatric Disease" Archives of General Psychiatry, Vol. 35, Nov 1987, pp. 1315-16.*

Sane Australia has suggested 90 percent of mental patients have untreated physical illness at the heart of mental symptoms. Increasing expenditure in the psychiatric sector (already after 3 decades of psychiatric spending rising out of proportion to general health budgets across all tiers of government) will not handle this basic issue.

The report partly justifies greatly increasing the number of psychiatric nurses to facilitate more diagnosis and drugging, partly on a pretext they are the best bridge between the psychiatric and physical illness. In fact, a significant portion of underlying physical illnesses affecting mental states are picked up by practitioners of natural health though they receive no proper recognition when the report speaks of allied health professionals!

It is also **very discriminatory and unreasonable that the report recommends a plethora of new Medicare items for psychological/psychiatric services at expense of physical care.** An example is the report recommends Medicare funds up to 20 treatments by a psychologist pa. (current maximum is 10) when I may receive only 5 chiropractic adjustments or physiotherapy sessions in Medicare yearly.

Sadly, a one-time neighbour (who like me, suffered prolapse of disc material between his 4th and 5th lumbar vertebrae) could not afford chiropractic care so had an operation. It failed. Unable to endure the pain, he had a nervous collapse then killed himself upon finding his psychiatric drugs had bad side effects and his physical agony remained. That his outcome much different to mine was perhaps largely a synergy of economic disadvantage and a rapacious psychiatric system.

Studies show consumption of sugar and caffeine in children has soared and causes symptoms indistinguishable from "ADHD". Processed food in Australia and America commonly has trans fats Europe stringently regulates due to strong links to heart disease and depression (*Ref: The Happy Fat: Are We Eating Our Way into A Collective Depression? New Scientist 24 August 2002*). Lack of iodine is strongly linked to depression and a slow thyroid. Dieticians warn iodine shortage in the public is worsening. Iodine is added to table salt but not salt in commercial food. Today's excessive carbohydrates also cause fatigue and depression.

A common artificial sweetener (Food Addictive E 951) can cause lethargy, depression or panic attacks (*Ref: Excitoxins: The Taste That Kills, Dr Russel Blaycock, Neurosurgeon*).

Excessive use of electronic devices is linked to introversion, poor posture and insomnia plus less exercise and fresh air.

Electronic devices have steadily raised low-frequency radiation, yet safe limits are uncertain. The optimistic quote studies not using *pulsed* waves (integral to electronics and more potent). Increased depression and reduced thyroid malfunction are known impacts.

5th Generation (5G) electronic devices, further raise radiation output, plus give a slight shift to higher wave frequencies, meaning more impact to eyes and

skin. The new waves travel shorter so 1,000's of minute base stations must go on buildings and poles near people. Professor Girish Kumar, Electrical Engineering Department (Indian Institute of Technology Bombay) says:

“Along with the 5G, there is another thing coming - Internet of Things. If you look at it combined the radiation levels are going to increase tremendously yet the industry is very excited about it... They project 5G business to be a \$7 trillion business”

Hawaii discouraged 5G devices by mandating producers accept liability for health risks. The Australian Productivity Commission's report could have detailed ways for individuals and whole of society to curb radiation exposure but its key idea of “preventing” mental illness is psychiatric screening, diagnoses and drugging that can entrench it!

Perspective as A Carer

My mother had psychiatric treatment at Chelmsford Private Hospital and elsewhere. Queries about her steady deterioration (including severe neurological damage, drug-induced) were met by callous indifference. She possibly had Deep Sleep. My grandmother entered a nursing home with terminal emphysema and died in 6 months. I was not told until she died, she had received psychiatric drugs and ECT. She had no prior psychiatric diagnosis or treatments. Psychiatric treatments, denying the elderly dignity are rising.

White “Help” To Indigenous

Many indigenous people, especially elders, are sceptical of psychiatry as culturally alien and a purveyor of yet more addictive drugs on top of existing substance abuse. Arguably, the Australian Productivity Commission's **recommendation to have more indigenous mental health professionals treat indigenous patients** is more about increasing indigenous acceptance of the Medical Model of Mental Health, than respecting “cultural sensitivity” especially given implications in the report that indigenous people should be educated to prefer white constructs of mental illness.

Indigenous speakers have expressed concern that more indigenous children suffering lower attention spans due to Foetal Alcohol syndrome will be diagnosed and drugged as ADHD. Solutions to pressing social problems of indigenous people lie beyond narrow confines of catch-all diagnosis and drugging that underpins the Standard Medical Model of Mental Health. If

mandatory psychiatric screening is added to Healthy Kids Check (a physical check) for indigenous infants whose parents are on welfare, **we will have a new Stolen Generation.**

Since strict church missions left indigenous settlements in the 1970's, and advent of secular policy permissive to alcohol and street drugs, assaults there have generally soared, and single mothers battling on pensions replaced stable marriage. An ancient mindset of indigenous males deeming females are property, makes a toxic synergy with domestic violence.

Literacy and diet declined in settlements as missions left, and loss of modern hygiene created ghettos. A practical approach of hunter gatherers to hygiene (to simply keep moving to clean space) is now inapplicable. Complications of scabies cause kidney failure. Trachoma, another hygiene failure is still causing blindness.

Today's welfare ration cards have backfired by a synergy of humiliation and cutting market access. What in modern and traditional culture, indigenous people accept is very debatable.

Ironically, the social and economic Gap grew in some places because of a constantly shifting political careerism. It is one which pursues racial separatism yet formal reconciliation. This careerism replaced both forced assimilation and many long-term personal commitments (some religious missionaries would stay with one indigenous community 3 to 4 decades so really know them).

Rise of ECT Since 1990

Due to its reputation, many Australian public think it is banned. Yet national rates tripled in one decade. Australian children under 5 have had ECT!

“Positive” effects last for the 4 weeks subjects are stunned into euphoria by closed head injury. There is no reliable proof of later benefit. Severe confusion, bouts of terror, extreme physical pain and effects e.g. blinding headaches and urinary and faecal incontinence, are initially common.

The brain damage can spark epilepsy, and reduce memory, fine motor co-ordination, cognitive thinking and emotional intelligence. Key researcher on ECT, Harold Sackeim (Columbia University) confirmed a long-term study shows ECT causes permanent amnesia and cognitive loss (*Ref: Journal of Neuropsychopharmacology, January 2007*).

Human autopsies in 1942 first noted brain damage (especially pin-point haemorrhages). Most haemorrhaging is initial, but some is subsequent, due to pressure against the hard surface of the skull reinforcing acute swelling in a vicious cycle over several days.

ECT is typically in bouts of at least 8 times (patients are repeatedly knocked unconscious to receive equivalent of a grand mal epileptic seizure). Ongoing ECT can cause vegetative states. Rupture of the brain blood barrier affects intake of toxins and drugs (a wild card in later drug prescription, often ignored). Due to vascular damage, there is more risk of heart attack or stroke during and subsequent to ECT.

Electricity can be applied at 2,000 times the normal amount of electricity the brain uses. The brain is a delicate and complex organ not built to handle pressure and temperatures that literally melt fat in cells and cause lesions in its vessels (*Electroshock, Scientific, Ethical And Political Issues by psychiatrist, Peter Breggin, International Journal of Risk And Safety In Medicine 11, 1998 5-40 IOS Press*).

Full analysis of studies show ECT does not cut depression or suicide overall. Harm by ECT is partly permanent. It can motivate suicide. In view of the lack of scientific basis, doctors in Piedmont, Italy are not obliged to ever prescribe shock treatment.

A report says: "there is no definitive randomized evidence that ECT prevents suicide". It suggests letting patients make Advance Directives against ECT (*Use of Electroconvulsive Therapy (ECT) In New Zealand: A Review of Efficacy, Safety and Regulatory Control, December 2004*). Psychiatrists usually state deaths from ECT as 1 in 10,000 but relatively stringent requirements for recording outcomes of patients in Texas, indicate short-term risk of death is 1 in 200. ECT offers handsome returns to psychiatrists, who flick a switch with minimal effort and after a seizure occurs, walk off to let hospital staff control life supports.

After the US Food And Drug Administration recognizing ECT devices as experimental and of unproven efficacy for over 70 years, psychiatrists have urged the Administration to deem them a "Category Two" device, which would side-step routine requirements for "medical" devices to have proven and acceptable efficacy and safety (contact lenses are a Category Two).

Psychosurgery

Psychiatrists calling it “neurosurgery” imply equation with surgery for known disease e.g. tumors. Psychosurgery is typically crude action on healthy brain tissue.

Deep Brain Stimulation (DBS) does not involve removing pieces of brain but is still ablative. Electrodes are inserted to deliver the brain electricity above normal rates. Removing the electrodes also involves risk, and our autocratic psychiatric system **makes it unlikely a psychiatric patient can ever get electrodes removed**. The pacemaker alone is over \$16,000. DBS is experimental psychosurgery causing:

- Hypertension
- Vascular damage (heart attacks and strokes)
- Brain swelling and hemorrhages
- Epilepsy
- Breathing problems
- Insomnia
- Speech impediment
- Falls associated with loss of ability to balance
- Infection and other side effects from invasive surgery
- Side effects (coma and sudden death included) due to random change in modulation or positioning of electrodes
- Cognitive impairment, memory loss included
- Depression, suicidality, hallucinations, hyper-sexuality and mania

DBS, even for patients with advanced Parkinson’s disease, is a last resort. But mental effects seem considerably worse if done for psychiatric reasons, possibly in part due to synergy with mental states.

For basic human rights and dignity and to direct focus on humane and effective approaches, we must ban all psychosurgery (including DBS done for psychiatric reasons) along with ECT nationwide. They are failed treatments over failed treatments. Today’s high-tech versions of overwhelming patients resonate with the brutal 19th century asylums.

Some Broad Social Factors Affecting Mental Well Being

Many mothers want to work part-time but mainstream media demeans part time work for them, and public subsidy is biased towards full-time childcare. Arguably parents losing income due to having a baby should be allowed to use

superannuation savings to pay mortgages (home ownership is the single most useful material investment for most Australians).

Exorbitant pricing of real estate (buying and rent) is partly based on families having two parents working full time, due to the number of mothers now working full time. Yet when both parents work full time, cost to quality family time, rest and personal leisure (including any free roaming for a child on a basis of an adult being home) can cause families profound stress. Today's very short hospital stays after birth, and government acceptance of third wave feminism have also imposed pressure for over-performance by women that fuels post-natal stress and strains families.

American psychiatrist, Nancy Mullan, has also noted "There is a terrific plummet in hormones when giving birth which needs to be normalized. Blood sugar imbalances, nutrient deficiencies, low adrenal gland function, thyroid imbalance and copper and zinc deficiencies should all be tested for. The last thing you need is an antidepressant masking or messing with this."

The report does not address such underlying issues.

Mainstream media's over dramatization of doom and gloom is affecting morale of people of most ages, at the same time as governments have largely shifted focus from achieving the broad economic and social conditions that let the public thrive. Government now surrenders more to autocratic and bureaucratic approaches arising from vested interests. The Australian Productivity Commission's Report is solidly in this category.

Authentic involvement in almost any religion reduces divorce, crime and suicide rates, substance abuse, incidence of mental illness and unemployment rates. It is linked to more payment of tax, voluntary work and children raised by two parents. Social and economic outcomes for children raised by single parents is especially bad for boys.

However, the report does not suggest a greater involvement of chaplains and other religious representatives in creches, schools and workplaces (or promote them in life generally) but rather professionals with psychiatric or mental health training oriented towards "identification of" mental illness that would promote increased rates of psychiatric diagnosis and drugging.

Overseas students must pay higher fees than Australian residents, and usually for accommodation, as family is back home. The report's suggestion that they could be made to take private health cover on top of Medicare could raise their financial stress.

Green Mental Health and Workable Approaches

Green Mental Health (involving nutritional, natural, sustainable and non-toxic remedies) is far more sustainable than the Medical Model with its arbitrary and catch-all diagnoses and addictive drugs. Yet it receives no coverage in standard psychiatric/psychological curricula. So many Australians are now on anti-depressants and other psychiatric drugs that traces in our waterways have been recently shown to be ecological disruptors in small life forms such as algae. This is serious.

The very disturbed may need sleeping drugs. They need quiet and restorative nutrition, ironically often because of nutritional deficiencies caused by drugs, especially street and psychiatric. Three daily cups of calcium and magnesium drink in a formula with an acid base for absorption e.g. citric acid, safely replaces most tranquillizers.

An 8-year study by the World Health Organization (confirmed by a second study checking basis of diagnosis) notes parts of the world with little or no drugging, have far better long-term recovery from schizophrenia. *Ref: The International Pilot Study of Schizophrenia: Five-Year Follow-Up Findings, Psychological Medicine Vol. 22, 1992.*

Psychiatrist, Loren Mosher, pioneered Soteria House in the 1970's. He achieved far better recovery for schizophrenia by little or no drugging. Professor, Giorgio Antonucci, repeated the results in Italy in the 1990's, to close 96 asylums. Israel, a world leader in mental health treatments, has adopted the Soteria House Model. An eminent psychiatrist, Dr Mosher resigned from the American Psychiatric Association, citing the Association's vested interest in *continuance* of mental illness.

Psychiatric professors successfully treating teenagers in Sweden's Karolinska Institute for Anorexia Nervosa, have declared that, *in every case, psychiatric drugs harmed, not helped physical recovery and progress of cognitive behavioural therapy.* They treat the condition as tipping-point reaction to semi-starvation not specifically a mental illness. Their key remedy is restoring

nutrition, especially zinc deficiency. Tragically, their results are largely ignored here.

Dr Hoffer (Canada) treated 5,000 people diagnosed with schizophrenia with high dose multi nutrients, especially with large doses of Vitamin B3 and Vitamin C. His published long-term follow-up reports reveal a 90% cure rate - defined as free of symptoms, socializing and paying taxes. A largely uncaring psychiatric industry has large sidelined his lifetime of research and results (*Ref: Optimum Nutrition for The Mind, Patrick Holford*).

Recent findings by Deakin University that measures such as more vegetables and ditching unhealthy food can ease even major depression follow a long line of studies showing nutrition is vital to mental well-being.

Psychiatrist, Ian Hickey (of Beyond Blue) notes exercise boosts mental outlook but grossly over emphasizes drugs.

The demand for yet more preferential psychiatric spending even threatens to undermine capacity of Australia to have basic universal health care in future (a point perhaps first very presciently outlined the Public hearing Into Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder (ADHD In Children and Adolescents, convened by NSW MP David Clarke on 12 May 2009).

The Positive Psychology Model and Strength Model of Psychology focus on raising ability. The Bioecological Model of mental Health is a holistic approach including nutrition, lifestyle and social settings. It is tragic for Australia that psychiatric screening and most mental health practices revolve around the Medical Model of Mental Health with its focus on diagnosing mental pathology and prescribing drugs.

Basic nutrients such as essential fatty acids, zinc and Vitamin B6 are vital to produce neurochemicals. Bad diet, street drugs, tobacco and excess alcohol all deplete the body's nutritional reserves to counter the toxicity. Add a hectic or "party" lifestyle and there is a synergy which is a root cause of symptoms of depression or "bi-polar disorder".

Conclusions

All recommendations of the Australian Productivity Commission's Mental Health Report should be put on hold. We must roundly reject the report's massive empire building.

Instead, we must conduct a Royal Commission into the state of the mental health or psychiatric industry and its outcomes in Australia, terms of reference to include:

- Suicides in our Military
- Services of psychologists
- Services of allied health and educational professionals in terms of expectancy to “identify” or counsel for mental illness/disorder)
- Harmful treatments
- Informed consent
- Effects of forced treatments
- Green Mental Health
- Soteria House Model being applied in Israel as Best World Practice
- Testimony of patients, including older children and adolescents
- Rights of mental patients to liberty and safety under state and Territorial laws
- Australian use of, and validity of criteria set in Version V of the American Psychiatric Association’s Diagnostic and Statistical Manual
- Compliance with the *UN Convention Against Torture And Other Cruel inhuman Or Degrading Treatments*
- Compliance with the *UN Principles for Protection of Persons With mental Illness and the Improvement of Mental Health 1991*.

Meanwhile, for basic legal protection of Australians, national legislation should

- Restrict ECT by banning it being done without consent and for the most vulnerable cohorts such as children, pregnant women and those over 65 (a full ban would be preferable as a progressive step)
- Ban all forms of psychosurgery
- Ban new prescriptions of psychiatric drugs to children under 18 which is off-label prescription, of any class of drug the child is not already being given
- Ban all psychiatric testing and diagnosis of children done without the consent of parents or guardians unless sanctioned by a court order
- Initiate a national data base, recording histories of psychiatric and street drugs in persons committing the most serious violence.

Also, the Commonwealth must release

- Dedicated figures for children under age 6 given psychiatric drugs
- All known details of institutional abuse of elders.