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[redacted]

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Dr A Beem
Committee Secretary
Mental Health Select Committee
Parliament House
George Street
Brisbane Qld 4000

Dear Dr Beem

Re: Improving mental health outcomes

Pursuant to the terms of reference as published, I submit the following material. My qualifications are that I recently retired from clinical practice after 47years in psychiatry. In that time, I worked in a variety of settings, including public and private practice, hospitals, outpatient clinics and prisons, in urban and remote regions in three states. I have extensive experience in military psychiatry, in isolated psychiatry, including six years in the Kimberley region of Western Australia as the world's most isolated psychiatrist; psychiatry with Aboriginal people and immigrants; chronic pain, etc.

Throughout, I have published extensively in the field of the application of the philosophy of science to psychiatry, and recently published a computational theory of mental disorder based in a novel theory of mind [1]. This is the first such theory in the history of psychiatry and is certainly the most highly developed theory of any kind available to psychiatry today.

Copies of my CV and publications list are attached to the email separately from my submission. I submit that I am qualified to address the Committee as an expert in the field of psychiatry.

My comments are directed at items 1 (f) and 1 (g) of the terms of reference (see note 1).

Yours faithfully

N McLaren

1. PSYCHIATRY'S NARRATIVE OF PROGRESS.

Anybody listening to psychiatrists speaking about their field will gain the very strong impression that over the past four decades, scientific psychiatry has made huge progress in understanding and treating mental disorder. With rapid development in the neurosciences, including diverse fields such as molecular genomics, neuropharmacology and other forms of brain treatment, psychiatry stands on the cusp of major breakthroughs in dealing with this important part of the health sciences. Accordingly, it will be said, this is not the time to stint on research funding or to consider reducing services in any way; rather, it is incumbent upon funding agencies to be bold and push ahead, even against opposition, to enable psychiatry to capitalise on these advances in our scientific knowledge base and bring the benefits to those suffering this most painful of disabilities.

Indeed, governments are responding directly to calls for more services. In Australia, for example, Jorm et al [2] showed that between 1992-1993 and 2010-2011, total government expenditure on mental health services increased by 178% in real terms. In the same time period, there was a 35% increase in per capita staffing levels for mental health staff. From 1990-2002, per capita prescription rates for antidepressants increased by 352%, while from 2005-15, rebatable electroconvulsive treatment (ECT) services (i.e. private practice) increased nationally by 87%, including 91% in Queensland and no less than 191% in Western Australia.

At the same time, there is rising awareness of the burden of disability imposed on the community by mental disorders. Classically, when we think of mental disabilty, we think of the devastating condition of schizophrenia but studies show that the real burden is the enormous and largely hidden levels of disability resulting from depression and anxiety. A major collaborative international study on global burden of disability by forty-one authors [3; GBD Study], including senior contributors from Queensland, concluded:

> … mental disorders remained among the top ten leading causes of burden (of illness) worldwide… To reduce the burden of mental disorders, coordinated delivery of effective prevention and treatment programmes by governments and the global health community is imperative

Nonetheless, as will be shown, these figures conceal as much as they reveal.

2. PSYCHIATRIC TREATMENT FAILS TO MEET ITS GOALS.

Psychiatrists are most unlikely to publicise the other side of these figures as, over the twenty years of their study, Jorm et al concluded for Australia:

> … there is no evidence for any reduction in prevalence of disorders or reduction in symptoms. If anything, trends are in the opposite direction.

This was also true of each country in their study, Canada, UK and US. The GBD Study reached the same conclusion:

> … there was no evidence of global reduction in the (global burden of disability) since 1990, despite evidence-based interventions that can reduce the burden … A coordinated response by governments and the global health community is urgently needed to address the present and future mental health treatment gap.

There is always some argument over whether these figures imply more people volunteering their symptoms, or better diagnosis by more alert general practitioners, etc., but some statistics, such as death rates, are impeccable. For example, in Western Australia, from 1985-2005, life expectancy for people with active mental disorder declined steadily, with the gap between men with diagnosed mental illnesses and those without increasing from 13.5 to 15.9years [4]. Bearing in mind that the life expectancy for the whole community increased during this time, and despite all the money and attention outlined above, the mentally-disturbed were decidedly worse off over the twenty year period. Suicides accounted for only 13% of this figure, the rest was due to physical illness, especially cardiac disease and cancer. According to the World Health Organisation [5], people on long-term treatment for mental disorders will die on average 19 years younger than their undrugged peers. In the US, where larger doses of more drugs are given for much longer and with less convincing reason, that figure is 25yrs. This is a drug effect and is not related to diagnosis. That is, the more treatment people are given, the worse the outcome. As Kingsley Amis noted in a different context, “More means worse.”

This is brought into sharp focus by a comment by Thomas Insel, director of the US National Institute for Mental Health (NIMH) from 2002-15 and second-longest serving director in its history:

> I spent 13yrs at NIMH really pushing on the neuroscience and genetics of mental disorders, and when I look back on that, I realise that while I think I succeeded at getting lots of really cool papers published by cool scientists at fairly large costs - I think $20billion - I don't think we moved the needle in reducing suicide, reducing hospitalisations, improving recovery for the tens of millions of people who have mental illness. I hold myself accountable for that [6]

And well he may. US$20billion is a great deal of money, the greater part of their research budget, and thirteen years is a long time in the life of a mental patient. Insel was a neurophysiologist whose reputation rested on his studies on voles; his practice of actual psychiatry was limited to his training many years ago and one or two brief periods thereafter. As director of NIMH, he bears a large degree of responsibility for psychiatry's headlong rush toward the biology of mental disorder, particularly when he was warned years ago that it could not and would not succeed in its goals [7, 8].

In the rest of this submission, I will argue that psychiatry's failure to benefit its patients is worse than is generally known; it was predicted; and it is due to the fact that modern psychiatry has no basis in science. Its treatments, such as they are, are based in serendipity, not in a scientific understanding of their field, while a proper analysis of its effects shows that the more we spend on modern psychiatry, the worse the outcomes. Psychiatry is aware of this but, given psychiatry's institutional sociology, the profession will act assertively to ensure nothing changes. In particular, psychiatry will always act to safeguard the egregious privilege granted it to negate the most fundamental human rights of its patients with impunity.

3. CRITICAL PSYCHIATRY

3.1: Psychiatry has no scientific basis.

It is not enough for a field to claim to be scientific: there are independent criteria which must be met. The first and most basic is a model of its field which shows how the subject matter is perceived. This model guides and controls practice, teaching and research. Without an articulated, readily available model, the field is at best a protoscience and, at worst, pseudoscience. Despite the trappings of science

(professional bodies with restricted membership, long training programs, research budgets, conferences, journals, laboratory technology, statistics, university research institutes, an impenetrable jargon, etc), mainstream psychiatry does not have, and never has had, a model of its subject matter.

Conventional psychiatrists often claim that they have a unique model, the biopsychosocial model, which guides their daily work and their research program. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has long advocated the notion that psychiatrists are defined by their use of this model [9]; they have engaged one of the world's best-known psychiatrists to fly to the Sydney conference in May this year to present a lecture entitled “In praise of the biopsychosocial model” [10]. He will be addressing a falsehood. The “biopsychosocial model” does not exist and never has [11, 12]. No psychiatrist in the world has ever seen it yet journal editors publish in the scientific literature a steady stream of articles which act as though it is real [13, 14].

Those few psychiatrists who have qualms about relying on a non-existent model justify their work with something they call the “biomedical model” [15]. They claim it shows that mental disorder can be reduced directly to a matter of brain disorder which can be discovered by routine application of standard techniques used in biological laboratories the world over. Again, there is no such model [16] and, moreover, could not be [17]. Psychiatry's biological research program, championed by Thomas Insel among so many others, is an ideology of mental disorder, not a science. It can never tell us anything about mental disorder which is both factually true and interesting. Any results of its prodigiously expensive research effort are either factually incorrect, or banal facts or truism. In terms of any beneficial effect on its client population, Insel's $20billion would have been better spent on public housing for the millions of mentally-disturbed Americans who bounce between homelessness and the prison system (where they get little treatment, if any).

3.2: Treatment is not effective.

There is now a large and rapidly growing literature which shows that psychiatry's forms of treatment are nowhere near as effective as claimed and are themselves largely responsible for the unacceptable death rate in long-term psychiatric patients. All claims that, for example, a drug “treats” a “mental illness” by increasing or decreasing this or that neurotransmitter are little short of fanciful. Nobody knows how neurotransmitters relate to normal brain function, let alone abnormal brain function. Drug manufacturers routinely manipulate research results so that only favourable results are published;

adverse side effects, such as suicide, are scrubbed from the studies; and research studies are constructed in such a way as to exaggerate the possible benefits of the drugs [18, 19]. This is done by active collaboration of psychiatric researchers with drug manufacturers, the goal being to channel research funds to specific psychiatrists and thence to their universities [20].

Psychiatric drugs are highly addictive, meaning patients cannot stop them without the most severe withdrawal effects, invariably and wrongly attributed by the prescribing psychiatrist to the return of the original condition. This means they must take them in the very long term, but the drugs are toxic in the long term. People who are ordered to submit to injections of psychiatric drugs against their will are being forced to take a form of treatment which the prescribing psychiatrist knows, or ought to know, will shorten their life span by as much as 25%. Quite apart from the inhumanity, this directly contravenes the Convention on the Rights of Persons with Disabilities (CRPD), which this country has signed [21; see endnote].

The team centred around John Ioannidis of Stanford, the world's most highly-cited medical researcher, has just published a major study on treatment effects in psychiatry [22]. This shows that most psychiatric treatments are only marginally better than placebo (sugar pills) or no treatment at all. They concluded:

> Thus, after more than half a century of research, thousands of randomized controlled trials and millions of invested funds, the “trillion-dollar brain drain” associated with mental disorders (i.e. loss of productivity) is presently not sufficiently addressed by the available treatments… realistically facing the situation is a prerequisite for improvement. Pretending that everything is fine will not move the field forward, nor will conforming and producing more similar findings. (NB. That should read “many billions” of research funds, and their final comment means “more of the same inadequate and/or misdirected research won't help”).

This is of critical significance. The most important single statistical measure in any form of medical treatment is known as “number needed to treat” (NNT). Its corollary is “number needed to harm,” (NNH). NNT means the number of patients who must be treated to prevent one additional bad outcome (death, stroke, etc.). If, for example, a drug has NNT = 5, it means five people must be treated with the drug to prevent one additional bad outcome. In the case of using aspirin to prevent strokes, this would

be entirely reasonable. With antibiotics, insulin or appendicectomy, NNT is very low: practically every patient treated will have a favourable response. In psychiatry, NNT is very high. In treating depression, for example, one goal is to prevent suicide. Taking into account the numbers of people who refuse to take the drugs due to side effects, the generally poor response rate and the numbers who use their drugs to commit suicide, the number of patients needed to treat with antidepressants to prevent one case of suicide is in the range of many hundreds, if not thousands. For ECT, as will be shown below, it is of the order many thousands, if it has any effect at all (despite frequent claims by psychiatrists [e.g. 24], all the available evidence is that it has no effect on suicide rates).

NNH measures poor outcomes such as side effects or complications of treatment. It means the number of patients who must receive a particular treatment for one additional patient to experience a defined adverse outcome. Ideally, this figure should be very high. We would like it to be of the order hundreds, but mostly it isn't. However, in psychiatry, it is exceedingly low: for example, practically everybody who takes psychiatric drugs will gain massive amounts of weight, which contributes significantly to the early deaths; all will experience moderate to severe loss of sexual function, which may be permanent; and addiction to psychiatric drugs is invariable, i.e. NNH = 1. This would never be accepted in any other field of medicine except perhaps chemotherapy (e.g. all these patients will suffer some degree of hair loss but that's what the drugs do; and that side effect has to be balanced against no treatment).

Most psychiatrists aren't aware of these figures and confidently tell patients that the drugs are safe, effective and they will be far better off taking them than not taking them. This, as the citations show, is completely false. My experience is that telling patients, especially younger men, that they will experience weight gain and moderate to severe loss of sexual function which may be permanent results in 100% refusal to take the drugs.

With regard to **ECT**, the RANZCP and all professional psychiatric bodies in the English-speaking world are strongly committed to this form of treatment, including for involuntary patients who object to it. This is despite the fact that each and every claim made on behalf of ECT by, for example, the RANZCP has been refuted [23]. ECT is *not* effective; it is *not* safe; it has *no* scientific basis (convulsive techniques were originally developed just because epilepsy induces diffuse, low-grade brain damage; electricity was simply the quickest, cheapest and most reliable way of doing it); ECT is

expensive; and it is not given to the people with the highest risk of suicide (i.e. young men). Instead, the world over, ECT is given to middle-aged, middle-class women, the specific demographic with the lowest risk of suicide who also happen to be the group least likely to object and most likely to be able to pay for it.

By a process of exclusion, I have shown that the primary motivation for the excessive and relentlessly rising use of ECT in this country is the financial rewards it generates for the psychiatrists, anaesthetists and private hospitals who give most of it. The nett effect of this $500million a year industry in this country is to divert the limited mental health budget away from those who need it most, to those who least need it. My lengthy experience at the tough end of psychiatry, without ever once using ECT, says that this money is wasted.

There is another factor to consider, that ECT machines have never been properly assessed for safety and efficacy. This is an historical error only but attempts to rectify this deficiency have been strenuously opposed by, among others, the RANZCP [23]. Somatics LLC, the US company that manufactures the Thymatron ECT machine, one of the most widely used in Australia, has recently revised its product liability warranty and now explicitly excludes any and all complications from its use. Under the terms of the sales contract, the operating psychiatrist is required to give full product disclosure so the patient can make informed consent, and to assume all liability for adverse effects of any sort which follow use of the machine [24]. This does not convey any sense that the manufacturer has confidence in its product but the real issue is “informed consent.” Any patients compelled to take ECT against their wishes are *ipso facto* incapable of giving informed consent, and we know that voluntary patients are rarely if ever given the full list of possible complications.

All this material has been summarised in my paper from 2017 [23] but has not been acknowledged in mainstream psychiatric circles, which continue to push ECT without regard for the evidence base against it. For example, the main RANZCP journal, the *Australian and New Zealand Journal of Psychiatry* (*ANZJP*) recently published a letter claiming:

> ECT remains one of most effective and fast-acting treatments for acute severe psychiatric conditions, and appropriate use leads to reduced hospital admissions and earlier discharges. It is important for psychiatrists to advocate for ongoing access to ECT [25].

As my 2017 paper explained, these claims are false: ECT is expensive and wasteful. Most emphatically, it does *not* lead to reduced admissions, shorter stays or lower bed occupancy [26]. Yet by dint of repetition of a falsehood, mainstream psychiatry has managed to convince the funding and supervisory agencies that not using ECT is verging on culpable. An *independent* enquiry into the whole ECT industry, and of private psychiatric hospitals, is long overdue. It would also be appropriate to extend this enquiry to question why psychiatrists in this country are taught to believe material that is manifestly false.

3.3. Human rights of the mentally-disabled.

A series of reports by Prof. Dainius Puras, recently retired from the post of Special Rapporteur to the UN Human Rights Council (HRC) on "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health," were critical of mainstream psychiatry [27-29]. In particular, the reports addressed two major themes, firstly, the universal and almost total disregard for even the most fundamental human rights of those who have the misfortune to become enmeshed in the inaptly-named "mental health system." Second, he criticised psychiatry's microscopic focus on the unproven individual biology of mental disorder. Unfortunately, instead of taking the well-researched, carefully-phrased reports of Puras' extensive team in the spirit intended, psychiatrists responded aggressively [309] to dismiss the findings.

Few psychiatrists are aware, or care, that:

- people detained under the Mental Health Act in Queensland have fewer rights than prisoners;
- that the great majority of them have broken no laws;
- that without legal representation, they will often have been detained indefinitely on unsworn and hearsay material submitted without evidentiary restraint;
- that in hospital, they are subject to arbitrary punishment without right of appeal;
- their rights of appeal against detention are severely circumscribed;
- most of them have practically no understanding of what is going on; and...
- orders are issued based on a misallocation of "perceived risk," away from the actual risk the patient represents to self or others to the reputational risk to psychiatry.

The questions asked should be “Is this person a tangible risk to self or others? Do we have effective means of reducing that risk without excessive damage to the individual?” but, within the bureaucracy, that becomes “If anything goes wrong, can we be blamed?” I submit, and many people agree that, *in toto*, this amounts to state abuse of the disabled and directly contravenes the CRPD.

As a group, psychiatrists appear to have learned nothing from the UN Council on Human Rights or from the CRPD. A chilling quote from Robert Kaplan, a highly regarded forensic psychiatrist, author and researcher (UNSW, U. Wollongong), is apposite:

> If one thing emerges from this study, it is that doctors, regardless of prestige, ability, qualification or training, are amongst the most willing accomplices of state abuse. They will play a leading role in perpetuating the system, support and participate in abuses and, where circumstances, permit, willingly accede to the leadership of repressive regimes. There is no indication that this is likely to change in future [31].

3.4. Mental Health Review Tribunals (MHRT)

These were established and/or formalised and extended following the Burdekin Review some thirty years ago. The Qld MHRT was recently reviewed [32] and a number of recommendations made but my (limited) advice on implementation of these changes is that they have been piecemeal rather than systematic, more dependent on personalities than service-wide. In any event, they don't address the central issues raised by the UN HRC.

Tribunals are prodigiously expensive: in 2020-21, Qld MHRT cost taxpayers $19,778,004 (p33, Annual Report). This does not include time MHS staff spent sitting in hearings or, more significantly, the enormous amounts of staff time spent on writing reports for the hearings. Together, these additional costs could easily double that figure. More to the point, there is no measurable evidence that this huge expenditure has improved the lot of the mentally-troubled. I have not found anything in the 2020-21 Annual Report that suggests this is even a consideration. MHRT members were, however, treated to a training course on ECT, during which, we can be sure, they would not have heard one word of criticism of this form of management.

I trained and worked for over 20 years under legislation that put all responsibility for detention on the shoulders of the one person who signed the order. We took it seriously but it is now the case that responsibility has been diffused through a labyrinthine system such that very few patients have any idea what is going on. This is, of course, the ideal bureaucratic solution to a significant legal and ethical problem, a complete split between authority and responsibility: all authority rests with the "system," but nobody can be held responsible. The result is that many patients have no idea when their hearings are scheduled, what will be said or by whom. If they get copies of the applications and reports, many people cannot understand them or, if they find errors, know how to have them corrected. Their only certainty is that they will not easily regain their basic human rights and if they object, things are highly likely to get worse. Objecting is taken as evidence of "lack of insight" which amounts to a "more severe illness" and justifies "more treatment." The system ratchets up, it never ratchets down.

3.5. The integrity of the psychiatric profession.

Outsiders assume psychiatry to be ethically impeccable, at least equivalent to the rest of medicine, even though readily available facts show this assumption to be false. It is, however, worse in that the psychiatric profession has a long-established habit of deception. It actively and successfully misleads the general public, the funding, supervisory and legislative bodies, patients and their families, and medical students and psychiatric trainees, into believing the narrative outlined in **S.2** above. For example, six months after publication of my 1998 paper on the biopsychosocial model, showing it does not exist, the RANZCP placed on its website a definition of a psychiatrist as a medical practitioner trained in and using the biopsychosocial model [9]. At that time, the final word in the scientific literature, in the RANZCP's journal indeed, was that it didn't exist. They ignored this, just because it didn't fit with their narrative of psychiatrists as the intellectual and moral equivalents of the rest of medicine.

Not one of the many psychiatrists who routinely use the term "biopsychosocial model" has ever published anything that would amount to a definitive statement of what this phantom model could amount to. It is now a shibboleth. I have recently submitted yet another letter to the *ANZJP* on the subject, which concludes:

> … in claiming that psychiatry has an articulated, integrative "aetiological model for mental disorders," psychiatry is deceiving itself, the funding agencies, the general public *and*, inexcusably, our students, our trainees and our patients. In other words, committing fraud.

A decision on this letter is overdue but regardless of the editor's decision, the matter will not be allowed to rest.

The same applies to the repeated references to the so-called "biomedical model" which none of them have ever seen. It doesn't exist and, in distinction to the biopsychosocial *concept* which only now, 45 years later, exists as an articulated model [1], a reductionist biomedical model could not exist [17, 33]. Psychiatry has known this, or ought to have known it, for the past quarter century. Nonetheless, medical students and trainees are imbued with the idea that the explanatory reduction of mental disorder to brain disease is *fait accompli*. Nothing could be further from the truth.

It should not be necessary to remind the Committee that the pharmaceutical industry is rife with unethical and often frankly criminal behaviour regarding their products. The recent successful criminal prosecutions of a number of multi-billion dollar companies in the US for their role in the so-called opioid epidemic shows we can dismiss outright the claims of "Big Pharma" to be an ethical, patient-oriented industry. From 2003-16, drug companies were fined some $33billion for misconduct, with many billions more since. The charitable interpretation is that they are not learning from their experience; more likely, they are looking at the balance of integrity vs. profit, and deciding that the money will always win. For Big Pharma, fines are just another tax-deductible business expense. We are now at the point where nothing a drug company, its employees or retained advisers say can be taken at face value. This certainly applies to psychiatrists who take drug company money, as the disgraceful conduct of the renowned Harvard psychiatrist, Joseph Biederman, shows [34].

Continuing, in March 2018, the RANZCP issued a press release via its website which contained a number of highly misleading statements, including the following:

> The prescription of antidepressant or antipsychotic medications is something that a psychiatrist *only ever* does in partnership with the patient and after due consideration of the risks and benefits (emphasis added) [35].

A complaint was quickly lodged with the president of the RANZCP, over whose name the statement was issued, alleging that not only was this claim false, but every psychiatrist in the country knew it to be false, and none could have known otherwise; and it was intended to deceive any non-psychiatrist who read it. Thus, it met the definition of a lie [36]. The statement was immediately removed from the website but she dismissed the complaint on the basis that the press statement was factually correct. Subsequent complaints to the RANZCP were dismissed by the president-elect (currently director of Qld MHS); complaints to the Qld Medical Board, the Australian Charities and Not-for-Profits Commission, and the National Health Practitioner Ombudsman and Privacy Commissioner were all dismissed. Thus, according to the highest authorities in the land, it is permissible for the peak body of psychiatrists in this country to lie to the general public on matters of major importance. And they do. I am of the view that this amounts to regulatory capture, that psychiatrists now control the bodies who are supposed to be supervising them.

Institutionalised dishonesty is also true of the UK where the president and senior officials of the Royal College of Psychiatrists were exposed after attempting to deny that antidepressants are addictive and routinely cause severe withdrawal effects [37, 38]. Across the Atlantic, exposing dishonesty on the part of the American Psychiatric Association [20] and drug companies [39, 40] is now a cottage industry .

There is no other branch of medicine where allegations of this nature would even arise, let alone be substantiated. What can be done to keep psychiatrists honest? At this stage, nothing: by virtue of assiduous control of the flow of information, backed by adroit manipulation of government bodies and supervisory agencies, they control the narrative on behalf of their patrons, the drug companies. The only remedy is public exposure, as the scientist and author, David Brin, commented:

> In all of history, we have found just one cure for error—a partial antidote against making and repeating grand, foolish mistakes, a remedy against self-deception. That antidote is criticism.

But when the profession is essentially united in suppressing criticism, then nothing changes.

4. CONCLUSION.

American author Thomas Pynchon said:

> If they can get you asking the wrong questions, they don't have to worry about the answers.

The terms of reference of this Enquiry are anodyne and read well; nobody will take offence at them. But it is unlikely that this Committee's enquiries will produce a constructive outcome because mainstream psychiatry has managed to get everybody asking the wrong questions. For orthodox psychiatry, there is only one question that counts:

> Do pyschiatrists actually know what they are doing?

No, they don't. That is not to say they haven't convinced everybody that they have the crucial questions of mental disorder almost within reach, because they have certainly managed that, partly by convincing themselves. However, modern psychiatry lacks the most basic feature of any field claiming to be scientific, a formal, articulated, readily-available model of its subject matter open to public scrutiny and criticism. It is therefore at best a protoscience or, at worst, pseudoscience.

Every psychiatrist in the world who wishes to be taken seriously must answer this question:

> What is the name of the model of mental disorder that you use in your daily practice, your teaching and your research? Give the name of the primary author and cite three studies in which those ideas have been critically analysed and developed to the point of making testable predictions.

Any psychiatrist who can't answer that question (and, despite all the high-sounding rhetoric and bluster, none can) doesn't actually know what he is doing. And so the costs go up and the results go down. Unfortunately, a very large number of lives will be ruined in the process.

5. Recommendations:

1. A major, independent study of electroconvulsive treatment in Queensland is urgently needed.

2. The Queensland Government should begin the process of legislation to implement the recommendations of the Puras reports with regard to the human rights of detained patients.

3. The training of psychiatrists in Australia is totally under the control of the RANZCP, which has an established record of deception. This needs to be investigated independently.

4. Regulatory capture of the various supervisory agencies by institutional psychiatry is *fait accompli*. This needs to be corrected.

Endnote: Convention on the Rights of Persons with Disabilities is explicit: involuntary detention and forced treatment should be phased out.
See WHO (2021) *Guidance on Community Mental Health Services: Promoting Person-Centred and Rights-Based Approaches.* WHO: Geneva, at pages 6-8.

References:

1. McLaren N (2021): *Natural Dualism and Mental Disorder: The biocognitive model for psychiatry.* London: Routledge.

2. Jorm A et al (2017). Has increased provision of treatment reduced the prevalence of common mental disorders? Review of the evidence from four countries. *World Psychiatry* 16: 90-99. Published online January 26, 2017. doi: 10.1002/wps.20388

3. Global Burden of Disease Collaboration (41 authors) (2022) Global, regional, and national burden of 12 mental disorders in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019. *Lancet Psychiatry*. Published online January 10, 2022 https://doi.org/10.1016/S2215-0366(21)00395-3

4 Lawrence D, Hancock K, Kisely S (2013). The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers. *British Medical Journal* 346:125-39 doi: https://doi.org/10.1136/bmj.f2539 (Published 21 May 2013)

5. WHO (2016) Excess mortality in persons with severe mental disorders. WHO reference number: WHO/MSD/MER/16.5. Accessed Feb 7th 2020 at: https://www.who.int/mental_health/evidence/excess_mortality_report/en/

6. Rogers A (2017). Star Neuroscientist Tom Insel Leaves the Google-Spawned Verily for ... a Startup? *Wired Science* May 11 2017. https://www.wired.com/2017/05/star-neuroscientist-tom-insel-leaves-google-spawned-verily-startup/

7. McLaren N (2010). The DSM-V Project: Bad science produces bad psychiatry. *Ethical Human Psychology and Psychiatry* 12: 189-199.

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

9. Wilson J. President's Letter. *Australasian Psychiatry* 1998; 6:83-84. Later inserted in RANZCP, (1998). *Position Statement No. 39*: 'What is a psychiatrist, and what does a psychiatrist do?' RANZCP, Melbourne.

10. RANZCP 2022 Annual Congress https://www.ranzcp2022.com.au/ Professor Allen Frances, USA: "In praise of the biopsychosocial model." (This item is difficult to find and will probably be taken down after the congress in May although the paper may be published in the proceedings)

11. McLaren N (1998). A critical review of the biopsychosocial model. *Australian and New Zealand Journal of Psychiatry.* 32; 86-92.
Revised version: McLaren N (2010). A life of its own: the strange case of the biopsychosocial model. Chapter 7 in *Humanizing Psychiatrists: Toward a Humane Psychiatry.* Ann Arbor, Mi.: Future Psychiatry Press.

12. McLaren N (2020). The Biopsychosocial Model: the end of a reign of error. *Ethical Human Psychology and Psychiatry.* 22:71-82.

13. Pies, R (2019). Debunking the Two Chemical Imbalance Myths, Again. *Psychiatric Times*. August 2, 2019. At: https://www.psychiatrictimes.com/depression/debunking-two-chemical-imbalance-myths-again

14. Lugg W. (2021) The biopsychosocial model – history, controversy and Engel. *Australasian Psychiatry* on line publication.doi.org/10.1177/10398562211037333

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

16. McLaren N (2013). Psychiatry as Ideology. *Ethical Human Psychol and Psychiat* 15: 7-18.

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

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

19. Whitaker R (2009). *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs and the Astonishing Rise of Mental Illness in America*. New York: Random House.

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

21. Maylea C, Hirsch A (2017). The right to refuse: The Victorian Mental Health Act 2014 and the Convention on the Rights of Persons with Disabilities. *Alternative Law Journal* 42(2):149–155. doi: 10.1177/1037969X17710622

22. Leichsenring F, Steinert C, Rabung S, & Ioannidis J (2022). The efficacy of psychotherapies and pharmacotherapies for mental disorders in adults: An umbrella review and meta-analytic evaluation of recent meta-analyses. *World Psychiatry, 21*, 133–145. Published online Jan 11, 2022. doi: 10.1002/wps.20941

23. McLaren N (2017). Electroconvulsive Therapy: A Critical Perspective. *Ethical Human Psychology and Psychiatry* 19: 91-104

24. Somatics LLC (n.d.) *Thymatron ® System IV. Cautions and Warnings*. Available at: http://www.thymatron.com/catalog_cautions.asp

25. Warren, N, Siskind, D, & Lie, D (2020). Electroconvulsive therapy during severe acute respiratory syndrome coronavirus 2 pandemic. *Australian & New Zealand Journal of Psychiatry* 54:12, 1224.

26. McLaren N (2021). Letter: Why should psychiatrists advocate for ECT? *Australian and New Zealand Journal of Psychiatry,* 55:1020-21. https://journals.sagepub.com/eprint/JZSZPV9HZMNJXQE9PQGI/full

27. UN Human Rights Council (2017) Report of the Special Rapporteur on the right of everyone to

the enjoyment of the highest attainable standard of physical and mental health. Available at: http://ap.ohchr.org/documents/dpage_e. aspx?si=A/HRC/35/21

28. Puras D (2019). UN Human Rights Council. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. UNHRC Document A/HRC/41/34 , at: https://documents-dds-ny.un.org/doc/UNDOC/GEN/G19/105/97/PDF/G1910597.pdf?OpenElement

29. Puras D (2020). UN Human Rights Council. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. UNHRC Document A /HRC/44/48

30. Hickie, I, (2019). Building the social, economic, legal, and health-care foundations for "Contributing Lives and Thriving Communities". *The Lancet Psychiatry*. https://doi.org/10.1016/S2215-0366(19)30378-5

31. Kaplan RM (2009). *Medical Murder: Disturbing cases of doctors who kill*. Sydney: Allen and Unwin.

32. Giuntoli G. et al (2019). Human Rights protection frameworks for people being treated involuntarily for a mental illness: Study findings (SPRC Report [to follow/19). Sydney: Social Policy Research Centre, UNSW Sydney.

33. McLaren N (1992). Is mental disease just brain disease? The limits to biological psychiatry. *Australian and New Zealand Journal of Psychiatry*; 26: 270-276. Revised version: Brain disease, mental disease, and the limits to biological psychiatry. Chapter 2 in *McLaren N (2007). Humanizing Madness: Psychiatry and the Cognitive Neurosciences.; Ann Arbor, Mi.: Future Psychiatry Press.*

34. Gotzsche P (2013) *Deadly Medicines and Organised Crime: How Big Pharma has corrupted healthcare*. London: Radcliffe Publishing.

35. RANZCP (2018) Press release March 6th 2018: RANZCP deeply concerned over stigmatising reporting of mental health treatment. Since deleted; available at https://www.MIA.com/2018/03/psychiatrist-dr-niall-mclaren-writes-ranzcp/

36. Frankfurt H (1986). On Bullshit. *Raritan Quarterly Review* 6 (2): 81–100. (Fall 1986). See also McLaren N (2016). Psychiatry as Bullshit. *Ethical Human Psychology and Psychiatry* 18: 48-57.

37. Read, J et al. Complaint to RCPsych. http://cepuk.org/wp-content/uploads/2018/03/Complaint-to-RCPsych.pdf

38. Moore J (2018) Professor John Read: The Royal College of Psychiatrists and Antidepressant Withdrawal. https://www.madinamerica.com/2018/03/professor-john-read-royal-college-psychiatrists-antidepressant-withdrawal/

39. Gottstein J (2020) *The Zyprexa Papers.* Gottstein: Anchorage AL.

40. Verma A, Cacey T, Powell E (2022). Biden Must Take on Big Pharma Over Cancer Drug That Costs $189,000 Per Year. *Common Dreams* Jan. 26th 2020, at: https://www.commondreams.org/views/2022/01/26/biden-must-take-big-pharma-over-cancer-drug-costs-189000-year?vgo_ee=tOVkf7gb3dyP5KrYKerpzb35hO7C%2FF3J%2FgQB9Uu3XAY%3D