

July 16th 2017

HUMAN RIGHTS COMMISSION ENQUIRY INTO IMPLEMENTATION OF OPCAT.

Submission pursuant to HRC Consultation Paper (May 2017)

1. Introduction;

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

Today, in Brisbane, I operate two bulk-billing practices, one in a middle class area with a surprisingly high rate of struggling younger families, the other in a Housing Commission suburb with many unemployed people, pensioners, immigrants and refugees. My offices are situated in busy shop-front general practices, which provide most of my referrals. Thus, I see the sorts of patients who would normally have to attend public services. Some of them have previously attended public services and are keen to change but are unable to as private rates for private psychiatrists (200-300% higher than Medicare rebates).

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

A brief CV and publications list are appended.

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

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

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

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

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

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

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

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

5. There is a quasi-judicial process involved in detaining a psychiatric patient but, as the [recent debacle](#) over the Mental Health Tribunal (MHRT) in Qld showed, it is hardly fool-proof. More to the point, there is an inherent bias built into the MHRT, in that psychiatrists sitting on the panels are trained in the same system as the hospital psychiatrists. They and the hospital psychiatrists are all firmly convinced that all mental disorder is biological; that patients cannot know their own minds; that enforced treatment is always better than no treatment and that the hospital psychiatrists, whom they mostly know, and the hospitals, where most of them trained, are never wrong [2]. The chances of a psychiatrist appointed to sit on the MHRT taking an independent or neutral position are vanishingly small.

The direct costs of MHRT in Qld are of the order \$11million a year. In addition, there are substantial indirect costs which would approximately double this sum. 97% of applications by hospitals are approved exactly as requested. Of the remainder, a few are dismissed while the rest are granted with strengthened conditions. Only 4% of patients have legal representation in these hearings, which can lead to practically all their human rights being extinguished in the very long term.

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The outcome of applications to MHRT is so predictable that a significant proportion of patients don't even bother attending. After the event, many or even most have no idea what the conditions are. They simply believe, and with very good reason, that, under threat of forcible readmission to hospital, they must do precisely as they are told by any and all MHS staff with no possibility of refusal.

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

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

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

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

8. As far as government and mainstream psychiatric services in this country are concerned, all mental disorder is necessarily a form of physical brain disease, for which physical forms of treatment are de riguer. A patient detained under MHA will be compelled to take powerful psychiatric drugs regardless of his or her wishes. Public services are not equipped to assess people for psychologically-determined mental disorders but, in any event, they don't believe there is such a thing. A very few patients will be offered the simplified form of moral treatment known as Cognitive-Behavioural Treatment (CBT) but the overwhelming majority will simply be drugged with as many as seven different psychiatric drugs. There is no evidence that polypharmacy does anything but cause severe and often dangerous side effects.

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For the record, there is ample evidence that psychiatric drugs are toxic and have major, long-term side effects [5]. Psychiatric drugs meet all standard definitions of "highly addictive substances." Drug manufacturers have actively suppressed evidence of serious side effects in their products. Australian adults who take psychiatric drugs in the long term die, on average, 19yrs younger than their undrugged peers. In the US, where larger doses and polypharmacy are the norm, that figure is 25yrs. That is, in order to "save an unfortunate's life," the treatment is highly likely to shorten his life dramatically.

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

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

For the record, I have practiced public psychiatry for just on four decades, in a wide variety of settings. In that time I have personally assessed and treated in excess of 15,000 unselected, consecutive patients. Not one of them has been given ECT. There has been one suicide among my patients in about the past ten years.

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

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

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

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

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

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

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

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

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

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

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

12. Conclusion:

To return to the axioms given above:

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

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

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

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

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

Note 1: Risks of suicide:

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

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

Note 2: Is ECT effective?

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

Studies show that the relapse rate after six to 12 months of ECT is approximately 50% in patients who underwent ECT due to refractory depression.... Sackeim et al. demonstrated that

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64% of the patients who received adequate pre-ECT antidepressant treatment relapsed in the first post-ECT year.

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

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

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

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

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

Note 3: The Risks of ECT.

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

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

A few years later, after watching pigs being stunned in a slaughterhouse, the Italian

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

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

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

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

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

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

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

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

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

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

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

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

Memory problems can be a longer-term side effect (of ECT). Surveys conducted by doctors and clinical staff usually find a low level of severe side-effects, maybe around 1 in 10.* Patient-led surveys have found much more, maybe in half of those having ECT...

Some memory problems are probably present in everyone receiving ECT. ... some people do complain that their memory has been permanently affected, that their memories never come back. ...It is not clear how much of this is due to the ECT, and how much is due to the depressive illness or other factors.**

Some people have complained of more distressing experiences, such as feeling that their personalities have changed, that they have lost skills or that they are no longer the person they

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were before ECT. They say that they have never got over the experience and feel permanently harmed. What seems to be generally agreed is that the more ECT someone is given, the more it is likely to affect their memory.... Between 30% and 50% of patients complained of difficulties with memory after ECT.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Note 4: Akathisia.

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

Akathisia for me was an anxiety so intense and deep seated I thought I was losing my mind. I also had an inner restlessness that made me want to keep moving, keep moving...

I was just extraordinarily restless. Not in the sense that I had to get up and go do something, but in the sense that it was distressing to stay still in the same position too long. You know how if you sit in the same position for too long, after a while your joints/muscles/whatever get uncomfortable and you have to get up and stretch or walk around or at least change positions? It was like that, only a million times worse, and it happened every 30 seconds. I had to keep moving, or my brain and body just would not shut up about how it was not OK to stay still.

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It's like the worst "bugs under your skin" feeling ever. I hate it...

...the most severe anxiety-kinda feeling EVER. Panic attacks are bad - that feeling is worse. Nobody ever called it akathisia when I experienced it on *Effexor* (venlafaxine, antidepressant). It got chalked up to anxiety and "histrionic behaviour"... bugs-under-your-skin is a good description. I could not stop moving, I felt like if I did my body would explode.

For me it also comes with a feeling of rage - I needed to scream almost as much as I need to move. I think it's just a product of the desperation I felt, though - at times I would also cry uncontrollably (but did not feel sad).

(Akathisia was) like I HAD to move, but the *Abilify* (aripiprazole, antipsychotic) had made me fatigued as well so I was in this horrible in-between state that was driving me insane. My doc said that people have actually killed themselves over it because they couldn't describe what was going on with them and get so upset and frustrated they kill themselves. I could NOT get comfortable anywhere, no matter what. I had trouble sleeping, I couldn't stop moving, I needed to move.

I am just coming down off severe akathisia from *Remeron* (mirtazepine, antidepressant). I was pacing back and forth and up and down stairs from 5am to midnight two days ago. It felt like I'd had 18 shots of espresso. Worst experience of my life. Emotionally, I flipped back and forth from extreme anxiety (just want to die because the world is ending and you're losing your mind simultaneously) to a giddy, silly, hypomanic-type mood.

When I had it the first time, it was mainly physical. I had no idea what it was and my psychiatrist said it was mania. It wasn't though. It was sit down, stand up, try to lie down, pop back up, pace, sit etc. Once I shoved myself around the living room on an office chair with loud music on. I recommend that. That would have been *Seroquel* or *Abilify* or both (quetiapine and aripiprazole, antipsychotics). Next time it was *Abilify* withdrawal/ discontinuation and it was more mental, as in dread, grim, doom, and the the constant refrain in my head "I can't take this another minute." By then I knew what it was, not that it helped anyway.

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

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

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

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