



MISDIAGNOSIS AND OVERDIAGNOSIS IN PSYCHIATRY: THE LOOMING CATASTROPHE

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BRISBANE, AUSTRALIA

OVERDIAGNOSIS CONFERENCE, QUEBEC, AUG 17-19 2017

MISDIAGNOSIS AND OVERDIAGNOSIS IN PSYCHIATRY

Australia: Hybrid system of

- * Commonwealth public services (including DVA)
- * state public services (general and psychiatric hospitals, community clinics)
- * private (practitioners, hospitals, laboratory)
- * Health expenditure ~9% of GDP
- * financed mainly by Commonwealth, with some state and private insurance.

Excellent health statistics across the nation.

By international standards, Australia rates highly on practically all parameters.

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- In private practice: Standard: Private practitioners bill the fee to Medicare for 85% of standard fee (bulk-billing). Patients pay nothing.
 - Advantage: Keeps people out of public system (cf. half hour at Goodna MHS \$275 vs my practice \$73.40).
- Alternative: Private practitioners can choose to charge what they like; patients often pay a large “gap” over the standard fee (100-200% or more).

BUT: Inherent inefficiencies in a private system such as....

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-no control over prescriptions.
 - Prescription rates for psychiatric drugs rocketing across the country.
 - Huge differences in prescription rates from one area to another (up to 7000%)
 - Antidepressants: 1% of population in 1990, to 10% 2015 (US = 13%).
 - Antipsychotic drugs worse: quetiapine up 85% from 2008-2011.
 - “Mood Stabilisers” (anticonvulsants): valproate up 800% from 1991-2012 (slight fall in epilepsy).

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- Does this matter?
- Side effects of antidepressants:
 - Drowsiness, confusion, delayed reactions;
 - Massive weight gain, loss of libido;
 - Akathisia, tremor;
 - Addictive and withdrawal effects (2yrs).
 - All side effects highly persistent. Tardive akathisia and dyskinesia.
- Problem for prescribers: Anybody who is given full list of side-effects of antidepressants won't take them.
 - Solution: Nobody tells them.

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- Qui bono?

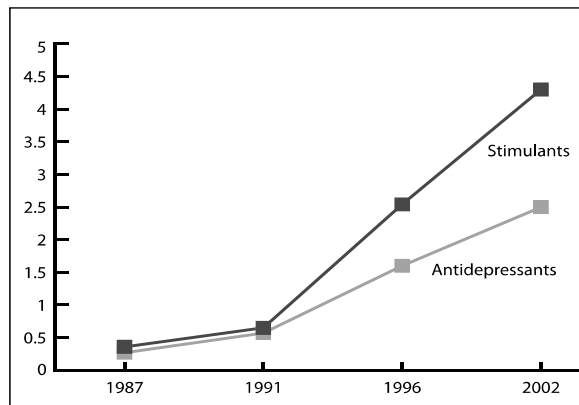
- *Zero evidence to say mental health improving.*
 - Community surveys, hospital admissions, burden of illness, early retirement;
 - E.g. Suicide rate recently hit peak (12.6/100,000), M:F = 4:1.
 - Early deaths from chronic psychotropic drug consumption (19yrs in Australia, 25yrs in US).
 - Massive and rapidly-increasing cost of psychiatric drugs.
 - Relentlessly rising disability pensions
- Qui bono? Certainly not the patients. Can this be right?

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AN EPIDEMIC UNFOLDS

The Iatrogenic Agents Spread

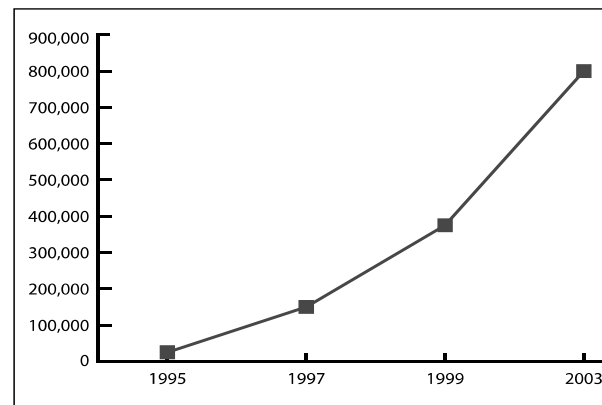
Percentage of American youth younger than 20 on a stimulant or antidepressant



The prescription rates are compiled from three separate reports. See in particular Zito, J. "Psychotropic practice patterns for youth," *Archives of Pediatric Adolescent Medicine* 157 (2003):17-25.

Juvenile Bipolar Diagnoses Leap

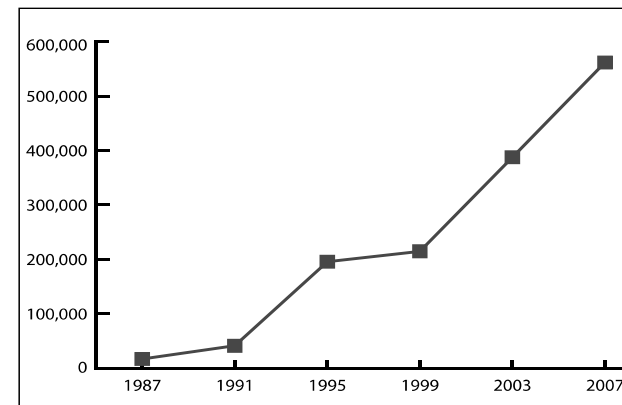
Outpatient office visits by youths under 20 with a diagnosis of bipolar disorder



Source: Moreno, C. "National trends in the outpatient diagnosis and treatment of bipolar disorder in youth." *Archives of General Psychiatry* 64 (2007):1032-9.

And Disability Numbers Soar

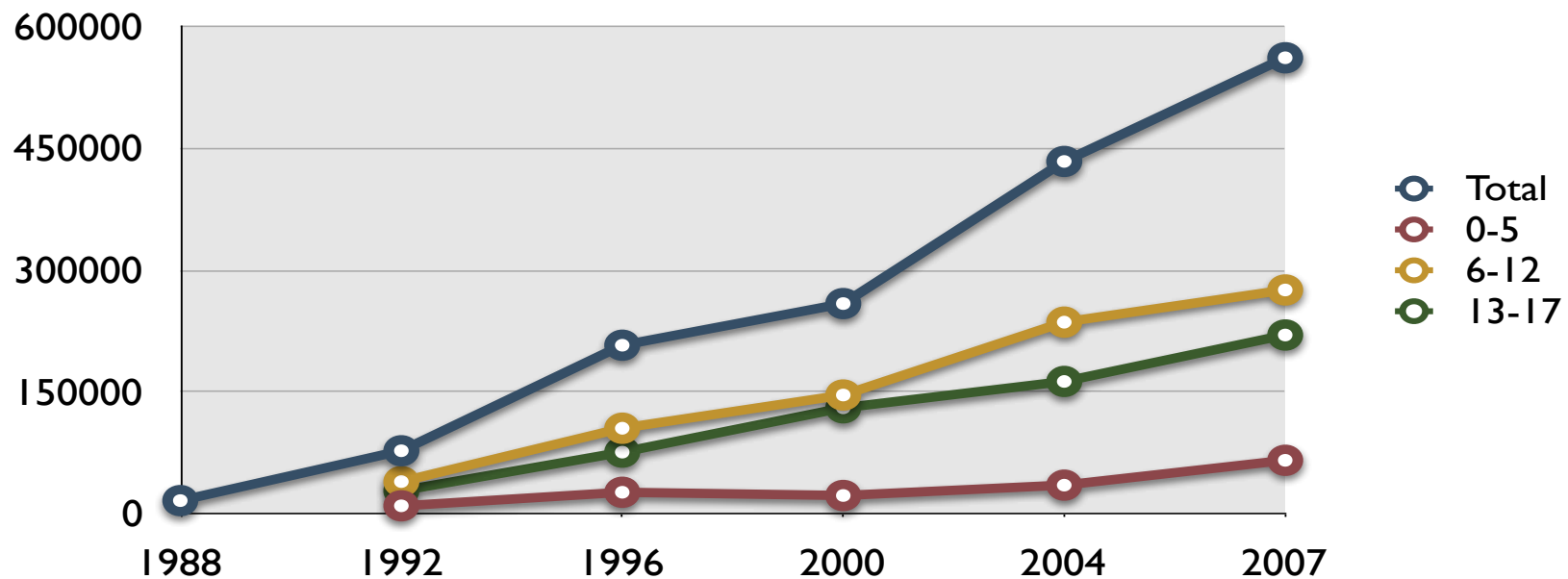
SSI recipients under 18 years old disabled by mental illness, 1987-2007



Source: Social Security Administration reports, 1987-2007.

The Epidemic in Children

Children on SSI Disability Due to Mental Illness



Prior to 1992, the government's SSI reports did not break down recipients into subgroups by age. Source: Social Security Administration reports, 1988-2007.

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- ECT:

- RANZCP: “ECT is valuable and essential form of treatment ... when clinically indicated.”
- Urgent life-saving treatment for severe depression.
- Norway: 8wk wait at ETC centres.
- Usage rates: Australia and US roughly equivalent.
- Australia vs NZ: 600%
- Australia vs UK: 1000% (Qld 4.8mln ~ England NHS 53mln)
- Poland 5000%; Italy 6250% (14 of 91 centres); Pavia....?

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- ECT:

- US: Median ECT patient EWWF (cf. YPEM)
- Australia: ECT given by male psychiatrists to female patients.
- 93% of ECT given by men.
- Suicide rate for women ~ 1/700 cases of depression, men 1/400.
- Misallocation of resources.
- Compare Australia and NZ: same college, only one difference.
- Conclusion: ECT is not valuable, not essential and only clinically indicated for one reason.

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- CV. (1970, 1977, 1987, 1993, 1996, 2012)
 - 40yrs: 12000+ consecutive, unselected public patients (veterans, military, Aboriginal, prisons, drugs and alcohol etc.)
 - Application of philosophy of science to psychiatry.
 - Five monographs, next nearly finished.
 - Numerous papers, articles etc.
 - Steady stream of complaints from mainstream psychiatrists

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Decorative background elements on a dark blue gradient include:

- White circular gauges and dials with numerical scales (e.g., 190, 200, 210, 80, 90, 100, 110, 120).
- White dashed lines forming circular paths.
- White arrows indicating direction.
- Small white star-like patterns.

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- What's the point of the travelogue?

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- Currently: Bulk-billing shopfront practice in working class area: high unemployment, disability, broken families, immigrants, drugs and alcohol, crime.
- 200 new cases a year, 2-7 day waiting list.
- Normal private practice in Australia: 40 new cases a year, 3-6 month wait.

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- Average Australian private psychiatric practice:
 - Old, female, well-educated, wealthy, white, well-behaved, extensive family support.
- Practice profile:
 - Young, male, ethnic, poor education, unemployed or DSP, criminal records, drugs and alcohol, isolated.

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- 50% of patients suicidal at referral:
 - Admission to hospital: 1% pa.
 - Antidepressants: 1-2% pa.
 - “Mood stabilisers”: Never (Jack Dreyfus)
 - Antipsychotics only in active psychosis.
 - Stimulants: Never.
 - ECT: Never (including hospitals).

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- Bulk-billing private practice rare due to perverse incentives:
 - Public practice: 50 sessions pa, \$150 p.hr.
 - Private hospitals: No limits, unlimited gap.
 - ECT: ~\$500 p.hr.
- Net effect:

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- Bipolar Disorder:
 - 1974: 0.1-0.2% prevalence.
 - 1984: 1.0% (Andreassen)
 - 2005: 5.4% (Judd & Akiskal).....?

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- “Dr. Lewis Judd has watched—and to a remarkable degree, helped shape—the evolution of psychiatry from its decidedly charismatic but often controversial past to its *empirical present as a data-driven, hard-charging neuroscience....* Judd was among the first and leading proponents for treating mental disorders like depression as the result of *neurological and biological dysfunction*, and arguing that they could be *effectively treated with appropriate, rigorously developed psychopharmaceuticals.*”
 - UC San Diego News Center, June 13th 2013.

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- **Bipolar Disorder:**
 - 1974: 0.1-0.2% prevalence.
 - 1984: 1.0% (Andreassen)
 - 2003: 6.4% (Judd & Akiskal)
 - 2011: 11.2% (Mitchell)
 - 2017: 15%

MISDIAGNOSIS AND OVERDIAGNOSIS IN PSYCHIATRY

- 15,000% increase in “genetic disorder” in one generation.
- How could this happen?
 - Lack of model of mental disorder.
 - Drug companies.
 - Academic psychiatry.

MISDIAGNOSIS AND OVERDIAGNOSIS IN PSYCHIATRY

- How could this happen?
 - Lack of model of mental disorder: “Mental disorder is brain disorder.”
 - No evidence whatsoever for a formal, reductionist model of mental disorder anywhere in the entire psychiatric literature, or philosophical, or psychological, or neurosciences.
 - McLaren N (2013). Psychiatry as Ideology. *Ethical Human Psychology and Psychiatry* 15: 7-18.

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- How could this happen?
 - Lack of model of mental disorder (Psychiatry as Ideology)
 - Drug companies. \$42billion in fines in 8yrs.

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DSM-5: Symptom	Mania	Hypomania	Anxiety
Irritability			
Disturbed sleep			
Talkative or pressure to keep talking			
Subjective experience of racing thoughts			
Distractibility			
Psychomotor agitation			
Impairs social or occupational function			

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Symptom	Mania	Hypomania	Anxiety
Irritability	Yes	Yes	Yes
Disturbed sleep	Yes	Yes	Yes
Talkative or pressure to keep talking	Yes	Yes	Yes
Subjective experience of racing thoughts	Yes	Yes	Yes
Distractibility	Yes	Yes	Yes
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 - Academic psychiatry: “biologisation of mental disorder.”

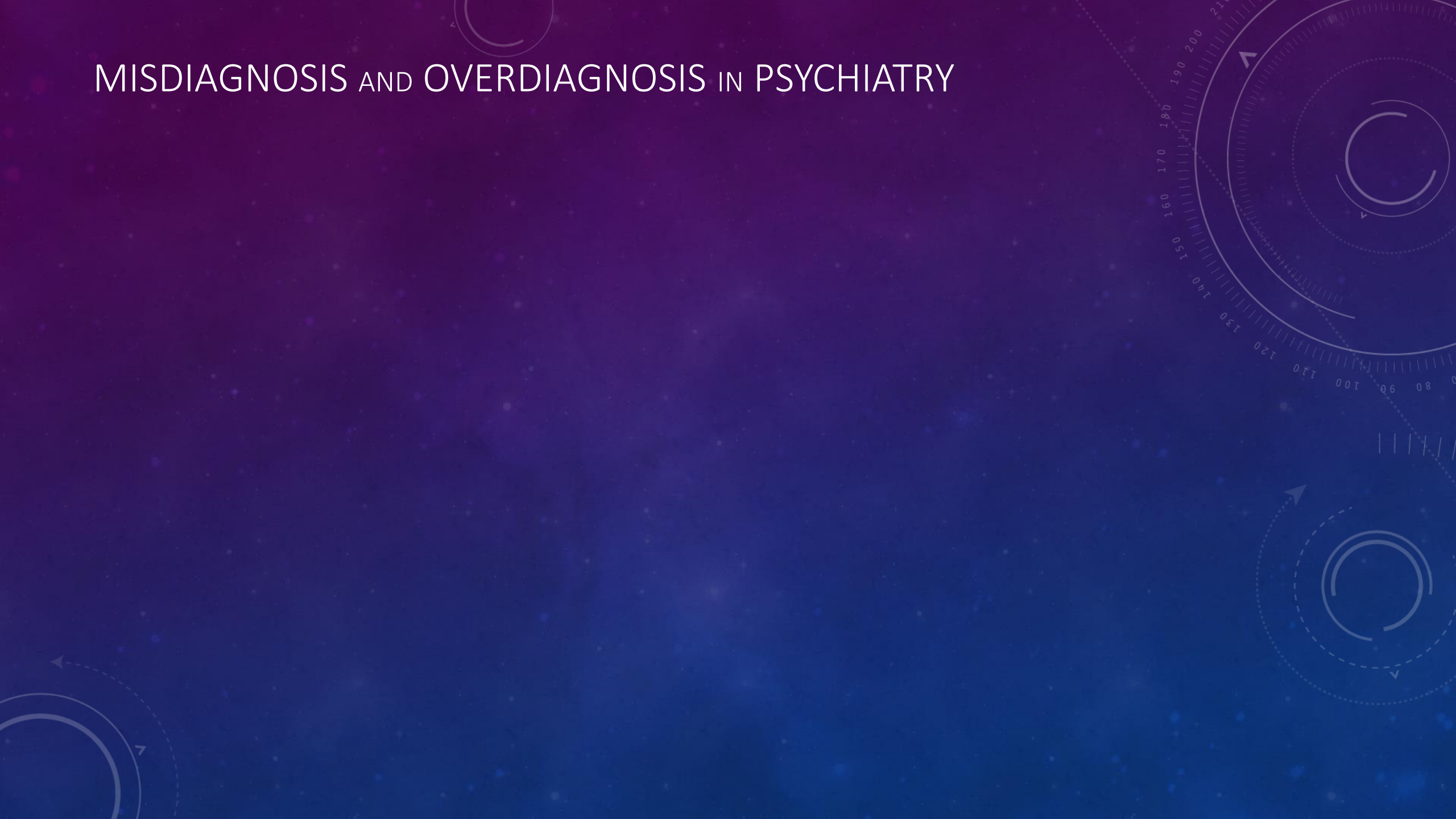
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- Lewis Judd: *Psychiatry as a data-driven, hard-charging neuroscience*
- mental disorders as the result of *neurological and biological dysfunction*, can be *effectively treated with appropriate, rigorously developed psychopharmaceuticals.*”
- psychiatry as *a real biomedical science.*
 - McLaren N (2016). Psychiatry as Bullshit. *Ethical Human Psychology and Psychiatry* 18: 48-57.

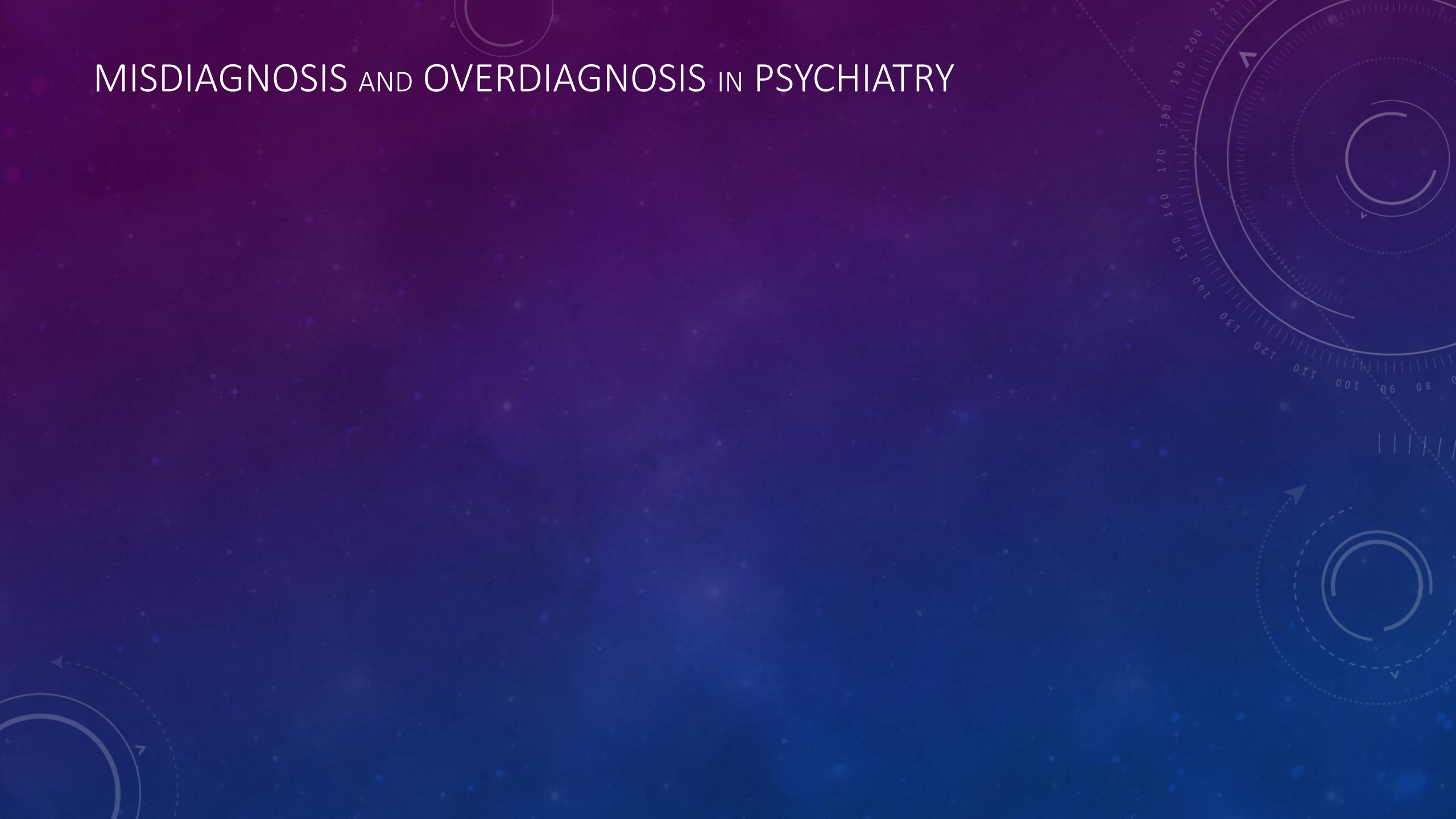
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- **THE LOOMING CATASTROPHE:**
- Psychotropic drugs:
 - Highly addictive;
 - Marginally more effective than placebo;
 - Early death;
 - Increase risk of dementia in veterans by up to 390%;
 - Very expensive; divert attention from psychological factors.

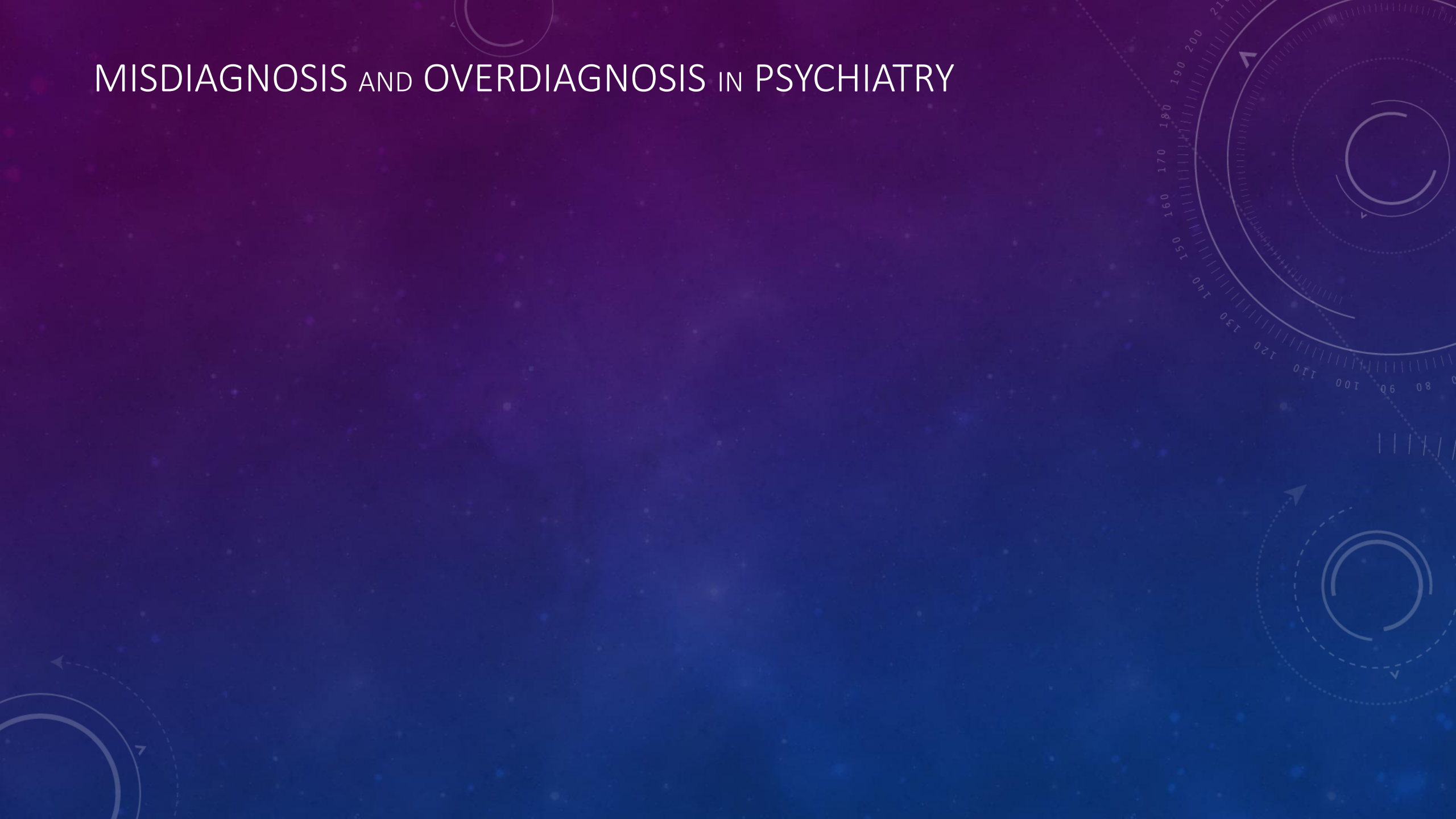
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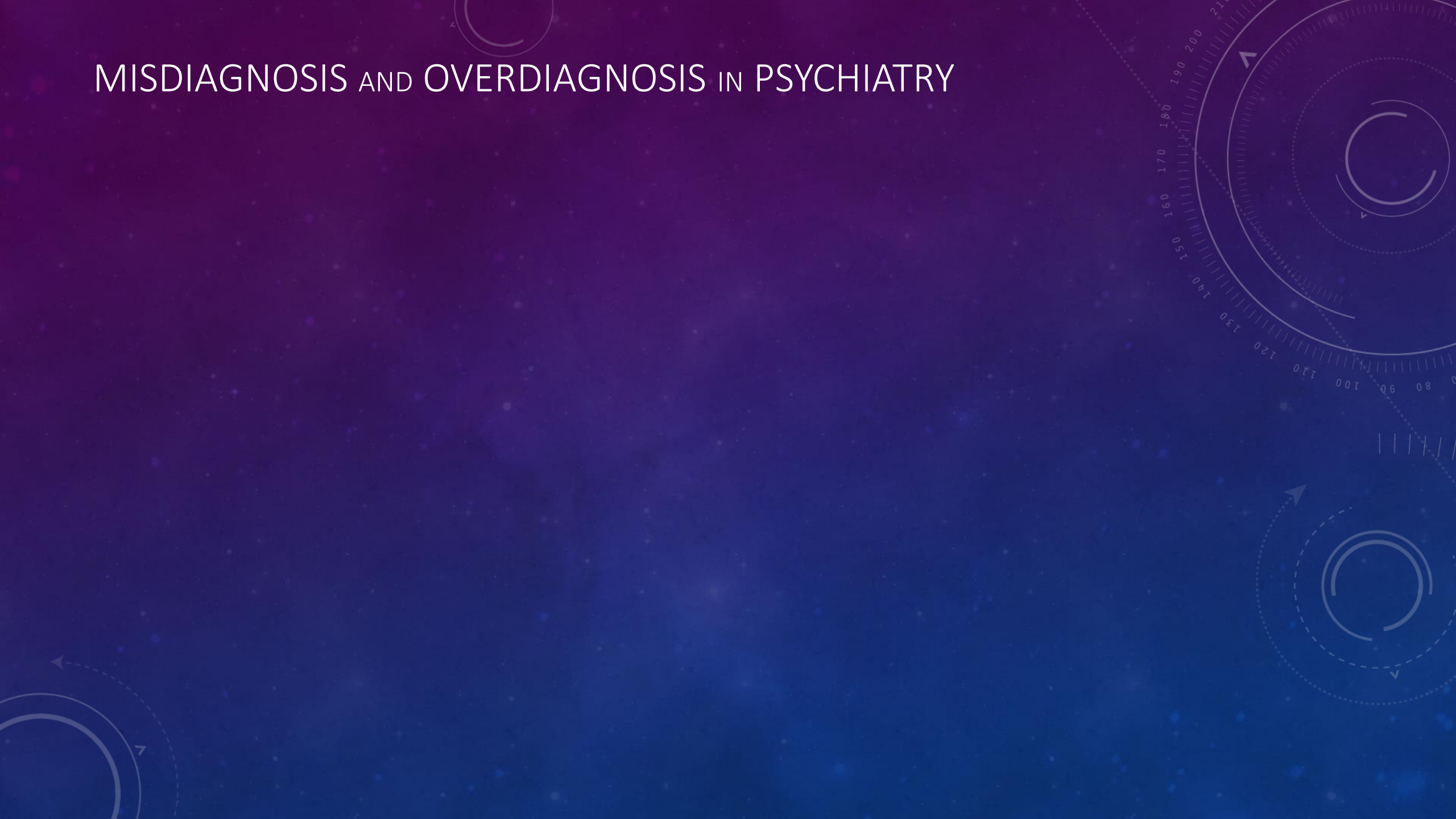
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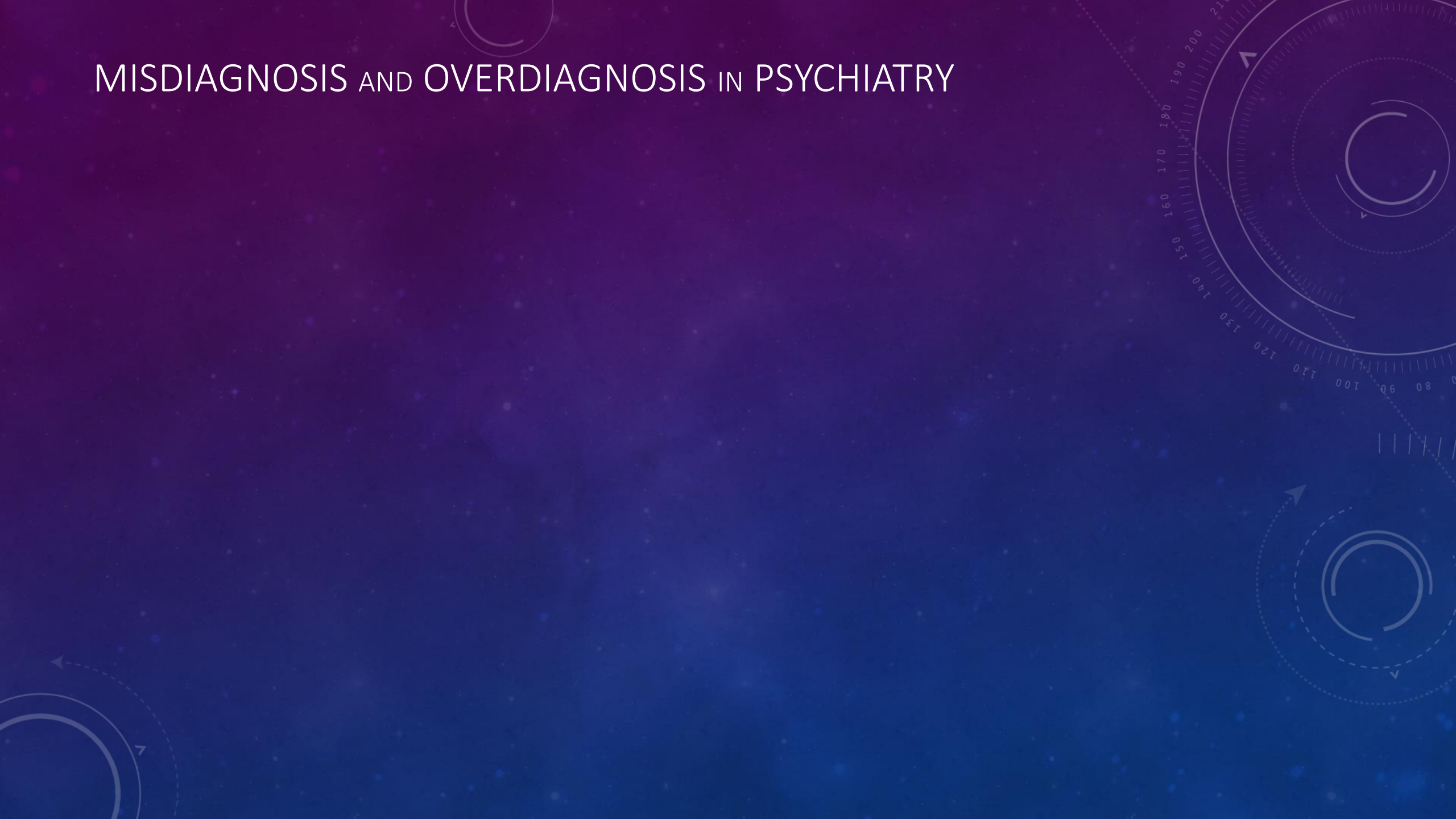
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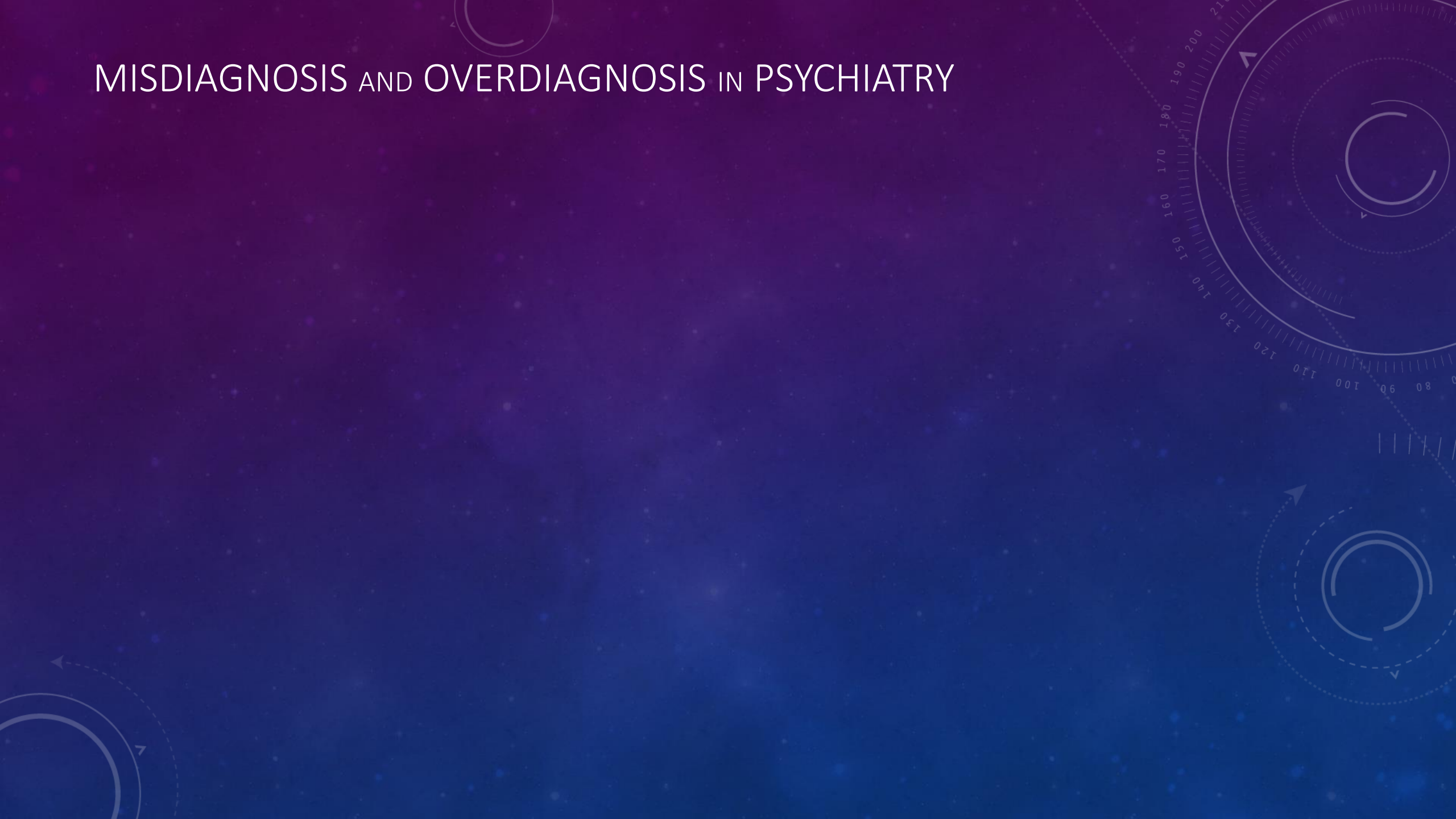
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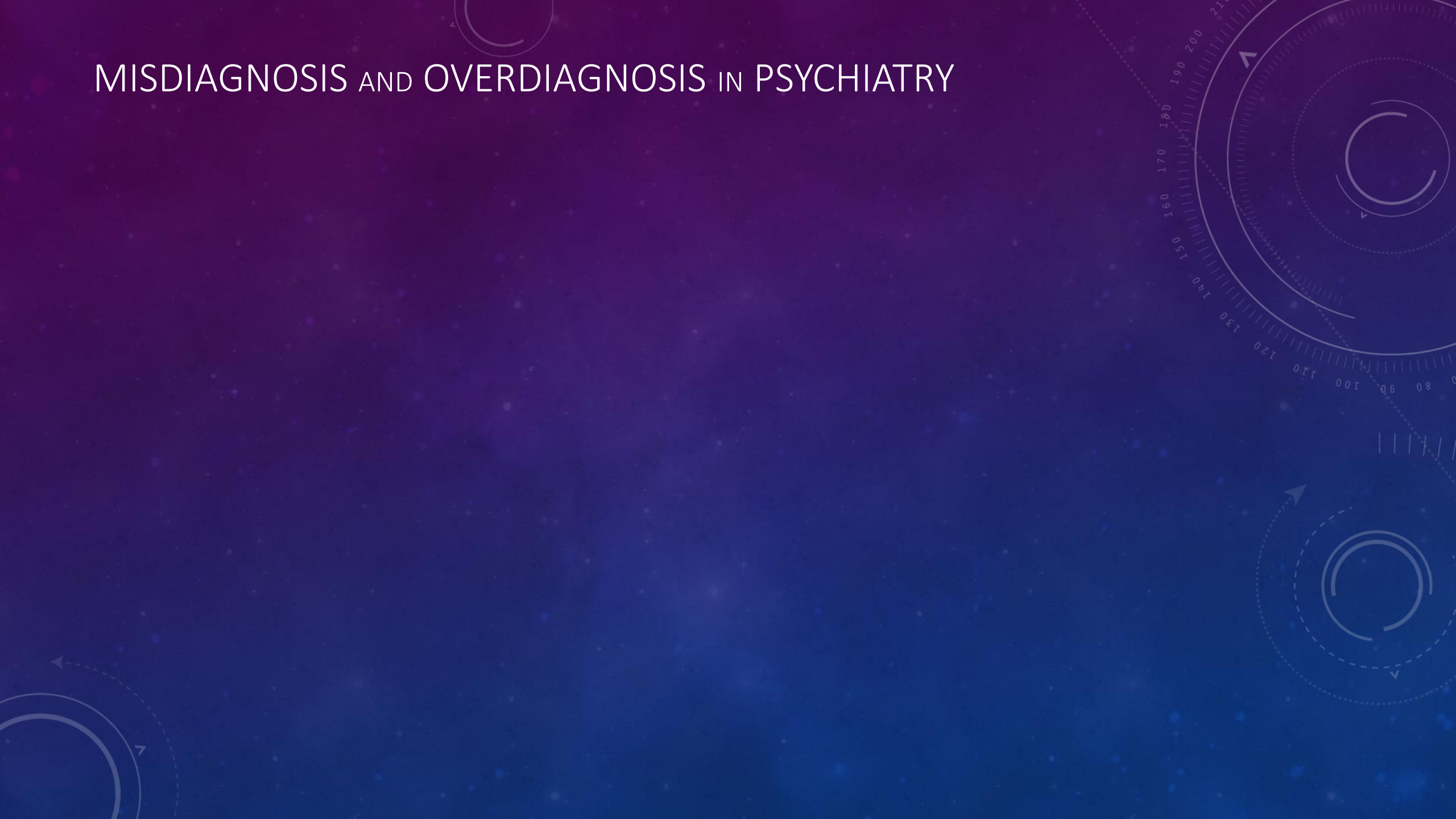
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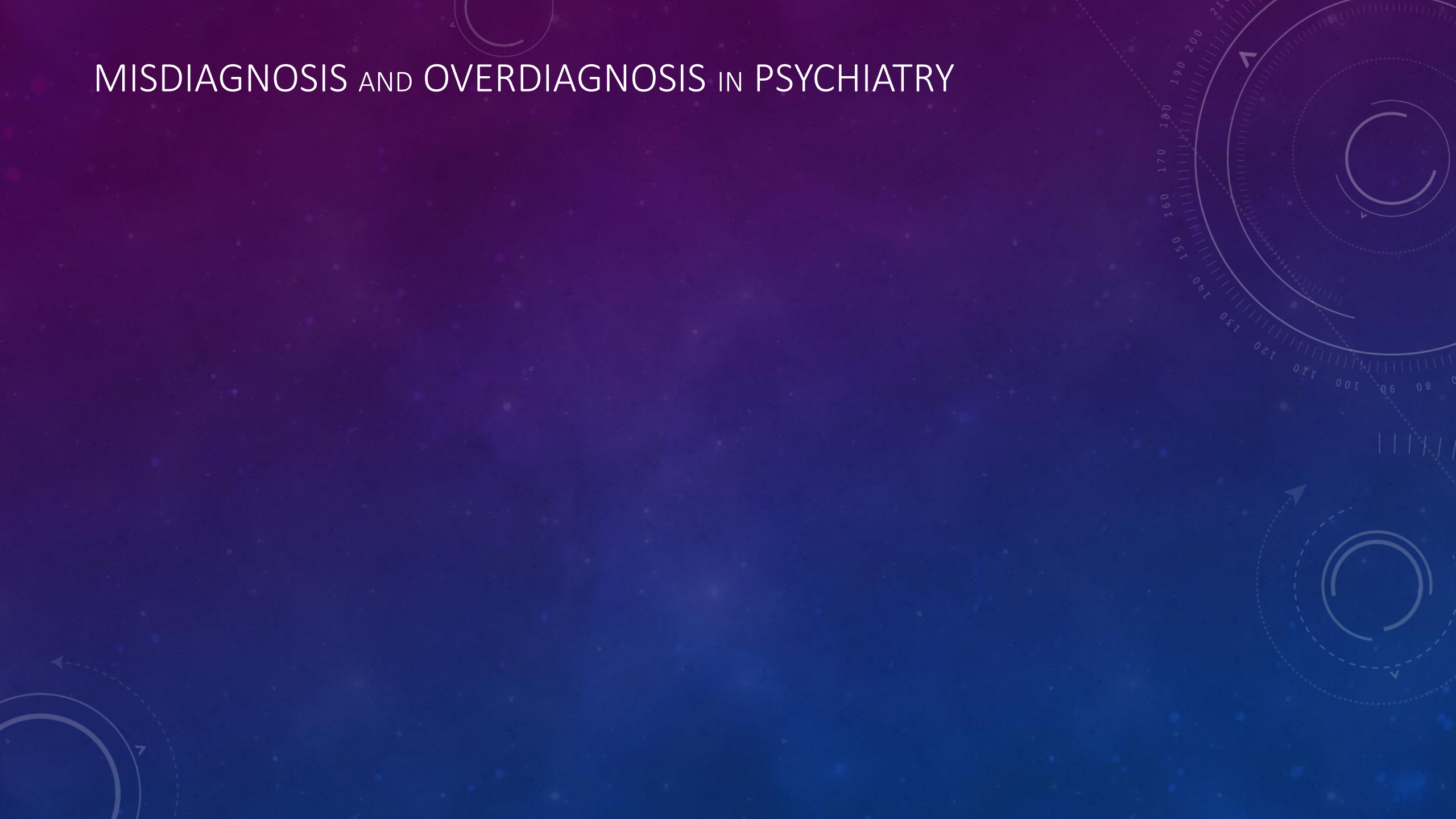
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