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July 3rd 2015.

Mr D Sullivan
Parliament House
Canberra ACT 2600

By email

Dear Sirs

Re: Senate Enquiry: <u>Mental health of Australian Defence Force Personnel</u>

Further to my recent telephone call to you, I attach a submission to the above enquiry. As explained, I did not know this enquiry was happening until just after submissions closed so I am most grateful you are still able to accept it.

The material should be self-explanatory but I would still greatly appreciate the opportunity to address the enquiry in person. I am not sure how this is done, whether in person or by video, but if my offer is accepted, I will contact you to finalise details. Please note that the pages in the file do not number correctly but I do not know how to correct it.

If you require any further information, please let me know by email.

Thanking you

Yours faithfully

N McLaren

Niall McLaren MBBS FRANZCP
Psychiatrist, Brisbane, Australia.

Submission to Senate Enquiry: **Mental health of Australian Defence Force Personnel**

1. Qualifications:

1.1: A brief CV is attached as Appendix 1. I submit that I have the qualifications and experience to give evidence to this enquiry as an expert in the area of mental health, including post-traumatic mental disorders. In addition, I have extensive training and research experience qualifying me to speak on theoretical matters in the broader field of psychiatry, specifically the application of the philosophy of science to psychiatry and theories of mind in psychiatry.

2. Current status of psychiatry as a discipline:

2.1: Despite the widely-held opinion, it is a matter of established fact that modern psychiatry lacks the most basic feature of any field claiming scientific status, a model of its own area of study. Modern psychiatry has no model of mental disorder. For many people, this is so counter-intuitive as to be astonishing, even impossible, but it is certainly the case that nothing published in the psychiatric literature justifies any person saying that he practices psychiatry from the basis of a proven, accepted theory of mental disorder. The claims that mental disorder is of this or of that nature, especially that it is biological in nature, have no warrant or substance in the literature. Such claims are wholly ideological [1]. The current biological research program in psychiatry is unjustified [2] and is most unlikely (read: unable) to produce the benefits its exponents claim.
Despite all claims to the contrary, the huge sums of money spent on biological research in psychiatry achieve nothing in terms of measurable change in the lives of sufferers.

2.2: Orthodox psychiatry is hostile to this conclusion but has signally failed to respond to it. Mainstream psychiatrists, including academics charged with teaching medical students and the coming generations of psychiatrists, rely on untested theories to establish their status as an independent discipline. For example, it is often said that psychiatrists use the “biopsychosocial model” in daily practice, and that this model distinguishes them from all other specialities and disciplines. For example, in Australia for five years from October 1998, this term was used on the official website of the *Royal Australian and New Zealand College of Psychiatrists* (RANZCP) as the defining feature of psychiatric practice.

2.3: What the website did not say was that in April 1998, a paper was published in the official journal of the RANZCP, the *Australian and New Zealand Journal of Psychiatry (ANZJP)* which showed conclusively that the so-called 'biopsychosocial model' did not exist [3]. This is, of course, potentially hugely embarrassing to the profession but orthodox psychiatry has perfected a way of dealing with embarrassments: ignore them, act as though they never happened. To this day, the website of the *Canadian Psychiatric Association* (CPA) declares that its primary objective is “...to uphold and develop the biopsychosocial approach to the practice of psychiatry.” They have been specifically told that there is no such thing but they ignore the warning, which is standard psychiatric practice for any news they don't like. Their journal says exactly the same thing but the editors reject any commentary on this point. This is the norm: it is not the exception.

2.4: Modern psychiatry has the trappings of science (a exclusive body of adherents, an arduous entrance procedure, rituals and paraphernalia, its own jargon, arcane publications, research programs, committees, conferences, and so on) but it lacks the essential features of a science. The claim that psychiatry is an applied science has no warrant or justification. Thus, mainstream psychiatry is highly antagonistic to dissenting views: trainees are required to learn only what they are told to learn, and opposing opinions are actively excluded. Postgraduate training in psychiatry is now very much more restricted than it was thirty years ago. Psychiatry has more in common with a religious sect than with fields generally accepted as scientific.

2.5: In the absence of any formal model of mental disorder (due to the lack of an articulated model of mind), psychiatry has no standard or agreed model of the concept of acquired or post-traumatic mental disorders. Over the past hundred years, dozens of terms have been used such as *effort syndrome*, *Da Costa's syndrome*, *disordered action of the heart*, *shell shock*, *war neurosis*, *neurocardiac myasthenia*, *anxiety-hysteria* and, most recently, *post-traumatic stress disorder* (PTSD). It must be understood that this is a meaningless term as, in psychiatry, there is no such condition as “stress.” PTSD actually means “the lasting mental disorder that develops after psychological stressors of severe or traumatic intensity.”

2.6: While nobody would dispute that sudden, massive psychological stressors readily produce quite profound acute or short-term effects (previously known as the acute stress response, now *Acute Stress Disorder* or *Adjustment Disorder*), there has long been argument over whether purely psychological causes could produce permanent mental disorder. While Shakespeare had no problem with the notion, the modern argument arises only because mainstream psychiatry is determined to find a biological basis for mental disorder, and allowing a category of acquired mental disorder upends their thesis. Note that the list abovedoes not include the most common “diagnosis,” malingering, i.e. the belief, extensively articulated by Prof. Thomas S Szasz and his disciples, that there is no such thing as mental disorder, that it is all an elaborate scam. A detailed case arguing against the Szaszian approach is available [4], with reference to his contemptuous views on military mental disorders.

2.7: Mainstream psychiatry actively conveys the impression that it has a complete understanding of all mental disorders, that all mental disorder is due to a “chemical imbalance of the brain,” but this is without factual basis. Having committed itself to a biological approach, it now has no options beyond drug management and other physical approaches such as ECT and various forms of brain stimulation etc. There is no theoretical basis for this whatsoever. Any claim that PTSD should be managed one particular way or another lacks a theoretical foundation. The only criteria for management are humanity and outcome, with cost a distant third.

2.8: The last thirty years, since the publication of the American DSM-III, have seen an explosive increase in psychiatric diagnoses, an even more explosive increase in drug consumption, and absolutely no reduction in psychiatric morbidity whatsover. The numbers of people on long-term psychotropic medication, retiring early or on pensions for psychiatric disorder, continue to rise exponentially: the more drugs the community consumes, the worse the outcome. Instead of getting better, every statistic says that people drawn into this industry get worse. People who previously would have been assessed as having an abnormal personality are given formal diagnoses of mental illness, especially bipolar syndrome, autistic disorders and ADHD, and are prescribed large to very large doses of powerful psychotropic drugs [5]. There is a constant process of “diagnostic bracket creep,” where a single feature of a major diagnosis trumps all the features of a minor diagnosis. In particular, the diagnosis of PTSD is now awarded far more liberally than was ever intended. People who are given this diagnosis are highly likely to leave

the workforce permanently. It is the diagnosis that produces the lasting disability, not the other way around.

2.9: The outcomes for major mental disorder are now worse than they were 35 years ago: people who are prescribed long-term psychiatric drugs die, on average, 19 years younger than those who have never taken them. There is a powerful case to say that the drugs are causing the epidemic of major mental disorders [6]. Mainstream psychiatry is bitterly antagonistic to this conclusion and actively does everything it can to ensure trainee psychiatrists are not exposed to it. Drug companies, of course, spend heavily on disseminating that mental disorder is extremely common, insidious and potentially lethal, and that their products are safe, cheap, reliable and effective. Nothing could be further from the truth.

3. Mainstream psychiatric management:

3.1: Practically anybody who sees a psychiatrist these days will walk out with a prescription for a range of psychoactive drugs. It should be clearly understood that these drugs are very powerful and have a huge range of unpleasant to potentially dangerous side effect, including compelling dependency states and very unpleasant, frightening and highly persistent withdrawal effects when they are stopped (see Appendix 2). Consequently, once started, most people never get off them. It is not at all unusual to see patients taking up to five or six different psychiatric drugs.

3.2: The drugs were never designed or tested for long-term use. The overwhelming majority of research studies are short term only. The long term effects are poorly understood and reports of adverse effects have often been suppressed by the manufacturers [6].

3.2: The vast majority of people given a diagnosis of PTSD by a mainstream psychiatrist will be prescribed large doses of drugs that can do no more than suppress the worst symptoms while producing debilitating side effects and a state of dependency indistinguishable from the most serious addictions. If the patient's condition deteriorates, the inevitable response is “more of the same,” i.e. more drugs, more hospital, more ECT, which necessarily means more costs. Psychiatry's response to poor outcomes is not to question the diagnosis or the treatment but to tell patients they have a life-long brain disease which can never be cured and can only be controlled – by drugs. When the treatment fails, the outcome goals are lowered. Needless to say, the great majority of these people will not return to the workforce. Moreover, many if not most will lose their families and friends, their hobbies and interests and will eke out their truncated lives seriously isolated, despairing and prone to drug and alcohol abuse. An unknown but significant proportion of them will come into conflict with the law.

4. Comparative costs of different forms of management:

4.1: Each year, huge but essentially unknown sums of money are spent on conventional psychiatric management but accurate outcome records are not maintained. In Australia, the Defence Dept. doesn't even know how many of its veterans commit suicide [7]. We know from the US that at least 22 veterans a day die by suicide, meaning that every year, the number of suicides exceeds the total combat deaths in the Middle East since 1991. British figures are not so bad but are trending in the same direction. There is no indication whatsoever that these trends will change. Completed suicides, however, are only the most obvious treatment failures: for every suicide, there would be a hundred damaged men carefully making sure they remain invisible because of their burning sense of shame. We have never seen a contingent of PTSD sufferers swing around the corner on April 25th.

4.2: The failure of successive Australian governments to keep accurate outcome records for the men it sends overseas on combat missions is institutionalised. In 1919 and again in 1945-46, the physical wherewithal to build an adequate data base did not exist but that excuse no longer applies. A data base to record ADF and veteran suicides throughout the country would cost no more than about $100,000 pa although a university would probably do it for very much less (in the UK, the BBC put a junior reporter on the task and quickly showed that suicides were exceeding combat deaths). In the absence of proper records, there can be no claims of therapeutic efficacy.

4.3: It must be understood that current treatment programs funded by ADF and DVA for serving members and veterans are based not on long-term outcomes, of which suicide is only one of many valid parameters, but on short-term outcomes. *By various means, these programs produce confirmatory bias which magnifies the apparent efficacy of the treatment, regardless of what it is.*

4.4: *In the history of psychiatry, there are so many examples of over-valued treatments that it is hard to know where to star*t: psychosurgery in the 1950s, insulin coma therapy from about 1935-55, and more recently, the use of stimulants (amphetamines etc) in children and adolescents. For a variety of reasons, there is now a huge industry across the world directed at dosing children with these powerful drugs of addiction [8]. The only decent long-term study of their effects has been in Western Australia. A study from UWA's Raine Foundation has shown that, over twenty years, these very expensive drugs are worse than useless [9]. They produce no measurable improvement in outcome and are responsible for an epidemic of amphetamine addiction.

4.5: The use of electroconvulsive treatment (ECT) in psychiatry illustrates this point. The RANZCP Position Statement on ECT (No. 74 of March 2014) states: “ECT remains a useful and essential treatment option that should be available to all patients...” In 2015, ECT is still quite widely used.

Since I graduated in psychiatry in 1977, I have seen approximately 15,000 individual patients in a wide variety of settings, mostly in conditions of quite extreme isolation. My patients are at the difficult end of the spectrum: predominantly young, male, paranoid and aggressive with high levels of drug and alcohol abuse, social isolation etc. Having worked for decades in public practice, I can state with no hesitation that the types of patients I see every day in my private, practice are exactly the same as are seen in any public out-patient service. I do not use ECT. The claim that ECT is “essential” has no basis in clinical practice.

From 1982-87, I was head of the psychiatry department at the former Hollywood Repatriation Hospital in Perth. From 1993-96, I was chief psychiatrist for Top End Mental Health Services in Darwin. In both hospitals, ECT had been used quite extensively prior to my taking up my appointments. For the duration of my appointments in each hospital, it was not used. In both cases, the admission rate, the bed occupancy rate and the mean duration of stay dropped dramatically (generally about 50% for each parameter). In each case, ECT was resumed some time after I left and their figures promptly worsened.

Patients receiving a course of 10-12 ECT are normally in hospital for 4-6wks. At about $1200-1500 per day for the bed alone, plus about $500 per individual treatment, the cost of this form of treatment is very high. Ten ECT over four weeks in hospital would cost approximately $40,000. This does not include the cost to the patient of lost work, memory damage, impact on the family, stigma, etc. My figures show it is completely unnecessary. It is possible to achieve at least the same if not better results, quicker, at very much lower cost and with less disruption to the patient's life, without using ECT.

It is, however, impossible to convince psychiatrists who use it that this is the case. Invariably,

they retort that my figures are “anecdotal.” This does not mean they have found fault in them, but they are point-blank refusing to read the information put before them. Fifteen thousand patients over nearly forty years is not anecdotal. *It now amounts to one of the world's longest-running naturalistic studies.* By labelling a report as anecdotal, psychiatrists believe they have the perfect excuse not to read it, as they are scientists and scientists don't read anecdotes. However, the crucial point about anecdotes is that while anecdotes do not add up to a general truth, a single anecdote can disprove a general claim.
My long experience shows that ECT is neither useful nor essential. It is an option, and a remarkably expensive option at that. People who say it is not possible to practice psychiatry without using ECT are saying only that they don't know how to practice psychiatry without using it. To me, that is an admission of failure.

4.6: In the absence of an adequate model of mental disorder that points to suitable forms of management, fads and fashions regularly erupt in psychiatry and take control of the therapeutic process. There is a perverse incentive driving practitioners, especially academics, to discover “the next breakthrough.” In the rest of medicine, technology and incisive thinking drive the breakthroughs (with a bit of luck, as Warren and Marshall showed). Psychiatry, however, has no technology of mind and the thinking is driven by a crude reductionist approach to mental disorder. Consequently, practitioners grab anything that shows a transient improvement and tout it as a breakthrough, which it never is.

4.6: Standard psychiatric management of the post-traumatic mental disorders relies heavily on large doses of powerful psychiatric medication in the very long term, coupled with extensive psychological counselling of various types. Intensive day patient courses are available, from 4-6wks, but the costs are not available. It is unlikely they would cost under $1000 a day for 20-30 days, quite possibly significantly more. During this time, of course, the patient will not be at work and must be supported, adding to the costs.
People who embark on the standard type of program generally do not return to work. Where this type of treatment is not available, outcomes are either no worse or even significantly better. The inevitable conclusion is that treatment produces its own bias, i.e. that a significant proportion of the morbidity of the modern post-traumatic states is iatrogenic.
The recent Four Corners documentary on PTSD in veterans [7] showed four cases, including one with a fatal outcome. Several of them had undergone high-input, expensive standard psychiatric treatment. These are exactly the types of patients I see every day and manage as outpatients without using psychiatric drugs and without using additional counselling services. The results are generally better than indicated in the documentary, very much quicker and at a tiny fraction of the cost.

4.7: The reaction by the mainstream “treatment industry” to this very low-key management of post-traumatic and other mental disorders in ADF and veterans is one of hostility and disbelief. It is not possible to get this type of material published by the local psychiatric journals or to present it at the main psychiatric conferences.

5. Managing veterans:

5.1: The ADF has always had a chief psychiatrist as well as senior administrative psychiatrists for each branch. It recently established a specific centre, the ADF Centre for Mental Health at HMAS *Penguin*, in Sydney (ADF-CMH). There is also the Australian Centre for Post-Traumatic Mental Health at Melbourne University (ACPMH, now renamed “Phoenix Australia”) and the Centre for Traumatic Stress Studies in Adelaide. Until Dec. 2014, there was also the Centre for

Military and Veterans' Health at U.Qld, in Brisbane (CMVH) . The website of ACPMH shows it has a board of six managers, five senior clinicians and seventeen other staff. ADF-CMH appears to have about half a dozen staff including psychologists and a psychiatrist.

5.2: For fifteen years from 1996-2011, I saw the great bulk of serving ADF members in Darwin. Not one of my patients was admitted to the private hospital and only a few were admitted to Robertson Barracks Medical Centre (RBMC). None of them received ECT; not one of them was prescribed antipsychotic drugs or the group of drugs known as “mood stabilisers” (lithium or anticonvulsants); practically none of them was prescribed antidepressants; to my knowledge none of them went to one of the residential or day patient courses on offer in the major southern cities; none were known to have committed suicide while still serving.
Since I moved to Brisbane and began seeing military patients here, I have quickly attracted about 85% or more of all psychiatric referrals in S-E Qld, about 440 patients in two years. One of these was admitted to a public hospital twice in an acutely psychotic state but no patient under my care has been admitted to a private hospital. Two patients admitted themselves against my wishes and were therefore taken over by other psychiatrists but my opinion was and remains that neither of them warranted admission (especially not for 30 days).
By national standards, the cost of treatment for the 440 ADF members was very low. Because the ADF and DVA do not provide a detailed statistical analysis, the only available comparison comes from the Medicare Statistical Feedback Sheet. This has now been discontinued but it gave a snapshot of where each psychiatrist stood in the national rankings for a range of clinical and cost parameters. In the last sheet provided, about 2007, I was on the 97%ile for numbers of patients seen and on about the 40%ile for cost per patient per annum. However, this only covered out-patient treatment: bearing in mind that none of my patients was admitted to hospital, the actual cost of management of what were typical public psychiatric out-patients was probably closer to the 3%ile. One day in hospital costs a great deal of money, about as much as twelve weeks of out-patient treatment.

5.3: Because I had shaped my practice around ADF referrals, I was able to see new cases within about 48hrs, occasionally on the same day. On occasion, I travelled to Enoggera to see members admitted to Enoggera Health Centre, including on weekends. I provide highly detailed reports to the referring medical officers, the great majority of them within 24hrs of seeing the patient. These reports are normally around 2000 words whereas the standard psychiatric response to a referral is 100-200 words. I am constantly told, and I believe it to be true, that my reports are unequalled in their detail and the assistance they provide the referring medical officer.

5.4: I do not believe any military force in the world receives better psychiatric care than I was providing in Brisbane, at rock-bottom cost.

6. Outcome:

6.1: In nearly twenty years of seeing ADF psychiatric referrals, I have had no contact whatsoever with any of the above centres. At no stage in that time has any Defence Department mental health practitioner contacted me to audit my work, assess my results, give feedback or question what I am doing in any way, shape or form. My only contact with an ADF psychiatrist was in 2001 when I heard the chief psychiatrist for ADF was visiting Darwin and I managed to speak to him briefly by phone. He did not attempt to contact me. Some years ago, I contacted the ACPMH and was put on their email list but this was of no value and it was somehow discontinued when I moved to Brisbane.
Until a month ago, I did not know the ADF-CMH existed. The chief psychiatrist for ADF

attended the national congress of RANZCP in Brisbane in early May this year but he did not contact the psychiatrist doing 85% of his Department's work in this large and militarily important region. Until June 20th 2015, I had never heard of him and I still know nothing about him. I had never heard of CMVH until today. It is the case that while I have done ADF work for nearly twenty years (and have probably been paid in excess of $1,000,000), I have never been invited to a post-graduate meeting or seminar of any kind at any of these research centres, either to present my experience or simply to listen to their work. If they all ceased to exist tomorrow, it would not have any effect whatsoever on my work or how I manage ADF referrals. In fact, the CVMH closed in December 2014 but I never knew it existed. Whatever they spend their money on, it does not reach me and it does not have any effect whatsover on my patients, who get better without entirely without the help of all the research funded by the Government.

6.2: On June 10th, my contract with Medibank Health Solutions to provide psychiatric services to ADF members was terminated without warning and without explanation. Initially, I was told that this was under Clause 9 of the contract (irregular treatment) but after I vehemently denied any irregularities whatsoever, this was changed to Clause 11 (general termination clause). There have been no clinical complaints against me and there have certainly been no financial problems of any sort. I cannot see any grounds for secrecy. I do not have a security clearance and do not have access to classified material but if I did, I would never release it.

6.3: I do not see any reason to believe that the ADF has acted properly in this matter. There was no audit of my work and no patients or referring medical officers with ADF were consulted beforehand. While the medical officers were apparently told a day before I was notified, I have had no contact whatsover with any member of ADF in connection with the cancellation of my contract. Apparently, no provision has been made to take up the large numbers or referrals I was seeing.

6.4: No doubt matters will now revert to status quo ante, where members had to wait months for a referral to see a psychiatrist who invariably prescribed drugs and then gave a brief report, weeks or even months later. For myself, as I had actively run down my practice to make room for ADF referrals, which amounted to about 75% of my case load, I believe I have been treated with the most breath-taking disloyalty. I now believe that the oft-repeated and very high profile claims that the ADF has the best interests of its members at heart have been shown to be hollow.

References:

1. McLaren N (2013). Psychiatry as Ideology. *Ethical Human Psychology and Psychiatry* 15: 7-18.

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

3. McLaren N. (1998). A critical review of the biopsychosocial model. *Australian and New Zealand Journal of Psychiatry* 32: 86-92.

4 McLaren N. (2012). *The Mind-Body Problem Explained: The Biocognitive Model for Psychiatry.* Ann Arbor, MI: Future Psychiatry Press.
Chap. 12: A critical review of Thomas Szasz. I: The major claims.

Chap. 13: Review of Thomas Szasz. II: The clash of morality and empirical science.

5. McLaren N. (2012). *vs.* Chaps 14-16: Testing the biocognitive model: Clinical syndromes.

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

7. *Bringing the War Home.* ABC Four Corners: March 9th 2015.

8. Whitely M. (2010). *Speed Up and Sit Still: the controversies of ADHD diagnosis and treatment*. University of Western Australia Press: Perth, WA.

9. Smith G et al. (2013). Raine ADHD Study: *Long term outcomes associated with stimulant medication in the treatment of ADHD in children*. Health Dept of WA/UWA, Perth, WA.

Appendix 1:

Curriculum vitae.

Niall McLaren MBBS FRANZCP.

1971: Graduated MBBS University of Western Australia.

1974: Commenced psychiatric training in Perth.

1977: 12 month appointment as registrar in training, Dept of Psychiatry, RGH Hollywood (now Dept of Veterans Affairs), Perth.

1977: December: Graduated MRANZCP

1978: Appointed to post of psychiatrist, WA Prisons Dept.

1979: Commenced private practice in Perth. Appointed as visiting psychiatrist RGH(H) and Royal Perth Hospitals.

1981-82: Visiting scholar, Dept. of Psychiatry, Prince of Songkla University, Haadyai, Thailand.

1982-87: Psychiatrist and head of Dept, DVA Hospital, Hollywood, Perth. Responsible for all psychiatric services for entitled veterans and their dependents in WA as well as some serving members of ADF.

1983: Began PhD program jointly in Dept of Psychiatry and Dept of Philosophy, UWA.

1985: Appointed senior psychiatrist DVA. Approved as FRANZCP.

1987: Appointed to newly established post of Regional Psychiatrist, Kimberley Health Region,

WA. This was the country's first truly isolated psychiatric service, meaning full-time in a remote area with no other staff or dedicated beds etc. Due to regulations in force at time, obliged to discontinue PhD program but continued the research and subsequently, while working in the most remote region in Australia, published papers on application of philosophy of science to psychiatry.

1993: Appointed Chief Psychiatrist, Top End Mental Health Services, Darwin, NT. Responsible for clinical services covering northern half of NT.

1996: Commenced private practice in Darwin. Began close affiliation with ADF in Darwin, seeing 90% or more of all ADF referrals in the region, as well as other personnel, eg InterFET troops from East Timor, visiting US, UK and NZ personnel etc. Regularly seeing migrant and refugee populations as well as busy private practice with 33% forensic component.

2001, July: Heard chief psychiatrist RAAF was visiting Darwin and managed to speak to him by phone. He advised under new ADF policy, each operational region was required to have a mental health committee with a psychiatrist member; invited to apply. He also strongly urged me to enlist in Reserves (had never done so as there was previously an age limit of 45yrs).

August: offered position on Regional Mental Health Committee, ADF NT/Kimberley Region.

September: applied to enlist in RANR.

December: no response or acknowledgement, called RAAF psychiatrist to see whether they were interested. Urged to press ahead with application.

2002: February: told to attend medical and psychological interviews, ADF Recruiting Office in Darwin.

April: Passed fitness tests.

May: Flew to Adelaide for intake interview. Accepted for training.

September: Advised to attend next RAN Reserve officer training school at HMAS Cresswell in October (two weeks). Sworn in, provisional appointment LTCMDR RANR. Due to leave Darwin 5.00am Saturday Oct. 12th. At 11.45am on Friday 11th, RAN Police officer arrives with signal advising my application to enlist had not been accepted and I was “neither required nor expected to attend” at Cresswell. Tickets and ID etc withdrawn. Subsequently withdrew from local area mental health committee but continued seeing same numbers of ADF personnel. Continued to maintain close working relationships with civilian and ADF medical staff in Darwin but no social contact at any stage.

2011, December: closed practice in Darwin and moved to Brisbane.

2012: Contacted ADF in Brisbane to resume appointment as consultant psychiatrist, told that no new appointments were being made pending privatisation of ADF medical services at end of the year. Told to call later in the year for application forms.

November: Contacted Medibank Health Solutions, prime contractor for ADF re appointment to list of approved specialists. Told they were too busy to do anything and to wait a few months before applying.

2013, April: lodged application for approval as specialist psychiatrist for purposes of ADF referrals. Commenced seeing referrals in June.

July: visited RAAF Amberley and Gallipoli Brks, Enoggera, to give talks to medical staff.

July: actively restricted civilian practice to make room for ADF referrals, which soon made about 75% of the practice.

2014: Seeing the great bulk of ADF referrals in S-E Qld region, probably 85% or more, of the order of 200 new cases per year. Providing unpaid professional support and assistance as required eg to Individual Welfare Boards, mental health staff, and others. Visiting Enoggera from time to time to see patients urgently. Maintaining close professional contact with medical staff but met only one of about forty medical officers socially on one occasion. Very aware throughout of major grievances among medical staff and patients of quality of previous psychiatric services in Brisbane.

Appendix 2: Side effects of psychiatric medication.

Practically all psychiatric drugs produce a range of highly unpleasant and potentially dangerous side effects.

1. Drowsiness.
2. Confusion.
3. Impairments of coordination.
4. Weight gain, ranging from minor (5kg) to massive (40kg +).
5. Lethargy.
6. Physical agitation (akathisia).
7. Numbing of emotional responses.
8. Apathy and inertia.
9. Profound loss of libido.
10. In males, impotence, anorgasmia and ejaculatory failure.
11. Acne.
12. Dependency.
13. A range of physiological effects eg cardiac function.
14. Adverse effects in pregnancy.
15. Severe withdrawal effects including seizures.

Individual drugs produce many more side effects, often toxic, especially in overdose.