

Australian Government, Productivity Commission, Inquiry into Mental Health

QUESTIONS ON COORDINATION AND INTEGRATION

“Are there aspects of mental health governance where roles and responsibilities are unclear or absent? Are the mechanisms for holding government decision-makers accountable for system performance sufficiently well-defined?”

Suicide Prevention and Comorbidities

“What changes do you recommend to healthcare to address the specific issues of suicides and comorbidities among people with a mental illness? What evidence is there to support your suggested actions and what types of improvements would you expect in terms of population mental health, participation and productivity?”

ABSTRACT

Current health care standards in Australia are regrettably poor. Surprisingly, practitioners and treating teams alike in mental health and disability sectors make far too many basic care-related mistakes, in addition to the more evaluative diagnostic mistakes that cause and amplify great harm. Too many practitioners fail to distinguish adverse effects for what they are and all too often treat adverse effects, instead, as comorbidities. This diagnostic failure is dangerous, because it generates and perpetuates harms and is costly in terms of patient welfare, notwithstanding the financial burden on everyone. In this submission my focus is on the misplaced authority bestowed upon psychiatry which additionally affects the governing and investigatory institutions reliant and informed by psychiatry. I address this concern as it specifically relates to Autism and the Service Providers who trade in this area of disability and to the associated governance institutions. Only in 2018 did we, as a nation, establish A National Guideline for the Assessment and Diagnosis of Autism Spectrum Disorders in Australia. Tragically, over the past four or so decades, many thousands of children in the USA and Australia similarly, have been misdiagnosed based on poor testing models and poor standards, whose lives have been ruined by subsequent inappropriate treatment regimens compounded no less by compliant regulatory, funding and investigatory bodies over-reliant on the misplaced expertise and authority of psychiatry and associated clinicians. Furthermore, this submission highlights unnecessary disharmony and conflict between the Guardianship and Administration Act 1990 of Western Australia and the subsequent Statutory Review of the Guardianship and Administration Act 1990 which saw the implementation of overextended unwarranted power of authority to Guardians, in direct conflict with the Disabilities Service Commission of Western Australia Voluntary Code of Practice for the Elimination of Restrictive Practices released in November 2015, also with the United Nations Convention on the Rights of Persons with Disabilities, and with the Carers Recognition Act of 2004 of Western Australia.

Current standards of Health Care as observed and exposed in the media concerning mental health, aged care, and disability sectors are poor and severely deficient. There are those fortunate enough to have good care, good carers and good clinical practitioners in the mix. It's not a total mess! However, the very nature and shape of mental health and disability services

has been influenced largely by psychiatry seemingly without regard for the inherent methodological problems bedevilling it as a clinical practice. Subsequently, what has transpired over the last few decades, is an over-reliance on the misplaced authority and so-called expertise of psychiatry. Psychiatry, by and large, presupposes that:

generalizable psychopathological entities exist that can be demarcated and that individuals who are categorized in a particular way share much in common with others who are assigned the same diagnosis. It assumes that mental disorders can be characterised independently from other characteristics of the individual who is affected. This was and is a hypothesis (Moncrieff & Steingard, 2019, p. 4.).

Controversy gravitates around the information contained, in general terms, within the Diagnostic Statistical Manual (DSM) among other guidance related documents that are arguably ill-informed, conceptually and empirically misaligned to what constitutes ‘traits’ of maladapted brain types or disorders when contrasted to those ‘states’, too often manifesting as a consequence of trauma, and of errant diagnoses and subsequent poor clinical management. That is, conditions manifesting as the iatrogenic damage of adverse reaction to medication and other treatment options (e.g. Electro-Convulsive Therapy (ECT)) that are regularly misidentified. Most, if not all, mental disorders represent heterogeneous syndromes. Debate regarding the etiology and treatment of major mental disorders still rages ‘between biological psychiatry and psychological psychiatry’ (Preston and Johnson 2019, p.1). Historically, in tandem with the influential growth of DSM-III Diagnostic system was an increasing application and administration of drug treatments. This adaptation became the primary therapeutic mode of psychiatry. Heavily influenced by the pharmaceutical industry, the prevalence of drug treatments contributed to the conceptual legitimacy of psychiatry as a medical branch under the impression it was sustained by having delineated pathological conditions targetable by using disease-specific treatments, as in medicine (Moncrieff & Steingard, 2019). This is not an assured account since far too many problems associated with psychiatry exist i.e. lack of disease specific biomarkers, diagnostic validity and reliability concerns, to name a few. Compounded no less with the addition of general practitioners (GP) prescribing psychotropic medication when they are seriously under qualified to be doing so. During an exploratory examination the clinician should be asking: to what extent is this disorder due to psychological or psychosocial factors (mostly does not require drugs) and to what extent is it due to a biochemical disturbance (often drugs may be required)? (Preston and Johnson, 2019, p. 1).

I consider psychometric use of psychological terms to provide a brief explanation. One distinction of relevance is between 'traits' and 'states'. 'Traits' refer to "broad and stable dispositions" regarded in two ways: as "either 'physical properties', such as visual acuity, strength, agility, etc. or 'psychological properties', such as intelligence". 'States', in contrast, are regarded as temporary qualities characterised by changeable moods, and understandably, by definition is quite broad, for example, being happy, then "sad, or angry, sleepy and the like" (Ackerman & Beier, 2006. P. 147). Pertinently, what constitutes a state includes anything that induces or disrupts one's mood, such as, a disruption caused by the ingestion of some causal agent, like psychiatric drugs.

An example of a medication-induced state causing delirium, or psychosis and violent behaviour, is medication-induced akathisia (Greek meaning: 'can't sit down'). "Akathisia is a dangerous adverse effect of antidepressants, antipsychotics and some other drugs that cross the blood-brain barrier" (Eikelenboom-Schieveld, Lucire and Fogleman, 2016, p. 65). Prescribed medicines can increase blood levels "towards toxicity because of genetically determined metabolizing capacities, high doses and interactions with co-prescribed CYP450 inhibitors and synergies" that often-times produce erratic and disruptive behaviour. Pharmacogenetics includes the "genetics of the cytochrome P450 (CYP450) system which are the otherwise invisible factor that can correlate with catastrophic behavioural disturbances" (Eikelenboom-Schieveld, Lucire and Fogleman, 2016, p. 65; Breggin, 2013, pp. 40-41). Severe akathisia-related effects causing violence and suicidality will "abate when medication is decreased, changed or slowly stopped. Suicidality and violence tends to get worse if the dose is not tapered slowly" (Eikelenboom-Schieveld, Lucire and Fogleman, 2016, p. 65; Lucire, & Crotty, 2011; Breggin, 2013, p. 41). The evidence is both genetically and behaviourally clear (Moncrieff 2008; Bentall 2010) yet many psychiatrists deny psychotropic drugs produce adverse effects. Much worse, too many psychiatrists are even convinced that "it is not an adverse effect of the drug but a positive sign that the drug starts working" (Bielefeldt, Danborg, and Götzsche, 2016, p. 385). What is not common knowledge even among psychiatrists is that "the CYP450 enzymes can be induced or inhibited by many drugs and substances resulting in drug interactions in which one drug enhances the toxicity or reduces the therapeutic effect of another drug" (Le, 2016, p. 1). The liver's capacity for metabolism through the CYP450 enzyme system with age "is reduced by $\geq 30\%$ because hepatic volume and blood flow are decreased" (Le, 2016, p. 1). Over time, consequently, maintaining or stabilizing a patient with treatment that is

recovery oriented is virtually impossible, particularly when the psychiatrist's reliance is to an ill-guided treatment option that very often turns out to be an unsuitable patient-drug treatment.

Glenn Doman is the founder of *The Institutes for the Achievement of Human Potential* in the United States. Doman describes in Appendix A: *Detoxification from Anticonvulsants 25 Years of Experience with Brain-Injured Children* (2005) that in 1971, he and the Institutes presented to the:

“World Organisation for Human Potential a cautionary note to the medical world and to the parents of brain-injured children regarding the widespread and sometimes indiscriminate use of anticonvulsant drugs. Since that time, we have regularly and successfully removed such drugs from many children and young adults. This practice has become an integral part of our treatment of brain injury” (p.289).

On a personal note, the relevance of this understanding has bearing on my son's life because at the young age of around forty-two months, largely on the basis of speech acquisitions problems (trauma-related aphasia?), he was prescribed anticonvulsant (Carbamazepine) and amphetamine based (Ritalin) medication which seriously impacted his development and natural maturation process and he was forever pigeon holed as intellectually disabled. His life as a consequence changed for the worst and the bright light of potential in his eyes dulled to a glimmer, dramatically so within a short period of time from these drugs being administered. Adverse effects manifested, yet the prescribing doctor added other drugs (i.e. Epilim). To cut a long story short, the mixture of drugs and dosages changed as the years went by to the detriment of his cognitive capacity and inherent potential.

Glenn Doman's (2005) detailed account of his life's experience as a practitioner dealing with brain-injured children and adults provides much needed insight for this examination of psychiatric and medical expertise. During a discussion regarding the reliability of standard intelligence tests used in the United States for testing the intelligence of a well child his consideration is that they achieve what they are meant to achieve, 'but nothing more'. Using the same tests on brain-injured children does provide a good result of the brain-injured child's disabilities. What is insightful about this account is that “disability is not to be confused with inability, which is an inherent lack of ability to perform an action; disability, on the other hand, arises from a deprivation or loss of the ability to perform an action” (Doman, 2005, p. 130). Testing abilities is standard practice and testing disability is acceptable as well but Doman adamantly indicates, only with one massive proviso:

Providing that when we are testing abilities we know we are testing abilities, and providing that when we are testing disabilities we know we are testing disabilities. But when we test disability and believe we are testing ability, only devastating results can follow, and that is precisely what occurs every single time we apply such tests to a brain-injured child. Yet the tests continue to be given and, worse, the ratings that result are often accepted as a basis for action. Brain-injured children by the **hundreds of thousands have been ‘put away’ in institutions for life on such evidence** (Doman, 2005, p. 130) (Emphasis added).

Tragic! The problem generally understood for Doman and his colleagues was finding alternatives to these tests which they realised simply did not work. Because a brain-injured child who is being intelligence tested is tested comparatively through expected stages of life to the well child’s abilities at respective stages of life, but in doing so incorporates a myriad of underlying assumptions not hitherto recognised. These assumptions and consequent problems are discussed at length to explain the salient draw backs inherent in these forms of testing and the alternative way Doman’s team came to realise and develop new approaches established after many years of research and practice (Doman, 2005, pp. 129-146). My son, I have no doubt, is one of these hundreds of thousands of children misdiagnosed as disabled because he was perceived as having not just speech acquisition problems. At that time, for his age, he was considered somewhat slow at learning (neuro-diversity?) yet his cognitive capacities, receptivity, inquisitiveness, ability to follow instructions, his engagement and social skills were considerably intact, yet these capacities steadily diminished once the psychiatric drugs took debilitating hold. But during the period of testing and before the pharmacological regimen started he had required grommets inserted to remedy and improve his hearing capacity in addition to having his adenoids surgically removed, so his developmental progress was hindered by those inhibiting conditions. All this coincided during a period of immense disruption in his life as he was bandied about from place to place, from respite centre, to child care centres, to different family members, support carers, to additional friends, all with their own styles of caring.

Some Service Providers (SP’s), as part of the services they provide, include accommodation for people with disabilities and, indeed several SP’s across Australia operate with integrated clinical management teams. It is not uncommon for them to trade under a business model which seems to rely on dependent-clients which guarantees continued funding. This practice tends to lead to treatment and management regimes that are not recovery-based but maintenance-based and the quality of service and treatment is indeed rather questionable. Historically, people with

intellectual disability were referred to by such names as ‘idiot’, ‘imbecile’, ‘feeble-minded’, ‘retarded’ and ‘moron’, putatively classified as falling within a ‘static’ or ‘dynamic’ (severe/mild) categories (Carlson, 2010: 39-44) which, by and large, persists today. Those considered within the static category are treated as if they cannot be improved, not educable and at best, their treatment focus is about maintenance. For those considered along a dynamic continuum, treatment regimens differ greatly, and of recent times great strides have been made to enable and improve the lives of those in this category. Yet this is part of the problem of understanding disability, particularly intellectual disability, for the presuppositions used to classify individuals far too often fall short of the mark, undermine potential and capacity, and the consequent diagnostic errors affect the lives of so many when treatment options are based on those errors.

I am speaking from my own lived experience, informed by Doctoral training in Philosophy of Mind, practicing and teaching professional applied ethics, and as an advocate and parent whose child lives with autism. I have had a long history of experiences with Service Providers operating with associated clinical management teams. My professional assessment is rather damning regarding an industry that trades and profits from disability. In my experience, having a loved one (e.g. one’s child) placed in the care of some of the service providers trading in this industry should always be the last resort; essentially, avoid them at all costs. When there is a loving home available, then that is where the child belongs with his/her loving family. It is rather disconcerting to witness the state of unprofessional, misguided and dangerous practices within the sector, and disheartening that they are allowed to persist! If ever there was a need for stricter regulation and robust oversight it is the disability services industry that is well overdue for major reform. Regular and insidious clinical management mistakes based on misdiagnoses, poor administration, lax record keeping, and moreover a fundamental lack of cogent behavioural management plans is quite common. Problems associated with psychiatric drug related adverse effects are simply not well regulated by the existing regulatory and investigatory bodies. What is required is greater responsibility and accountability for errors made by practitioners, which currently seem non-existent and the regulatory authorities rather lax it must be said. Yet funds are siphoned from the Disability coffers to finance extremely costly care packages, on the part of some service providers, when alternative treatment measures and accommodation is available, particularly when considered against what was avoidable, as is the case with my son’s situation. This is not an isolated case.

Normalising harm associated with mental health and disability treatment regimens, with behaviour caused by adverse effects of medication/psychiatric drugs and poor clinical management, too often rationalised as comorbidities, should not be defended. It is alarming for its deception for it cannot be ignorance, as the literature is replete with longitudinal studies that expose this harm and misunderstanding. In 2016 the number of deaths from ‘Intentional Self Harm’ in Australia was 2866, noting that 1808 of those death events were associated with prescribed medication; in 2017 the number increased to 3128. That is an additional 262 lives lost to suicide (ABS, 2018). These statistics are disturbing and highlight ethically challenging prescriptive practices around Australia that has a number of advocacy agencies, family members and friends of the deceased, irate about the lack of accountability regarding the prescribing clinicians. Equally of concern, though, not featured in these statistics, is the scope and range of adverse effects suffered by individuals administered psychiatric drugs. Moreover, the use of both physical and chemical restrictive practices in health care and residential institutions for Mental Health and Disability services requires immediate attention. These problems are amplified resoundingly by those whose lives are affected by the loss and harm when endeavouring to lodge complaints of concerns to authorities. The Mental Health and Disability Services in Australia are in crisis.

Additional concerns relate to constraints imposed under the authority of Guardianship as substitute decision-makers. This area is riddled with tension-fuelled conditions that provide opportunities for unintentional and intentional abuse of power with unnecessary and often devastating consequences that can be avoided with better minimisation governance controls.

Matters of Guardianship concern requiring greater oversight and reform.

“Power tends to corrupt and absolute power corrupts absolutely. Great men are almost always bad men, even when they exercise influence and not authority; still more when you superadd the tendency of the certainty of corruption by authority”
(Lord Acton)

A plenary guardian specifically refers to the appointment of a guardian in line with the Guardianship and Administration Act 1990 of Western Australia which:

...recognises that people may need...assistance not only to ensure their quality of life is maintained, but also to protect them from the risk of neglect, exploitation and abuse... A guardian is appointed by State Administration Tribunal to make personal medical and or lifestyle decisions in the best interests of someone who is not capable of making those decisions for themselves... The decision-making authority of a guardianship order may be limited to specific areas such as medical

and accommodation (limited order) or apply to all areas of the person's life (plenary order) (State Administration Tribunal, 2011, p. 3).

This last part "... to apply to all areas of the person's life" referring to Plenary Guardian, is open to abuse. Whereby, ordinarily, safeguards, by way of agencies, statutory bodies, meant to provide oversight, to mediate and to protect the vulnerable are, as I have discovered, easily crippled, often by their legal limitations, rendered ineffectual by the opposing imposition of the Guardian, hence exposing an inherent and systemic vulnerability within the mental health and disability sectors and their governing jurisdictions. Abuse is almost always related to power!

One objective therefore in this submission concerns minimizing the role of substitute decision-maker in the form of plenary guardian particularly against diminishing the voice and role of the other highly involved parent. Thus, ensuring reform to protect against, not only the plenary guardian abusing their assigned power, but furthermore to ensure the interests of the child are actually protected and observed. For that assigned power is easily abused by the Guardian who may well also be protecting their own interests. When the guardian shifts from a consultative process with the other parent to one of dictatorial subjugation affectively rendering the other parent subservient that is abuse of power. Increasingly made worse when the Guardian is supported by an interested Service Provider profiting from such relation, often, at the emotional and psychological expense of the child, and of course, made possible by its being endorsed by law as enacted in Plenary Guardianship. It is extremely difficult to get around that, and so it promotes or legitimates, perhaps unintentionally, nonetheless, a form of abuse by the Plenary Guardian as I recognise first-hand for its destructive capacity.

What avenues are there available for challenging this kind of privileging without proper and effective checks and balances? What kind of sanctions are in place? I have exhausted every conceivable avenue without capacity to achieve recognition of the harm perpetrated on my son. Why? The Department of the Attorney General in November 2015 released the *Statutory Review of the Guardianship and Administration Act 1990* and within *Part 5 – Guardianship –* under recommendations 24 and 25 clearly outlines the permissible parameters. Compare these parameters to *Part 2 - Principles to be observed by the State Administrative Tribunal*. In addition to *Part 3 of the Act* - the three positions provide a kind of tension that incites prejudice and disharmony.

Recommendation 24:

Restraint

Stakeholders, including those directly involved in implementing the Act, support amending the Act to clarify that a plenary guardian is able to make decisions regarding restraint of the represented person. It is noted that under section 45 of the Act, the authority of a plenary guardian is described by reference to parental responsibility as if the represented person were a child lacking in mature understanding but **excluding the right to chastise or punish the represented person.** (Emphasis added)

Under section 68 of the *Family Court Act 1997*, parental responsibility means all the duties, powers, responsibilities and authority which, by law, parents have in relation to children. In support of the amendment it is noted that:

- There are instances where a guardian is required to make a decision which is contrary to the wishes of the represented person and which may require some compulsion either in the provision of medical treatment for behaviour management procedures to ensure the safety of the represented person or for the protection of others.
- Restraint was considered by the previous Guardianship and Administration Board (BCB [2002] WAGAB 1) when the Board found that restraint did not fall within the definition of treatment, and in the decision clarified a range of matters regarding treatment and restraint.
- The amendments to the Act which came into effect in February 2010 provided a new definition of treatment, but did not include restraint.
- **The Tribunal continues to make specific orders relating to restraint to ensure that consent is always obtained appropriately** (pp. 17-18) (Emphasis added).

Recommendation 25:

That the *Guardianship and Administration Act 1990* is amended to provide that the role of a plenary guardian can also include the authority to:

- **make decisions regarding restraint of the represented person including in relation to making decisions about chemical and/or physical restraint**
- **consent to medical research, experimental health care, and clinical trials** (p. 18) (Emphasis added).

Compare the role and increased authority of plenary guardian in relation to Part 2 Statutory

Review of the Act:

Part 2 - Principles to be observed by the State Administrative Tribunal

Section 4(2) states that:

The primary concern of the State Administrative Tribunal shall be the best interests of any represented person, or of a person in respect of whom an application is made.

The Public Advocate notes that the principles reflect the intent of the *UN Convention on the Rights of Persons with Disabilities* that 'safeguards shall be proportional to the degree to which such measures affect the person's rights and interests' (p. 12).

Under Part 3 of the Act - Carers to be included in proceedings:

Carers WA submits that Tribunal proceedings should require that the existence of a carer should be determined prior to hearings. The family carer should be identified, requested to provide information and receive information and be referred to carer supports. **This would be consistent with arrangements in the health, mental health and disability sectors and would support the goal of preserving existing family relationships.** Information from the carer should be requested and taken into account in considering the competency of the person (Emphasis added).

From the preceding then the *Statutory Review of the Guardianship and Administration Act 1990* generates a tension and disharmony when compared to what is expected as recently specified by the Disabilities Service Commission of Western Australia *Voluntary Code of Practice for the Elimination of Restrictive Practices* released in November 2015. In sum, suggests that what has transpired in the clinical treatment and management of my son clearly calls into question his treatment and the response by the governance bodies to all complaints lodged over many years. Insipid and lax governance for not properly investigating the Service Provider, for not questioning the construction of the isolation section of the house where my son was required to reside for 3 years or so, and arguably for privileging the plenary guardian without due diligence.

Additionally, my sentiment and dismay is echoed and corroborated as gleaned from the Disabilities Service Commission Code under subheading **2.2.1 Effective service design:**

2.2.6 Service providers will recognise the use of restrictive practices may reflect a failure in the service system to understand the nature and function of the individual's behaviour.

2.2.7 Service providers will recognise that the use of restrictive practices is not an effective long-term strategy to manage risks and behaviours and can result in long-term physical and psychological harm.

2.2.8 Service providers will actively facilitate the person's engagement with family, carers, other friends and advocates who know them well, are concerned for their best interests and can support them in decision-making, unless there is clear evidence that the person does not consider this to be in their best interest.

The disharmony and conflict between these aforementioned Acts and Codes is startling. For, I have Standing under the Carers Recognition Act of 2004 of Western Australia. I am a primary stakeholder, parent, and lifelong carer. Lapses in duty of care for my son, are appalling, as spelt out in the Medical Board of Australia Code subsection 3.10 Adverse Events: 3.10.2; 3.10.5; and, 3.10.6 of the Code resulting from poor clinical management practices as rendered by the Service Provider.

Good Medical Practice: A Code of Conduct for Doctors in Australia (The Code)

3.10 Adverse events

When adverse events occur, you have a responsibility to be open and honest in your communication with your patient, to review what has occurred and to report appropriately. When something goes wrong you should seek advice from your colleagues and from your medical indemnity insurer. Good medical practice involves:

3.10.1 Recognising what has happened.

3.10.2 Acting immediately to rectify the problem, if possible, including seeking any necessary help and advice.

3.10.3 Explaining to the patient as promptly and fully as possible what has happened and the anticipated short-term and long-term consequences.

3.10.4 Acknowledging any patient distress and providing appropriate support.

3.10.5 Complying with any relevant policies, procedures and reporting requirements.

3.10.6 Reviewing adverse events and implementing changes to reduce the risk of recurrence (see Section 6).

3.10.7 Reporting adverse events to the relevant authority, as necessary (see Section 6).

3.10.8 Ensuring patients have access to information about the processes for making a complaint (for example, through the relevant healthcare complaints commission or medical board).

The Code, properly understood, draws upon the Common Theory of Morality whereby primacy rests upon the principles of Respect for Client, Non-maleficence, Beneficence and Justice. In health care, there is concomitant the positive obligation to provide benefit rather than merely avoiding the infliction of harm, as properly understood, is the telos of medicine. Pragmatically balancing benefits and harm is based on the principle of utility or proportionality. When poor clinical management and poor practices lead to avoidable, and in particular damaging harm, then, the practitioner's duty of care must be questioned. However because there exists an over-reliance on the expertise of psychiatrist more pointedly, not excluding the service provider, investigators fail in their due diligence more often than not, it appears.

Alarmingly, overall, it is estimated that only about five-percent of adverse events are reported by practitioners, nationally. The Minister for Health the Hon. Greg Hunt in a letter dated 20 August 2018 to the Chair, Standing Committee on Petitions, acknowledged that under-reporting of adverse events is a global issue (author sighted letter).

Reporting Abuse – Protective Measures

It would be prudent to adopt appropriate measures to encourage people/carers, support workers to come forward, testify, when observing harmful practices. That, of course, may require incorporating appropriate whistle-blower's protection to ensure the safeguarding of whistle-blowers and family members when reporting harmful and abusive practices and poor clinical management concerns. Perhaps develop a Whistle-Blowers register which could be

operationalised by CarersAustralia and CarersWA? This requires changes to governance structures and associated institutions in line with appropriate standards of health care amendments and enforcement mechanisms.

In May 2017 a two-day conference took place in Perth, Western Australia. It was the 11th National Forum: *Towards the Elimination of Restrictive Practices* involving both Government and Non-government bodies where many insidious practices were exposed by the researchers, clinicians and various presenters. More than two hundred participants attended the conference and it is obvious that the governing bodies are aware of the multitude of serious concerns about what ought not to be regarded as acceptable practices and poor standards of care. It makes me livid that the service provider responsible for caring for my son is permitted to practice in the manner it has for so long now and due to its own deficiencies, whether unintentionally or not, for inflicting so much harm on my son that they are permitted to continue to do so and trade with absolute impunity. The failure of the associated investigatory agencies, tribunals and agents themselves, stems from a lack of understanding, working from a model or framework whose training fundamentally lacks an anthropology of the human person. People are sentient beings not simply the product of electro-chemical reactions. Those in the service of oversight whose role it is to ensure the safeguarding of the vulnerable lack trauma-informed training it appears. When I consider that the Hippocratic Oath, sacred to physicians even today, named after the ancient Greek physician, Hippocrates, the father of Western Medicine, then conveyed a promise to uphold the covenant of medicine.

“I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice. I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect”.

Throughout history there have been adjustments to the Hippocratic Oath, amended variations due to changing attitudes, manifested over time and geography. Nonetheless it still provides guiding principles for practice towards healing and recovery. A modern-day version includes this important covenant regarding the patient and clinician approach towards medicine and therapy:

“I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug”.

As an academic and professional ethicist, I am concerned that the funding drawn from Disability services to cover and mitigate the clinical management errors affecting my son, in

particular, must be exceedingly costly, rather extreme, and should have long ago been the subject of intense scrutiny. To ruin a young man's life and for the perpetrator's actions to be legitimated somehow, allowed to continue practicing in like manner under the guise of care is an injustice of the highest magnitude, an affront to humanity, and a callous disregard for the human rights of the disabled. In my capacity as an advocate, I have increasingly become more involved with several advocacy groups in Perth and around Australia. The numerous stories shared disclosing clinical mismanagement and diagnostic errors, the countless accounts of individuals suffering severe adverse effects from drug treatments and from psychiatric hospitalisation is vast in numbers and the stuff of nightmares. Far too many lives have been seriously impacted more so by the treatment than the condition experienced. My life has been shaped by what has been occurring to my son.

Throughout his life he has spent weekends with me and extended periods during the school breaks and festive holidays or whenever I was required. For over a year now, due to restrictive measures imposed by the plenary guardian (son's mum), for no other reason than for challenging his treatment and exposing the rot, I am only allowed to see him at a local park along with his two rostered support workers (24 hour rotations times 3 different paired support workers) and only usually for up to an hour a visit, often less. Under the direction of the guardian the support workers determine whether I see my son or not. In a 14-month period one support worker when rostered to work on Saturday's with my son (the only day I am allowed to see my son) has inhibited my visits with my son because of his power to determine whether or not, the visit between me and my son is appropriate, given that his report on my son's state is what determines the visit. Rather incredibly, my visit during his rostered days had only occurred twice in 14 months. That is out of a possible 20 Saturdays that this same support worker was on duty, as my records indicate, I saw my son twice whilst that support worker was on duty. In 2018, I got to see my son 15 times for a duration totalling around 12 hours for the year. I submitted this information to one of the regulatory bodies investigating officers at an interview prior to a Complaints Hearing, and he thought nothing of it. At that recent Hearing I complained about the restrictive practices enforced on my son, also about the isolation section of the house where he resided, and for my limited and restricted visits but because they were the determination set by the plenary guardian, the authorities turned a blind eye.

This very same service provider diagnosed my son as autistic in 1992. Yet they were only officially licenced/authorised to diagnose clients with autism in 2016. They diagnosed my son,

when he was around five years old, using similar faulty tests described above by Doman. How many other children has this happened to in the ensuing successive years? Perplexingly, as it happened, just prior to the diagnosis reached by the Service Provider a prominent autism researcher, at that stage working from a local University, was conducting research that involved groups of autistic children. Significantly, when testing my son for suitability to be included into the research group, that researcher considered my son **atypical**. Not typically autistic and therefore he was not incorporated into the trial. By the time the Service Provider diagnosed my son he had by then undergone the administration of psychiatric drugs for over twelve months. Recently this information was disclosed to an officer from the Office of the Public Advocate tasked to investigate my concerns for my son and about a current civil-law trial, but he took no notice of it. That included documented footage of the isolation section of the house where my son was required to reside for over 3 years. Yet ironically this individual was happy to cast aspersions about my report to him by accusing me of fabricating the account of the isolation section of the house. I had also referred to the legal case in Victoria against the Education Department for similar misdiagnoses and for the lives ruined as a result: The FEED SBS. Children 'misdiagnosed' with intellectual disabilities using 'inappropriate tests'. Monday November 12, 2018. Available online @ <https://www.sbs.com.au/news/the-feed/children-misdiagnosed-with-intellectual-disabilities-using-inappropriate-tests>

RECOMMENDATIONS

1. Greater mediation measures and safeguards to minimize the role of substitute decision maker in the form of Plenary Guardian. Importantly, to safeguard against diminishing the voice and role of the other parent particularly so when that parent is highly involved in the care of child to ensure protection against the plenary guardian abusing their assigned power. When two parents are involved assigning authority with the capacity to subjugate the other parent is conceptually ill-conceived and invites the specter of psychological and emotional harm to the child; for emotional blackmail to be perpetrated against the non-guardian parent; further legitimating the capacity to thwart natural justice in terms of unwanted investigations as outlined above; impedes consultative debate; incapacitates the opportunity of the non-guardian parent to seek second opinions regarding medical treatment. Broad range expert opinion consulted within the health care sector over the last year concede that the State Administration Tribunal by and large is ill-placed to mediate on family matters of mental health and disability.

2. Promote greater awareness of the serious adverse effects of psychiatric drugs.
3. Promote, respect, and value the voices of individuals, their loved ones, and supporters, impacted by psychiatric drugs.
4. Advocate for greater investment in a wide range of approaches to, and understanding of, the causes of mental distress, which are not medication based.
5. Encourage and facilitate improved literacy around treatment options, including alternatives to psychiatric drugs.
6. Establish National Tapering (withdrawal) Guidelines (Guidelines informed by Pharmacogenetics). Tapering must be supported under appropriate medical supervision.
7. Greater involvement of pharmacists to oversee current poor prescription practices.
8. Review and enhance clinical education for psychiatrists. Education to promote an understanding of the dangers of polypharmacy, dosage administration, drug-drug synergy, drug-to-drug reactions (effects pharmacokinetics). Education to promote recognition to readily distinguish medication-induced psychiatric symptoms (adverse-effects) so that they are not regarded and treated as comorbidities.
9. Education for psychiatrists should incorporate critical and reflective thinking skills to enhance decision-making capacities to improve diagnostic considerations.
10. Greater oversight and compliance measures be established particularly when any drug administered to patient has a therapeutic range and toxicity range close together. For example, treatment with lithium should only be initiated after necessary lab tests are conducted. With high dosages side effects are more common and compliance is much poorer (Preston and Johnson, 2019, p.24).
11. Promote the use of pharmacogenetic testing to establish patient-drug suitability as an empirical protective measure to minimise the onset of drug-induced psychiatric conditions. Suggested inclusion in the Pharmaceutical Benefit Scheme.
12. Clinicians, before psychiatric medication is prescribed must ensure psychosocial stressors are not the cause of mental distress, and if so refer for psychotherapy.
13. Increase the onus of responsibility for clinicians to report adverse-effects (we learn more when we can establish a clearer picture of the range and scope of adverse-effects).
14. Establish whistle-blowers register and protection mechanisms to promote increased compliance to reporting psychiatric drug-induced adverse-effects.

15. Clinician awareness of the importance of reporting adverse-effects is low. This has to change! Measures are required to improve awareness and of its significance to medicine and so mechanisms that encourage this based on information gathering be promoted rather than focusing on punitive consequences. Punitive measures should be enforced when errors are repeated and the clinician's standard of practice is not accordingly modified.
16. Rethink current Health Care Standards. Standards better informed by Polypharmacy concerns, Restrictive practices concerns, Chemical restraint concerns, and Drug-induced adverse-effects. Safeguard against the onset of psychiatric conditions regarded and treated as comorbidities.
17. Establish protective safeguards in order to monitor and review residences, those provided by service providers that accommodate people living with disabilities and for people with mental health concerns, to protect against restrictive practices and safeguard against chemical restraint, poor and abusive care.
18. Support-worker education standards enhanced. Education and level of competence should be subject to type of duties and responsibilities, particularly more robust controls established for when drug administration such as PRN's may be required.
19. This submission provides reason to rethink the clinical authority bestowed on psychiatry and reason to reevaluate current governance and investigatory standards.
20. Prescription of psychiatric drugs should not be considered a permanent, lifelong solution. A plan for discontinuation of psychiatric medication should be based on shared decision-making principles negotiated between the service user, their supporters and the clinical team.
21. Greater recognition and support be given to recovery oriented prescribing practices, which means the person's recovery goals and vision are central and privileged and clearly defined.
22. Therapy should be guided by the principle of prescribing at the lowest dose for the shortest length of time.

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