

My submission is based on my experience in NSW predominately with the public Mental Health System and little with private psychiatrists, the NSW Mental Health complaint system, my own personal views, and knowing what is written in my files due to having copies under freedom of information. I am an ex-patient whose misadventure in the public Mental Health system was a result of being a scam victim: the fallout eventually got me admitted to a Mental Hospital but the fallout didn't stop there as there were more admissions, and the fallout spread to other areas, like I have had far more contact with police since the scam than in my whole life before the scam. I somehow have been diagnosed with a number of disorders that I know I don't/ never had, being bipolar, schizoaffective disorder, schizophrenia, personality disorder and delusional disorder when I have only admitted to feeling depressed. The schizophrenia personality and delusional disorder's were an all-together diagnosis due to the practice of "diagnosis stacking," where differing opinions result in the diagnosis's being stacked upon each other, more on this later. I am currently not on any medication, psychiatry or other, and I know I have done the right thing for my health both psychically and mentally by going through withdrawal and coming off the antipsychotic medication. These along with other happenings have me referring to my life being like a movie, and it is like one.

I will try hard to say little about the Mental Health treatment quagmire myself, and have provided links for lectures/documentaries/news articles from more qualified and credible people than me. Making more treatment available won't help much if the treatment is of the same current standard, quality should be the priority. Psychiatry has two types of psychiatrists, the predominately mainstream, and a minority of progressive psychiatrists who some are featured in links to lectures, documentaries and articles in this submission.

One of the biggest problems I see from my files is the accuracy of what written in them. These files are your Mental Health History therefore if what's written in them isn't accurate then your history isn't accurate. There is the accuracy in diagnosis issue, and my file has widespread exaggeration and factually wrong information, some by mistake and some I know to be on purpose. When information is recycled and used again it can change with the change always being in a more negative way.

Psychiatrists are given godlike powers by the government, but there is little in the system to ensure they use these powers responsibly nor ethically nor correctly. Psychiatrists believe they should lie to patients so they do, and believe they should give the patient as little information as possible. Staff in complaints department can choose to only find substance with the worst of the worst complaints.

Psychiatrists choose to have a dictatorship relationship with patients. What they dictate becomes best or fact. If the patient disagrees with anything then the patient is lacking insight. Psychiatry always has been a profession that abuses human rights and still is. Psychiatry has overinflated the DSM, is a diagnoses stacking, medication stacking, self-critiquing profession that administers medication with severe side effects and collectively overrates the professions medication and its ability to diagnose. Their arsenal of medication closer resembles the definition for a chemical weapon than a medication. The problem with the profession overrating its self and its medication benefits is that the public and courts get an unrealistic view of both capabilities. A patient seeing a private psychiatrist has that psychiatrist administer treatment and record how good their treatment is working, a patient in the public system is seen by different psychiatrists and has how good the establishment's treatment is working . **In the absence of science based testing to evaluate effectiveness better or worse, this psychiatry self-critiquing itself is a conflict of interest. The best**

and only way to reduce (it won't stamp it out) fudging from the Psychiatrists/Mental Health Nurses self-critiquing and exaggeration is to make it mandatory for all interviews to be video and audio recorded and saved in conjunction with the current record keeping guidelines, the actual record keeping often falls short of guidelines. This video audio recording should extend to Psychiatrists and Mental Health Nurses wearing body cam-recorders on home visits. I concede this will probably result in more patient complaints being put in about their treatment, but currently the "playing field"(correct words to use) is too much in favour of psychiatry. Much of what I am putting in this submission are positive reasons why Australia should change to keeping audio video treatment recordings alongside current file records, currently this audio/ video recording is only done and kept for and with the Mental Health Review Tribunal procedures.

Medication Free Treatment

My view is that the best Mental Health treatment is one with no medication side effects. Medications prescribe by Psychiatrists have severe negative health consequences for patient, more on this further on in links. **Why is it that Psychiatry has ignored the data from the following medication free treatment, and promotes their psychiatry drug treatment as being gospel?** It has been recorded by qualified people to know, that I am schizophrenia, delusional and lacking insight. I therefore would not put this following information in this submission unless I believed that it may be of least some value, and should be further looked into.

Science has proven the benefits of fasting with repair of the body through process called autophagy. The next will be somewhat controversial: There is a Soviet Union Psychiatrist (Dr Uri Nickolayev) that it's claimed had success using fasting as a treatment for Mental Illness. His treatment and study was done 1946-1969. A Japanese study since claims to have validated the claims of Dr Uri Nickolayev. The link to Japan's study is first, it is less in size to read.

<http://www.yogamag.net/archives/1981/emay81/jap.shtml>

Below link details the USSR Mental Disorder fasting treatment. (there are other references to this study online)

<http://orthomolecular.org/library/jom/1971/pdf/1971-v03n01-p002.pdf>

This below link is the only fasting documentary that I know of that mentions Dr Uri Nickolayev's treatment, this part starts at 12min 50sec in this documentary. It is this documentary that made me aware of this treatment. I had watched a "Michael Mosley Documentary – Eat Fast and Live Longer" a number of years ago, I then started to watch others on fasting.

<https://www.youtube.com/watch?v=t1b08X-GvRs> (Science of Fasting)

Below is story on relationship to high white blood count, double inflammation level and schizophrenia. The high white blood count with double inflammation level scenario could further suggest that the fasting treatment could be successful, in some cases as the data didn't show 100% success. High white blood count is associated with things like infection, stress, trauma and inflammation: and in the below article inflammation levels were double normal levels. Fasting has

been proven to reduce inflammation, which is being linked to schizophrenia in link below, and depression two below suggesting fasting could work as claimed in Mental Disorder treatment.

<https://www.abc.net.au/news/2018-09-13/how-white-blood-cells-could-hold-key-understanding-schizophrenia/10237732>

<https://www.youtube.com/watch?v=fqyjVoZ4XYg> (The Underlying Mechanisms of Depression)

To add more to this pot, Scientists have started to refer to your microbiome (gut bacteria) as your second brain and refer to the communication path (via vagus nerve) from gut to brain as “gut brain axis.” Getting back to the USSR’s validated by Japan fasting treatment for mental illness that showed success but not 100% success: could this success rate be improved with some changes to the patients microbiome? One of the other reported benefits (other than reduce inflammation) of fasting by scientists is a better combination of bacteria in ones gut, therefore could a bit of tweaking of the patients microbiome to make it more better resulted in giving better results than what reported in the USSR and Japan? I strongly believe funding should be made available for a study on fasting as treatment for Mental Disorders, and the patient’s microbiome should be studied in this study.

Some links to science on articles that can explain the relationship between the gut and brain better than me. The last two article links are there because it may explain why people on antipsychotic medication gain weight, maybe the medication could be putting their gut bacteria into dysbiosis.

<https://psychscenehub.com/psychinsights/the-simplified-guide-to-the-gut-brain-axis/>

<https://www.medicalnewstoday.com/articles/324362.php> (Gut bacteria might influence depression, and this is how)

<https://www.medicalnewstoday.com/articles/312734.php> (Gut bacteria and the brain: Are we controlled by microbes?)

http://www.bbc.com/future/story/20190218-how-the-bacteria-inside-you-could-affect-your-mental-health?ocid=global_future_rss

<https://www.theguardian.com/science/2018/mar/19/wide-range-of-drugs-affect-gut-microbes-not-just-antibiotics>

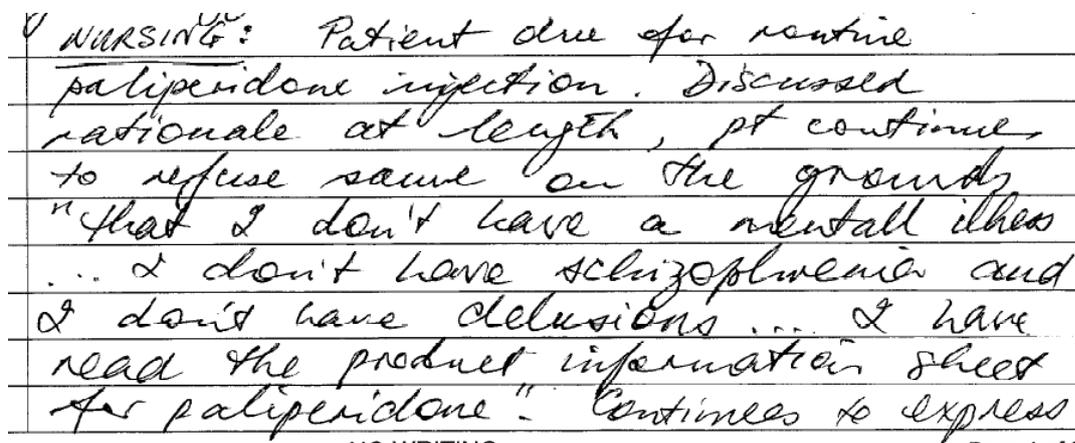
<https://www.hyperbiotics.com/blogs/recent-articles/these-medications-could-be-affecting-your-gut-health>

Auditing of Health Care Records

I have a copy of my Mental Health records and I know that that the standard of recordkeeping and recording falls way short of NSW PD2012_069 Health Care Records – Documentation and Management. This Policy Directive details the “Auditing” of Health care records for compliance within this PD. My records have very obvious non-compliance issues, and the records were from more than one treatment facility, therefore I have to believe that the audits were not being done and signed off as if were, or the person/s doing the audit seen the problems and chose not to

acknowledge them. Furthermore, many of the problems are not going to be able to be detected by an audit. For Example, In this PD, 2.2 (j) states records must **“Be accurate statements of clinical interactions between the patient / client and their significant others, and the health service relating to assessment; diagnosis; care planning; management / care / treatment / services provided and response / outcomes; professional advice sought and provided; observation/s taken and results.”** How can anyone doing an Audit know if an entry in patients Health Care Records complies with this? Staff can write or leave out whatever they decide in the patient’s record, nobodies looking over their shoulder. The only way you could “Compliance Audit PD 2.2 (j)” is if all interactions between staff are being video/audio recorded and kept, and that would take allot of time comparing what written in file to the audio/video version.

Here is one example from my file, and I’ll tell the true story. There can be a tendency for staff when recording to make themselves the hero and the patient the zero. The file extract below is an example of this. What really happened is not what written as below: the nurse forewarned of the antipsychotic drug injection, I then verbally protested it on grounds that I am not schizophrenia or delusional and I don’t want or need it, then the nurse told me “if you refused it then you will be held down and injected”, which is what I already knew would happen. What psychiatrists decide, they get, if they want to play god with somebody’s brain they can. There was no “Discussed rational at length” and the “I have read the product information sheet for paliperidone” as recorded, did not happen. This makes the nurse look like the hero for discussing rational to me and reading me the product information (drug side affects) sheet, even though it didn’t happen, and makes me the zero for lacking insight on my condition that only can be fixed by being injected with drugs, which I know is not true. The nurses and psychiatrists don’t care about the side effects, they aren’t the ones forced to have the drugs. And if they threaten the patient they are not going to write it in the file.



A handwritten note on lined paper, written in cursive. The text reads: "NURSING: Patient due for routine paliperidone injection. Discussed rationale at length, pt continues to refuse same on the grounds 'that I don't have a mental illness ... I don't have schizophrenia and I don't have delusions ... I have read the product information sheet for paliperidone'. Continues to express". The note is written on a grid of lines.

When in a Mental Health Hospital if staff want to leave something out of the file they can and do. Any disagreeing debate with staff will get recorded in the patient’s file. This one didn’t: I was trying to get access to my file to read what was been written. I was telling staff that I wanted to see it and it was my human rights to be able to see it and staff were refusing. After a little back and forth on this staff then started to tell me more than once that if I didn’t drop the issue and go away then they would call security and have me injected. Of course, they didn’t write about this incident in my file.

I know I am not the only one that recognises problems with file recordings. Somebody I was talking to who had obtained a copy of their file was telling some of what written in their file in regards to what they said to psychiatrist. This person had been bullied at school, so wasn’t pleased to find that

the reference to conversations on them being bullied was simply written by psychiatrist as “was unpopular at school and didn’t fit in”. It sounds to me like the psychiatrist is blaming the patient: in that the person should have been more popular and fitted in, then they wouldn’t have been bullied. I have always found psychiatrists to be very cold people that lack understanding of my situation: their flat emotionless look on their face when you are telling them your problems matches this.

The Military

It is a fact that what patients say is not deemed credible and what psychiatrists say is deemed highly credible. I hope that what Military veterans/members (and their families) from various countries are saying about psychiatry treatment, and in particular the medication, in this documentary below is deemed credible.

<https://www.youtube.com/watch?v=YmvuYTH5nU0> (The Hidden Enemy: Psychiatry)

Australia’s veteran suicide rate gets a mention (near end along with other countries) and since the making of the documentary above it has gone up as per article below.

<https://www.theage.com.au/national/victoria/veterans-2017-suicide-toll-is-84-say-activists-20171231-h0bs1p.html>

Children Teenagers Mental Illness and Depression Medication

I am against any sort of child/teen screening for Mental Health if it gets children/teens in front of a psychiatrist. This is because the only thing psychiatrists do is prescribe medication, and follow up (self-critique) on how the patient is responding to the medication, and there can be a tendency for the psychiatrist to over-rate the effectiveness of their treatment. A child’s brain is still developing so it should be a practice to try and avoid giving a child serious mind altering drugs and hope for the best.

The connection between Australia’s increase in medication and suicide in children needs to be examined more closely. This Headline “Australia’s mental health crisis deepens as the number of children taking anti-depressant pills doubles in just six years to 100,000 after spate of youth suicides”. The headline sounds like more children are prescribed antidepressants because of the rise in youth suicide, so to prevent it. But is that really what is happening? Sometimes media articles have accuracy/wording problems. Could the rise in youth suicides be caused, or partially caused by the rise in antidepressant use in youth?

<https://www.msn.com/en-au/news/australia/australias-mental-health-crisis-deepens-as-the-number-of-children-taking-anti-depressant-pills-doubles-in-just-six-years-to-100000-after-spate-of-youth-suicides/ar-BBTWT3V?li=AAgfIYZ>

In the below documentary at viewing time 1.00:00 (1hr 00min 00sec) a number of different psychiatrists (from different countries) respond to question asked “From your personal experience what is the earliest age you can diagnose a child with a mental disorder” . I think there is some

overrating of abilities going on here and why the different responses?

<https://www.youtube.com/watch?v=gazEyr86RVY> (How Psychiatric Drugs Can Kill Your Child)

The link directly below shows using freedom of information the finer details of how drug companies get and use their data to get their drugs approved.

<https://www.youtube.com/watch?v=IQ3d7isADyc> (Do Antidepressant Drugs Really Work?)

The next two links have very relevant information to consider in this inquiry, our children are Australia's future. The first a lecture on the increasing use ADHD diagnosis and medication, the second being USA Government Congressional Testimony.

<https://www.youtube.com/watch?v=gigZD4RIXhg> (Part 4: Children & ADHD - Robert Whitaker - Psychiatric Epidemic - May 14, 2014)

https://www.youtube.com/watch?v=SBJfZtB_3cc (Peter R. Breggin, MD - Antidepressants & Suicide - Congressional Testimony)

The next two lectures (links below) is a two part lecture done on consecutive days. The first is on antidepressants, second antipsychotics, their histories how they work and their affect on brain short to long term. Antipsychotics are next main heading. These lectures reveal the truth about medication that mainstream psychiatry is not revealing, unfortunately they are a bit long, but I feel it very important to put the argument forward that a drug free treatment is best for both patient and Australia in the long term.

<https://www.youtube.com/watch?v=Ep1ODxCoYII> (Psychiatric Drugs: Do Psychiatric Medications Fix 'Chemical Imbalances' in the Brain)(Part 1)

<https://www.youtube.com/watch?v=UgMaxx0dbv8> (Robert Whitaker - Psychiatric Drugs: Do They Fix Imbalances or Do They Create Them - Part 2) In Part 2 there is some rehashing of the day before lecture for a bit over the first 20mins of the lecture.

Antipsychotic Medication

Statistics are showing that the longer somebody is on antipsychotics the worse their outcome is in a number of different ways, and antipsychotics drugs shrink the size of the brain. Funding has been given to prominent UK progressive psychiatrist Dr Joanna Moncrieff, who has started a study on the Discontinuation and Reduction of Antipsychotics (the RADAR program) versus the current Stay on Them Till You Die thinking by mainstream psychiatry. Australia should pay attention to the results of this trial when finished. The next five links are all to do with why this UK study is being done, the fourth/fifth links being recorded lectures. The fourth link (lecture) is a very in-depth analysis of the antipsychotics patient outcome using worldwide data.

<https://joannamoncrieff.com/2016/03/02/new-research-into-antipsychotic-discontinuation-and-reduction-the-radar-programme/>

<https://joannamoncrieff.com/2013/12/09/long-term-antipsychotics-making-sense-of-the-evidence/>

<https://joannamoncrieff.com/2013/12/13/antipsychotics-and-brain-shrinkage-an-update/>

<https://www.youtube.com/watch?v=CUTOhnM0PPM> (Rethinking Antipsychotics)

<https://www.youtube.com/watch?v=IV1S5zw096U> (Joanna Moncrieff - The Myth of the Chemical Cure: The Politics of Psychiatric Drug Treatment) (Lecture)

The three links below, yes, are all negative in tone to mainstream psychiatry and its current practice.

<https://www.youtube.com/watch?v=Kq1xzZw9n-I> (Concerns Grow Over Blockbuster Antipsychotic Drug Seroquel (November, 2013)) (ABC TV The 7.30 Report)

<https://www.youtube.com/watch?v=9cfjK0mPF8> (Prof Peter Gøtzsche: Why Few Patients Benefit and Many are Harmed)

<https://www.theguardian.com/commentisfree/2014/apr/30/psychiatric-drugs-harm-than-good-ssri-antidepressants-benzodiazepines>

People with Mental Health problems often have had high stress in their lives. It is being reported (as below) that high stress could be shrinking ones brain, and there is a link between antipsychotic medication and brain shrinkage. Together this could be a double whammy for patients.

<https://www.msn.com/en-gb/health/mindandbody/could-high-levels-of-stress-shrink-your-brain/ar-BBPfwCL>

Australian Ketamine Trials (Recorded/Reported Data Inaccuracy Self-Critiquing)

My section here on our Australian Ketamine Trials for depression is not here because I in some way think it a good thing or will work, I think we should drop the idea. It is here because I feel it helps by using others to explain the accuracy/exaggeration/fudging/ self-critiquing issues that I believe is a far bigger problem in the bigger picture than most would realise. The three links below are to do with ketamine for depression and are in order.

In the first, the article portrays Ketamine (due to the promising data from USA, but this only mentioned in second article) as being a new wonder-drug for depression after short trial.

<https://www.abc.net.au/news/2017-07-24/psychiatrists-optimistic-about-ketamines-use-to-treat-depression/8737638>

In the second article, the Australian Researches who stopped the trials still think the promising data has to be good, and that they just need to do a bit more tweaking on the drug dosage and dosage method.

<https://www.smh.com.au/healthcare/depression-researchers-stop-ketamine-nasal-spray-trial-because-of-psychotic-like-effects-20180315-p4z4hm.html>

Now listen to a podcast from USA Dr Pam Popper on Ketamine, and the so called promising data. The timeframe start for the Ketamine talk is at 7min 45sec and at timeframe 13.26 she mentions

how staff administering ketamine “exaggerated potential benefits” .(fudging in self-critiquing their treatment)

<https://www.youtube.com/watch?v=-y9b9KVkrj8> (Ketamine Clinics) (Dr Pam Popper)

It appears to me, from the three above; that the Australian researches have been fooled by exaggeration from USA into thinking Ketamine will be successful. Exaggeration has a habit of creeping in everywhere to do with Psychiatry. Trying to explain how bad the exaggeration is, will sound like exaggeration. The exaggeration is recorded in both ways, when about patient it is negative or some bad way, when about staff (themselves) it is in a positive or good way.

Wrong Diagnosis, Diagnoses Stacking and Fabricating Evidence of Mental Illness

Wrong Diagnosis

It is common to hear about wrong diagnoses by a GP, it is very rare to hear about wrong diagnoses in Psychiatry, yet it should be more common than in General Practice, due to the fact that there is no science backed test done in psychiatry. This news story on the cost of wrong diagnosis in Australia doesn't does not even consider what is really going on with psychiatric diagnoses.

<https://www.msn.com/en-au/health/medical/the-deadly-cost-of-medical-misdiagnosis/ar-AAvNoF6>

Psychiatrists feel very uncomfortable about saying another psychiatrist is wrong as shown in this example below. This correspondence wasn't sent to whom or where the wrong diagnosis was made, yet the author still could not say “wrong” and said “has fun (typo error should be run) course more consistent with a diagnosis of schizophrenia” . I know I not/wasn't either bipolar or schizophrenia.

been seen by our service for around 22 months after making accommodation and refusing to continue in treatment. He has been treated for a psychotic illness initially diagnosed as bipolar affective disorder at ██████████ Mental Health Unit, ██████████ but has fun a course more consistent with a diagnosis of schizophrenia with predominantly negative symptoms. Over the last 12 months

In a meeting with this above psychiatrist who thought I schizophrenia, I was trying to debate the fact that I didn't have schizophrenia and I said “I had been diagnosed with bipolar before” the psychiatrist replied “well I think you are bipolar and schizophrenia”. I knew this was a lie back then, as he only thought I was schizophrenia, and finding this above, written in file later, shows it was lie.

The reason this psychiatrist as above thought I was schizophrenia is because my life is like a movie, he didn't believe what I was saying about my life, and in psychiatry the quicker a psychiatrist can diagnosis the better the psychiatrist they are. Once you are wrongly diagnosed with a mental illness you don't have it becomes your medical history as if you actually were, and very hard to undo. You are also forced to take addictive antipsychotic drugs, so once out of the treatment facility you then have to continue the drugs, or stop using them and suffer going through the withdrawal process.

With it virtually unheard of to hear of somebody being wrongly diagnosed with a mental illness, I think famousness played a part in this person being classed as misdiagnosed in below news story.

<https://www.msn.com/en-in/health/medical/kanye-west-misdiagnosed-with-bipolar-disorder/ar-BBOjLUZ>

What would happen if somebody with a hidden camera went to a number of different psychiatrists complaining of feeling the same way to the different psychiatrists? Well it has been done and you can see just what happens at time 1.15:50 in link to documentary below. For those who assume the person will get same diagnoses by all, you will be disappointed.

<https://www.youtube.com/watch?v=PWKUujRXTCO> (Abuse in Psychiatry)

Diagnosis Stacking and Fabricating Evidence of Mental Illness

One of the problems for anyone who gets into the Mental Health system is diagnoses stacking. A patient in the public Mental Health system will be seen by different psychiatrists that can have different opinions therefore different diagnoses. When this happens the psychiatrists don't have a "Psychs of The Round Table Meeting" to figure out who right/wrong or if anybody right at all. It is an unwritten gentlemen's agreement for psychiatrists not to challenge another's diagnosis. And they can't: for a psychiatrist to argue that they are correct and their colleague/s are incorrect then they would have to be able say why the patient satisfies the criteria for their proposed diagnosis and why the patient doesn't satisfy the criteria for their colleague/s proposed diagnosis. (Psychiatrists can't even explain how the patient meets the criteria for their own diagnosis, this is obvious to me as not one has recorded in my file what/how I meet criteria {the equivalent to a medical test result} from the list for their mental disorder diagnosis.) What happens is they make everyone correct by stacking all the diagnoses on top of each other deeming the patient suffers from everything proposed. This nobody is wrong everyone is correct mentality has caused another problem for the patient, where speed of diagnosis is more important than accuracy. It doesn't matter if the diagnosis is correct (accuracy) because the patient isn't qualified to dispute it and if the patient tries to then they lack insight (further evidence they mentally ill) and if another psychiatrist believes the patient to be a different diagnosis then diagnoses stacking is used to make everyone correct. In a profession that it is very hard to be proven wrong (accuracy) in diagnosing, the only thing left to differentiate between average and better than average psychiatrist is speed, so the faster a psychiatrist can diagnose the better the psychiatrist they are. Furthermore, with speed being more important than accuracy in diagnosing then accuracy isn't important when recording information in patients file. I know diagnosis stacking sounds like a ridiculous thing to be happening when psychiatrists have differing opinions, but that's exactly what happens, as proven in their own words soon below.

The example of diagnosis stacking also has fabrication of evidence for mental illness linked within this example, so will be presented together, starting very briefly with the background. I verbally complained about illegal actions of one public servant to another public servant that realised I had been in the public Mental Health System and this Public Servant called the police who then got a public Community Treatment centre involved. A Mental Health nurse at that centre tried to get me admitted by writing a "Schedule 1" and submitting to police so they could legally pick me up and take me to a Mental Hospital. I was able to dodge police for the duration of "Schedule 1". The nurse then tried harder to get me admitted and the more I resisted the harder the nurse tried. To write a "Schedule 1" there has to be evidence on it. The tactic she used to fabricate evidence: was to turn up at my place knocking on my door, then when I answered and abused her for harassing me and referring to my life being like a movie by saying things like "stop making a movie out of my life", She

then wrote this contact to appear like evidence on the "Schedule 1". She managed to convince a new junior psychiatrist registrar to do the same. It was also the amount of contact time that was exaggerated, me talking to them for about 5 mins then shutting the door resulted in the observed time recorded as 15mins. A psychiatrist registrar is a junior psychiatrist doing On The Job Training, in this case he's getting trained on how to make up evidence by a Mental Health Nurse. After I had dodged four "Schedule 1" taken out on me she managed to convince a Chamber of Magistrate at a local court that I needed to be admitted, the Chamber of Magistrate then issued an "Order for Medical Examination or Observation", and I got admitted.

Blame due to insightlessness. He claims he is the subject of a Hollywood movie being made about his life.

EXAMINATION

a) He is agitated & verbally aggressive - stating a movie is being made about his life - wants to sue the government

EXAMINATION

The snippets above and below were taken from "Schedule 1's" taken out on me and used as evidence trying and eventually succeeding in having me admitted. The two above were written by Mental Health Nurse that desperately wanted me admitted, the one below was written by Psychiatrist Registrar who worked with this Nurse for part of week and worked at Mental Hospital where they eventually got me admitted the rest of week. Me saying to them things like "stop making a movie out of my life" and "public servants have turned my life into a movie" resulted in them making changes and using it as evidence for mental illness. Below "grandiose delusions" was recorded with the twisting of my life like movie joke into evidence. **This is why body video cameras need to be worn at home visits, to stop this sort of behaviour.**

grandiose delusions that his life story has been made the subject of a movie. Appeared tortured by his symptoms.

EXAMINATION

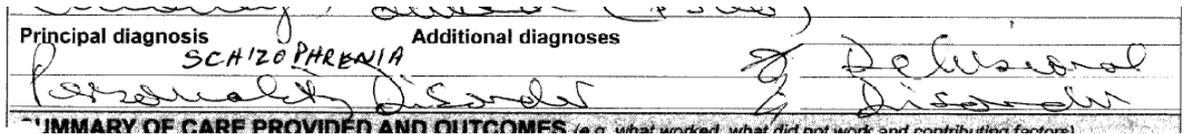
This below shows how "Diagnosis Stacking" works. On a 2012 Discharger Summary is written "He has been the subject of varying diagnosis given him in the past. He certainly demonstrates Axis ii features at the very least. But others diagnosing him variously as having a Delusional Disorder & also Schizophrenia. Psychotic features were not clearly demonstrated during this admission. He was agitated

SUMMARY OF CARE PROVIDED AND OUTCOMES (e.g. what worked, what did not work and contributing factors)

He has been the subject of varying diagnoses given him in the past. He certainly demonstrates Axis ii features at the very least. But others diagnosing him variously as having a Delusional Disorder & also Schizophrenia. Psychotic features were not clearly demonstrated during this admission. He was agitated

DISCHARGE SUMMARY

This 2012 Discharge Summary (part seen above and below) had "Personality Disorder" recorded under "Principle Diagnosis" and "Delusional Disorder" recorded under "Additional Diagnoses". On a later review of the garbage written in my file after discharge by a different psychiatrist the "Principle Diagnosis" was changed to "Schizophrenia", he didn't like the fact that his opinion wasn't the winner so trumped the original author by writing "SCHIZOPHRENIA" in, or was it because with "Activity Based Funding" Schizophrenia is worth more funding points for his place of work, or both? (the different handwriting as seen below)



This review and subsequent change resulted in the "Discharge Summary" and "Clinical Coding Summary" (the official diagnoses) having impossible recordings as "Schizophrenia" is recorded as "Principle Diagnosis" and "Personality Disorder and Delusional Disorder" are recorded as "Additional Diagnoses". Any psychiatrist or psychologist will realise that it is impossible (by the DSM) to be diagnosed with schizophrenia and delusional disorder at same time, as "delusions" are one of the possible listed in "Criteria A for Schizophrenia". For someone to say that somebody has both Schizophrenia and Delusional disorder at same time, then they have to be able to distinguish which of their delusions are symptoms of schizophrenia, and which of the delusions are due to delusional disorder. The relevant part of the Clinical Coding Summary is below.

DRG

U61A Schizophrenia Disorders W Mental Health Legal Status

PCCL

0 PCCL 0 - SDX is not a CC, or is included in ADRG definition, or is excluded

MDC

019 Mental Diseases & Disorders

ICD-10-AM Principal Diagnosis

(2) F209 Schizophrenia, unspecified
DRG

ICD-10-AM Additional Diagnoses

- (2) F609 Personality disorder, unspecified
- (2) F220 Delusional disorder
- (2) F121 Mental and behavioural disorders due to use of cannabinoids, harmful use
- (2) Z911 Personal history of noncompliance with medical treatment and regimen

The author (a Mental Health Nurse) of the below remark (written after discharge at a community treatment centre) being the person who went to "great lengths" to eventually have me admitted concedes that "a diagnoses was still never clarified at d/c". They understand the given diagnoses are not clear, as it clearly can't be both schizophrenia and delusion disorder, and the personality disorder is vague being unspecified. She and a psychiatrist registrar fabricated evidence to have me admitted, this fabricated evidence then become medical history that was used in the diagnosing process to try and diagnose me, then she writes that "a diagnosis was still never clarified at d/c" (by the psychiatrists). This person also took something else I said, wrote it in a number of different ways

making me look all over the place with what I said knowing it would appear as symptoms of mental illness.

Given that great lengths were exhausted to eventually have this chest admitted and that a diagnosis was still never clarified at d/c, and he has not ~~then~~ accepted any f/u since d/c (no injections, not wanting to see a doctor) and CTO not thought implementable decision is to discharge from care of MHT.

Below is entries in my file whilst admitted, by the Psychiatrist Registrar involved in having me admitted. This time he didn't change my "movie talk" from what I said, but he is still using it to infer mental illness. With me saying that "Public servants have turned my life into a movie" and "they can do what ever they like to you because they won't be sacked". The Psychiatrist as below, turned my negative thinking on Public Service into me being "Extremely paranoid". This is a huge leap from the usual threshold level for the unwarranted suspicion mistrust theme for paranoid. And before I was admitted he used the "my life like movie expression" twisted into evidence to be "grandiose delusions"(as above further back on snippet from Schedule 1) then after admitted he used it as evidence "Extremely paranoid" as below.

1e k)	Note: All entries must be legible, written in black pen and include the health care provider's printed name, designation and signature.
	"Public servants have turned my life into a movie"
	"They can do whatever they like to you (public servants) because they won't be sacked."
	Extremely paranoid.

This time that I was supposedly Extremely paranoid (as recorded above) is the exact same admission that it was written (as shown prior) in Discharge Summary "Psychotic features not clearly demonstrated this admission..." so this sounds like the original author of Discharge Summary didn't believe the "Extremely paranoid" lie by this very junior psychiatrist registrar involved in having me admitted . Another psychiatrist changed that Discharge Summary putting Schizophrenia on top, but not specifying what sub-type: shows they thought the "Extremely paranoid" to be totally ridiculous as they didn't combine it with Schizophrenia as sub-type "Paranoid" (making me a Paranoid Schizophrenia). The psychiatrist who wrote the "Extremely paranoid" was only just out of psych school and the more senior psychiatrists must have thought his exaggeration was too extreme to use.

3) Mr. ██████ believes that public servants are responsible for his life being turned into a movie.

Snippets above and below. The junior psychiatrist registrar had got to do “work experience” by writing “Report to Mental Health Inquiry” (Mini Kangaroo Court) where he used my life being like a movie joke as evidence of paranoid delusions. Of course he violated my Human Rights by not letting me see any of the garbage he wrote (the evidence) before the Mini Kangaroo Court. On the Discharge Summary, as said before is written by senior psychiatrist “Psychotic features not clearly demonstrated this admission...” What about the “paranoid delusions” as on report? They were the “Legality” to keep me admitted and give me drugs! What does this mean for patients when a psychiatrist just out of Psych School is already so good at exaggeration and making up evidence?

Conclusion:

Mr. ██████ is mentally ill as defined by the Mental Health Act. He holds a number of paranoid delusions.

There is a psychiatrist able to conclude I have a “Personality Disorder (Unspecified)” but not anything about it, what cluster, A,B or C it from, or the specific personality disorder. The DSM-IV-TR (current at time I diagnosed) says “...the particular personality features must be evident by early adulthood.” I joined the Army at 21yrs old and served for 24yrs. Therefore no GP doctor, psychologist or psychiatrist I had seen during that time was able to conclude I had this “Personality Disorder” then 10yrs after separation from Army a psychiatrist was suddenly able to see I have a “Personality Disorder”, but not know anything more about the finer details of it. The actual problem is: psychiatrists can say anything and not be considered wrong.

The “Mental and behavioural disorders due to use of cannabinoids, harmful use” and the “Personal history of noncompliance with medical treatment and regimen” had nothing to do with the admission. The admission, as said previous, was due to one Public Servant not like me complaining about another Public Servant. Psychiatrists like to blame the patients if they get re-admitted to a Mental Hospital. The “..noncompliance with treatment regimen” is saying my admission was due to me not taking medication that I know is no good for me. Refusing to take mind altering antipsychotic medication for me is the right thing to do. I have lost the weight gained when on it before, got out of the pre-diabetic region that I got in, I am in overall better health and reached the life expectancy age for somebody diagnosed with schizophrenia, and achieved this in better health than the average person my age. I am not on any medication, not diabetic nor high blood pressure or cholesterol, with low BMI so low that it low for someone aged in their 20's. I only ever admitted to feeling depressed, I don't know where they got all the diagnosed Mental Disorders from.

Anybody mentally ill or not can be classed as mentally ill and held against their will put on antipsychotic medication, I know this sound “delusional” but that's literally how psychiatrists can do that, as delusions alone is enough to be held in a Mental Hospital. I so-far have not met one Psychiatrist or Mental Health Nurse who doesn't need their “delusion detector” recalibrated, as their threshold is set way too low. It is not possible for the patient via body language to know that the psychiatrist doesn't believe them because the psychiatrist sits there with their emotionless, flat, poker face look on them. Once a psychiatrist, rightly or wrongly, believes that somebody is delusional, then they are half-way to being classed as Schizophrenia. Furthermore, in NSW, the

Mental Health Inquiry conducted by the Mental Health Review Tribunal (MHRT) that will supposedly release a wrongly held patient held in Mental Health Hospital is nothing more than a “Mini-Kangaroo Court”. The patient is charged with having a “Mental Illness” but not given any information on the allegations, the what/how/why, so therefore can’t defend themselves against the allegations. The Report to Magistrate written by the Psychiatrist that the patient doesn’t get to see is a “Targeted Report” written to hit the target the psychiatrist wants. To make it worse for the accused mentally ill, they only find out about the allegations in front of the magistrate, and is only allowed to speak when and how long for with the magistrate’s permission. The way they can legally conduct these “Mini-Kangaroo Courts” is under the guise of the “Harm” clause. If the psychiatrist decides (and they will) that some sort of harm may arise from the patient seeing the information on them (patient file, psychiatrists/social worker Reports to Magistrate) then the Psychiatrist can get permission from MHRT to withhold all information to the patient, of course the MHRT goes along with the psychiatrist no questions asked. This happens for all patients represented with Legal Aid solicitors. I can’t say if it same for the patients able to afford a private solicitor, I haven’t been around any. I am sure what I have said about the withholding of the patient information by the psychiatrist can be backed up by reviewing the statistics on how many patients are denied access to their information at MHRT. The conclusion I have come to as to why the psychiatrists refuse to let the patients have the information on them for MHRT Inquires is about protecting from harm, but not in the correct context. Under the definition of harm in the Mental Health Act it can be harm to reputation of patient or other. If the patient can win a MHRT Inquiry thereby get released against a psychiatrist who is trying to keep the patient in the Mental Hospital, then the psychiatrist losing has their reputation harmed in front of their work colleges for losing. This of course is a violation of the patient’s human rights, but it more important to protect the psychiatrist’s reputation than protect the patient’s human rights.

The problem with psychiatrists treating somebody for delusions when they are not is the “shut-up or double up” dilemma the patient is in. I know about this problem first hand. When the psychiatrist wrongly thinks somebody is delusional and gives them medication the psychiatrist is looking for the patient to stop saying the thing/s perceived as delusions. The patient won’t know at first that it is thought they delusional and will find out in front of a magistrate in a MHRT hearing. If the patient continues to say the same thing that is perceived as delusional then at some time the psychiatrist will double the dose of antipsychotics as they will automatically assume that the dose isn’t strong enough as the delusions are still there. The psychiatrist won’t make the correct assumption; being that they are not delusions therefore the antipsychotics will not block them. (at least not until the vegetate medicate state) Therefore the patient has to shut-up speaking about what thought delusional or double up in medication dose, the “shut-up or double up” dilemma.

In this US News Story below a women who owned a BMW was held and drugged in a mental hospital because it was believed she was delusional in saying she owned her BMW. I concede that race may have played some part in the admission but if so that part had to of stoped once in the hospital door, as it was then psychiatrists (I sure Harlem Hospital would have African-American psychiatrists) took over and continued the she’s delusional theme.

https://www.huffingtonpost.com.au/entry/kamilah-brock-nypd-bmw_us_55f2c9aae4b063ecbfa3e60d

Although this is American, the same can happen here. If a psychiatrist decides you are delusional then you will not be told they believe you are delusional and you will be drugged to clear the delusions from your head and held until the psychiatrist decides to release you.

Does Activity Based Funding (ABF) Effect Treatment in Anyway?

I concede I do not know much about ABF. The Clinical Coding Summary,(in part pasted in further back), has me under " DRG" as "U61A Schizophrenia Disorders W Mental Health Legal Status" . With the ABF Points Scheme, for Schizophrenia there is a U61A (Major Complexity) and U61B (Minor Complexity), with U61A Major Complexity earning more funding points (due to the patients being more of a handful to look after) for the facility. The same goes for other disorders, example: Anxiety Disorders has a U65A Major Complexity and U65B Minor Complexity.

My question is: do staff at treatment facilities act in any way at all with treatment or diagnosing to earn or fudge more funding points, therefore more money for their facility? If there is an "A (Major Complexity)" and" B (Minor complexity)" variations with the disorders, one would expect that both of these variations are appearing on "Clinical Coding Summary" for funding due to both these complexities appearing in patients. If only the "A (Major Complexity)" variation are put through to ABF for funding points for the treatment , then one has to assume that all patients are put in this category for the purpose of getting more funding points, otherwise what is the point of having the "B (Minor Complexity) if there is never anyone that fits that category. In my case when the review of my discharge diagnosis was done the diagnosis was changed to U61A (Major Complexity) Schizophrenia, coincidentally this changed earned the facility the most amount of ABF points possible therefore the most amount of funding for having me as their guest.

Listening

Near the end of last year there was a two episode series on TV SBS called HOW "MAD" ARE YOU? This was based on the same format UK series that was on Australian TV a few years ago. In this series a group volunteers, with 5 people who had never been diagnosed with a mental illness before and 5 people who had been. The volunteers were put together for a week, were all given same task or group task with video being streamed to a room with a three person panel of Mental Health professionals. The panel's task was to listen/observe and try to work out who had been diagnosed with a Mental Illness and what Mental Illness from a given list to choose from. No link to the series is given, I believe it is still on SBS website and that you will need a user account to access.

I will only bring up one point about the series that happened in episode, that I feel is of great importance, that is the Mental Health worker's ability to listen. In episode one the first person to finish the drawing task said "I am well aware that drawing is not something that I am good at" Senior Clinical Psychiatric Nurse, Alfred Hospital Jan Macintire said to the other two on panel "What she said was, it's still something I am good at". Not hearing the "not" word changes the context to opposite.

I know this is an exact problem that I have had. On reading my files I know that important keywords I have said that reverse/shift the context have been missed. With these wrong recordings some have been recycled and used again.

More on Exaggeration

The easiest entry that shows not just, but gross exaggeration is the entry below. In 2007 it was recorded in Mental Health file that I had “**Chronic** bronchitis.” This was due to having what all smokers (in my case cannabis) do, a smokes cough. After this 2007 entry I continued to smoke cannabis, verified by it recorded in the “snippet further back” of 2012 Clinical Coding Summary “Mental and behavioural disorders due to use of cannabinoids, harmful use” . I took up running (again) and aged in my late 50’s in 2017 was able to run 5km in around 20min. The result table further below are my results from Parkrun’s website. The link for my results will be supplied, along with my athlete barcode and number to Productivity Commission to show that they are my results.

Chronic bronchitis.
1 2010

Run Date	Run Number	Pos	Time	Age Grade	PB?
01/04/2017	217	21	20:31	76.85%	
25/03/2017	216	27	21:22	73.79%	
18/03/2017	215	14	21:09	74.55%	
11/03/2017	214	13	19:41	80.10%	PB
04/03/2017	213	32	23:09	68.11%	
25/02/2017	212	21	20:46	75.92%	
18/02/2017	211	11	20:17	77.73%	
11/02/2017	210	15	20:45	75.98%	
04/02/2017	209	20	20:48	75.80%	
28/01/2017	208	24	21:06	74.72%	

The World Health Organization’s definition for Chronic Bronchitis, is pasted from their website below along with the link to this their reference.

COPD: Definition

Chronic obstructive pulmonary disease (COPD) is a lung disease characterized by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible. The more familiar terms 'chronic bronchitis' and 'emphysema' are no longer used, but are now included within the

COPD diagnosis. COPD is not simply a "smoker's cough" but an under-diagnosed, life-threatening lung disease.

A COPD diagnosis is confirmed by a simple test called spirometry, which measures how deeply a person can breathe and how fast air can move into and out of the lungs. Such a diagnosis should be considered in any patient who has symptoms of cough, sputum production, or dyspnea (difficult or labored breathing), and/or a history of exposure to risk factors for the disease. Where spirometry is unavailable, the diagnosis of COPD should be made using all available tools. Clinical symptoms and signs, such as abnormal shortness of breath and increased forced expiratory time, can be used to help with the diagnosis. A low peak flow is consistent with COPD, but may not be specific to COPD because it can be caused by other lung diseases and by poor performance during testing. Chronic cough and sputum production often precede the development of airflow limitation by many years, although not all individuals with cough and sputum production go on to develop COPD.

<https://www.who.int/respiratory/copd/definition/en/> (Link to above description)

This "Chronic bronchitis" recording was either gross exaggeration, or I should be world famous and a study case as the only person able to achieve this remarkable transformation from this "life-threatening lung disease" . My view is that it's gross exaggeration. I had a smokers cough that was exaggerated to be chronic bronchitis.

Scanning File Entries for Dirt

I believe the below file snippet shows that staff in public Mental Health do quickly scan files for dirt to use elsewhere.

Continued.
Staff members forcibly removed
him - Client was <u>not</u> abusive
or violent before or after
injection - but considered
he did not require medication
& that he wanted discharge
Client asleep HTR - Observed

You will notice in the above file recording the word "not" is underlined. This is the only time in this or any other file that a word has been underlined. My experience in Mental Health Facilities along with having copies of files makes me believe I know exactly this little three letter word has been underlined: the person who wrote this was being a conscientious worker at that time.

When somebody is looking through a file for any reason, like for information to put on a report, they are quickly scanning pages looking for dirt. The words "abusive" "violent" would stand out when somebody quickly scanning for dirt. The author underlined not to ensure it wasn't missed next to the

glaring type of dirt words that are being looked for in a file, ensuring a mistake not made being when information is quickly sought and used in another way, like on a report.

Culture

I have been divorced twice. The second divorce happening with somebody I met online from overseas and I brought to Australia, with me not realizing that it was a only a scam to gain Australian citizenship. This scam was the major contributing factor for my contact with Mental Health. In the public Mental Health System, psychiatrists are considered all the same, there is no choice. I disagree with this thinking. A multicultural country has psychiatrists from different culture backgrounds, with different amounts of divorce in their home culture, ranging from similar rate as Australia to almost non-existent due to it being taboo. I believe that a psychiatrist from a country where divorce is taboo is not qualified to interview me by virtue of the fact that the psychiatrist doesn't understand the concept of divorce. I believe the below news story, about a male mental health nurse's own experience adds weight to this belief.

<https://www.abc.net.au/news/2018-10-12/divorce-akin-to-ptsd-with-most-men-ill-equipped-to-handle-it/10355172>