MISDIAGNOSIS AND OVERDIAGNOSIS IN PSYCHIATRY: THE LOOMING CATASTROPHE

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OVERDIAGNOSIS CONFERENCE, QUEBEC, AUG 17-19 2017
MISDIAGNOSIS AND OVERDIAGNOSIS IN PSYCHIATRY

Australia: Hybrid system of

* Commonwealth public services (including DVA)
* State public services (general and psychiatric hospitals, community clinics)
* Private (practitioners, hospitals, laboratory)

* Health expenditure ~9% of GDP

* Financed mainly by Commonwealth, with some state and private insurance.

Excellent health statistics across the nation.

By international standards, Australia rates highly on practically all parameters.
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• In private practice: Standard: Private practitioners bill the fee to Medicare for 85% of standard fee (bulk-billing). Patients pay nothing.
  • Advantage: Keeps people out of public system (cf. half hour at Goodna MHS $275 vs my practice $73.40).

• Alternative: Private practitioners can choose to charge what they like; patients often pay a large “gap” over the standard fee (100-200% or more).

*BUT*: Inherent inefficiencies in a private system such as....
MISDIAGNOSIS AND OVERDIAGNOSIS IN PSYCHIATRY

• ....no control over prescriptions.

  • Prescription rates for psychiatric drugs rocketing across the country.

  • Huge differences in prescription rates from one area to another (up to 7000%)

  • Antidepressants: 1% of population in 1990, to 10% 2015 (US = 13%).

  • Antipsychotic drugs worse: quetiapine up 85% from 2008-2011.

  • “Mood Stabilisers” (anticonvulsants): valproate up 800% from 1991-2012 (slight fall in epilepsy).
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• Does this matter?
• Side effects of antidepressants:
  • Drowsiness, confusion, delayed reactions;
  • Massive weight gain, loss of libido;
  • Akathisia, tremor;
  • Addictive and withdrawal effects (2yrs).
  • All side effects highly persistent. Tardive akathisia and dyskinesia.
• Problem for prescribers: Anybody who is given full list of side-effects of antidepressants won’t take them.
• Solution: Nobody tells them.
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• Qui bono?
  • *Zero evidence to say mental health improving.*
    • Community surveys, hospital admissions, burden of illness, early retirement;
    • E.g. Suicide rate recently hit peak (12.6/100,000), M:F = 4:1.
    • Early deaths from chronic psychotropic drug consumption (19yrs in Australia, 25yrs in US).
    • Massive and rapidly-increasing cost of psychiatric drugs.
    • Relentlessly rising disability pensions
  • Qui bono? Certainly not the patients. Can this be right?
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AN EPIDEMIC UNFOLDS

The Iatrogenic Agents Spread
Percentage of American youth younger than 20 on a stimulant or antidepressant

Juvenile Bipolar Diagnoses Leap
Outpatient office visits by youths under 20 with a diagnosis of bipolar disorder

And Disability Numbers Soar
SSI recipients under 18 years old disabled by mental illness, 1987-2007


The Epidemic in Children

Children on SSI Disability Due to Mental Illness

Prior to 1992, the government’s SSI reports did not break down recipients into subgroups by age. Source: Social Security Administration reports, 1988-2007.
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• **ECT:**
  - RANZCP: “ECT is valuable and essential form of treatment ... when clinically indicated.”
  - Urgent life-saving treatment for severe depression.
  - Norway: 8wk wait at ETC centres.
  - Usage rates: Australia and US roughly equivalent.
  - Australia vs NZ: 600%
  - Australia vs UK: 1000% (Qld 4.8mln ~ England NHS 53mln)
  - Poland 5000%; Italy 6250% (14 of 91 centres); Pavia....?
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• ECT:
  • US: Median ECT patient EWWF (cf. YPEM)
  • Australia: ECT given by male psychiatrists to female patients.
  • 93% of ECT given by men.
  • Suicide rate for women ~ 1/700 cases of depression, men 1/400.
  • Misallocation of resources.
  • Compare Australia and NZ: same college, only one difference.
  • Conclusion: ECT is not valuable, not essential and only clinically indicated for one reason.
MISDIAGNOSIS AND OVERDIAGNOSIS IN PSYCHIATRY

  • 40yrs: 12000+ consecutive, unselected public patients (veterans, military, Aboriginal, prisons, drugs and alcohol etc.)
  • Application of philosophy of science to psychiatry.
  • Five monographs, next nearly finished.
  • Numerous papers, articles etc.
  • Steady stream of complaints from mainstream psychiatrists
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• What’s the point of the travelogue?
MISDIAGNOSIS AND OVERDIAGNOSIS IN PSYCHIATRY

• Currently: Bulk-billing shopfront practice in working class area: high unemployment, disability, broken families, immigrants, drugs and alcohol, crime.

• 200 new cases a year, 2-7 day waiting list.

• Normal private practice in Australia: 40 new cases a year, 3-6 month wait.
MISDIAGNOSIS AND OVERDIAGNOSIS IN PSYCHIATRY

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

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

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

• Net effect:
• Bipolar Disorder:
  • 1974: 0.1-0.2% prevalence.
  • 1984: 1.0% (Andreassen)
  • 2005: 5.4% (Judd & Akiskal)......?
• “Dr. Lewis Judd has watched—and to a remarkable degree, helped shape—the evolution of psychiatry from its decidedly charismatic but often controversial past to its empirical present as a data-driven, hard-charging neuroscience.... Judd was among the first and leading proponents for treating mental disorders like depression as the result of neurological and biological dysfunction, and arguing that they could be effectively treated with appropriate, rigorously developed psychopharmaceuticals.”

• UC San Diego News Center, June 13th 2013.
MISDIAGNOSIS AND OVERDIAGNOSIS IN PSYCHIATRY

• Bipolar Disorder:
  • 1974: 0.1-0.2% prevalence.
  • 1984: 1.0% (Andreassen)
  • 2003: 6.4% (Judd & Akiskal)
  • 2011: 11.2% (Mitchell)
  • 2017: 15%
MISDIAGNOSIS AND OVERDIAGNOSIS IN PSYCHIATRY

• 15,000% increase in “genetic disorder” in one generation.
• How could this happen?
  • Lack of model of mental disorder.
  • Drug companies.
  • Academic psychiatry.
MISDIAGNOSIS AND OVERDIAGNOSIS IN PSYCHIATRY

• How could this happen?
  • Lack of model of mental disorder: “Mental disorder is brain disorder.”
  • No evidence whatsoever for a formal, reductionist model of mental disorder anywhere in the entire psychiatric literature, or philosophical, or psychological, or neurosciences.

MISDIAGNOSIS AND OVERDIAGNOSIS IN PSYCHIATRY

• How could this happen?
  • Lack of model of mental disorder (Psychiatry as Ideology)
  • Drug companies. $42 billion in fines in 8yrs.
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  • Drug companies. $42 billion in fines in 8 yrs.
  • Academic psychiatry relentless broadening and blurring of definitions.
# MISDIAGNOSIS AND OVERDIAGNOSIS IN PSYCHIATRY

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  • Drug companies. $42billion in fines in 8yrs.
  • Academic psychiatry relentless broadening of definitions.
  • Academic psychiatry: “biologisation of mental disorder.”
MISDIAGNOSIS AND OVERDIAGNOSIS IN PSYCHIATRY

• Lewis Judd: Psychiatry as a data-driven, hard-charging neuroscience

• mental disorders as the result of neurological and biological dysfunction, can be effectively treated with appropriate, rigorously developed psychopharmaceuticals.

• psychiatry as a real biomedical science.

MISDIAGNOSIS AND OVERDIAGNOSIS IN PSYCHIATRY

• THE LOOMING CATASTROPHE:

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