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Productivity Commission Inquiry into Mental Health
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Submission to Productivity Commission inquiry
into the role of improving mental health to support
economic participation and enhancing
productivity and economic growth.

Executive Summary of Submission

At a time when Australian governments are funding a focus on mental health and calling for reform in the sector, such as "a serious plan to extend service provision in regional Australia" the de-facto hierarchy of government-endorsed fee and referral structures is counterproductive. Effects are most acute in regional areas where bottlenecks in training supervision create long waiting lists for a limited number of well-paid provider groups while an underclass of experienced and well-qualified providers remains marginally paid or working as volunteers. Particularly dangerous are policies for 'early detection'. The National Competition Policy agreement was intended to put the onus of proof on legislation and policies supporting any such regulations, incentives and restrictions of competition.

Summary of Recommendations on Mental Health

1. Review the entire fee and hierarchical structures in the Mental Health Sector in terms of The Competition and Consumer Act and The National Competition Policy agreement
2. Review impediments to creation of a paid workforce of Counsellors
3. Review the need for hours of supposed 'professional development', particularly by psychologists
4. Review the justification, if any, for the AHPRA Board-endorsed Psychologists to have a different level of fees and referral structures to other Psychologists
5. Review justification for MBS exclusion of diagnostic and assessment services by psychologists and Allied Health
6. Review justification for prohibitively expensive 'latest version' psychological tests
7. Review the number of MBS sessions for Psychiatry including monitoring and disincentives to refer to others
8. Review alternate referral paths to 'mental disorder' labelling for MBS psychological services
9. Review the justification for calls to fund activities such as EMDR, Mindfulness, and Psychodynamic Therapy
10. Review MBS impediments to group therapies and less-clinical alternatives
11. Review 'gap fee' policies
12. Review the dangers of supposed 'early intervention' assessments in light of overseas warnings.

The clearest proof of market failure in *"delivering value for money and the best outcomes for individuals, their families, society and the economy" ...*

… can be found on the website of the Productivity Commission's Inquiry into Mental Health: *If you need specific help or advice, you can contact one of the services below: Lifeline Australia..." (Productivity Commission website, 2018).*

The same can be found on the websites of each of the government authorities currently reviewing the mental health sector. These government bodies are not advising us to contact a doctor, mental health facility or other AHPRA-registered mental health professional, but rather openly acknowledging that the front line is commonly unpaid, un-registered volunteers such as those at Lifeline who pay out of their own pockets for training:

- Senate Community Affairs References Committee Secretariat: *"Where to get help … Lifeline ..."*
- Accessibility and quality of mental health services in rural and remote Australia: *"If you or anyone you know needs help you can contact one of the services below: Lifeline …*
- Mental Health Commission: *"Get Help … Lifeline …*
- Victorian Royal Commission into Mental Health ... *access immediate support by contacting: – Lifeline:*

At the same time that these people make negative incomes, other practitioners in this sector seek over $400/hr and have

waiting lists of months. It also acknowledges that 'suicide prevention', prominent in the Inquiry's Terms of Reference, is routinely being handled outside the scope of government or market forces.

"We must involve people with lived experience"

The Medical Consumers Association (MCA) is a consumer group which was formed in 1977 in a meeting at the University of New South Wales. We are aware of the Commission's well-intentioned interest in consumer views. MCA is not funded by any government or corporate sponsors. Its main role is to ensure that a diversity of information and consumer perspectives are made available for policymakers. MCA does not claim to be a consensus of 'consumer voices'. Rather we draw on public information and the experience of our members, many of whom are also healthcare providers, including the key 'lived experience' of whistle-blowers. MCA cautions that the views and needs of one sector of consumers in mental health may be in complete opposition to the views and needs of others within this immense sector.

"we intend to give greatest consideration to where there are the largest potential improvements ... people with a mild or moderate mental illness (such as anxiety and depressive disorders) because they account for the vast majority of Australians with a mental disorder"

MCA cautions that there is no homogeneous consumer experience. ABS figures conflate depression, anxiety and substance overuse and press coverage often hypes the impression that traditional severe conditions like psychosis now afflicted half the population. This is the trap of 'diagnostic inflation'. Severe mental illnesses have no bearing on how the "vast majority" should be treated and there is danger that their 'urgency' is extrapolated to policies that will harm the majority through mislabelling and dangerous treatments. Concerns about *"involuntary incarceration, unnecessary hospitalisation and use of seclusion and restraint"* are only relevant at the extreme end of the spectrum and should have no bearing whatsoever on consumers involved in custody, compensation, workplace bullying disputes, and other areas in which mental health issues are contested. Indeed, they allow weaponization of mental health labels cavalierly tossed around courtrooms to discredit claims.

"… driven by consumer demand and trained and distributed by competencies rather than professional categories".

Again, consumers with severe mental illnesses will have entirely different and likely polar opposite 'demands' to others drawn into the sector. A locked ward or jail facility might require 'competencies' in first aid and self-defence, which ought to have little relevance to psychologists assessing a bereaved person in a clinic.

There is plenty of evidence that there are few proven 'competencies' in the sector and no justification for competency assessment. *"The imposition of educational and competency standards"* in health care has long been a focus of ACCC concern.

Questions on structural weaknesses in healthcare: Why have past reform efforts by governments over many years had limited effectiveness in removing the structural weaknesses in healthcare for people with a mental illness? How would you overcome the barriers which governments have faced in implementing effective reforms? What, if any, structural weaknesses in healthcare are not being targeted by the most recent and foreshadowed reforms by governments? How should they be addressed and what would be the improvements in population mental health, participation and productivity?

The biggest limitation has been reliance on advice from a cartel of expert panels and committees. This is contrary to law. All who restrict trade are supposed to have this approved under the Competition and Consumer Act (Cwth) 2010 and National Competition Policy to *"review and where appropriate reform of all laws that restrict competition unless the benefits of the restriction to the community as a whole outweigh the costs and the objective of the law can be achieved only by restricting competition, and a requirement that all new legislation that restricts competition meet this test"*.

These professions have never presented their case to the Australian Competition and Consumer Commission (ACCC). They would have no case to present as ample scientific literature has long contradicted their claims. From its inception the Australian Competition and Consumer Commission (ACCC) watchdog has regularly reported on the professions and in particular the health sector as an important area of concern. Professor Allan Fels, represented "*The ACCC's view*" (1997) outlined the issues:

- "Structural regulations of professional markets:
- *regulate entry into the market (including the imposition of educational and competency standards, licensing and certification requirements and restrictions on entry by foreign professionals and para-professionals);*
- *define the field of activity reserved for licensed or certified professional practitioners;*
- *separate the market functionally into discrete professional activities (including those performed by accredited*

specialists such as insolvency practitioners, barristers and medical specialists); and

- *impose restrictions on the ownership and organisation of professional practices.*
    - Conduct regulations include those which:
- *limit the fees which professionals may charge or require the application of fee scales for particular professional services;*
- *prohibit certain kinds of advertising, promotion or solicitation of business by professional practitioners; and*
- *specify professional and ethical standards to be observed by, and disciplinary procedure to apply to, professional practitioners."*

Evidence is abundant for distortions of each of the structural and conduct categories outlined by the ACCC. The MCA believes that the requisite demonstration of public benefit can never take place as there has long been abundant evidence to the contrary. Some of the evidence that has been assumed and/or tendered in support of the MBS fee structure has possibly been *"Misleading or deceptive"* in terms of the ACL.

The onus of proof is not supposed to be on the Productivity Commission, ACCC, consumers, the MCA or even those who make policy. It should be on any who purport to offer evidence as to why any barriers to market entry or competition satisfy the test that *"the objective of the law can be achieved only by restricting competition"*. A formal exemption is supposed to be sought from the ACCC to justify restrictive practices. Professor Fels' (1997) 'ACCC view' cautioned that *"Members of the professions often present the view that rules prohibiting anti-competitive conduct should not apply to them as the conduct complained of has the purpose of protecting the public. … But if there is something that is anti-competitive and it really is for the patient's benefit or client's benefit that is, for the public's benefit (as distinct from being a private benefit for the doctors/lawyers etc) - then Parliament has set up a mechanism whereby that conduct can continue with immunity from Court action - seek authorisation. That is, demonstrate that the public benefit of that conduct outweighs its anti-competitive detriment and obtain immunity from Court action for that conduct." [Prof. Fels' underlining]*.

MCA provides sufficient evidence that there is currently not merely a lack of public benefit, but rather a demonstrable public detriment. Any genuine review of the evidence will negate benefit claims. The following review is presented in the framework of the ACCC's stated "view" (1997) on issues related to professional markets:

Structural regulations

Regulate entry into the market (educational and competency standards, licensing and certification requirements and restrictions on entry by foreign professionals and para-professionals);

"What this means for workforce and research capacity … What restrictions exist on the scope of practice for different professions, such as GPs, nurses, clinical versus other psychologists, and social workers? Are these restrictions unwarranted and, if so, how could they be addressed and what would be some of the costs and benefits? (Productivity Inquiry Terms of Reference)"

There is no scientific basis for the psychology registration process, much less for supposed 'specialities' or 'board-endorsements'. The Psychology Board of Australia (2017) notes that *"The history of psychology regulation in Australia began in 1965 in response to the perceived threat to the public of Scientology"*. Such regulation is based on potential for harm rather than skills, standards or benefits. Other sciences such as Economics and Physics can also do great public harm but have never been registered as this would only produce an 'orthodoxy' of accepted beliefs. Psychologists claim their potential for harm mainly because they commonly take vulnerable individuals, including children, into closed rooms and have a mandate to manipulate their thinking. As with clergy, this has potential for abuse and boundary violation. The Royal Commission into Institutional Responses to Child Sexual Abuse saw such vulnerability in residential institutions, out-of-home care, schools, sport, recreation, arts, culture, community and hobby groups, detention environments and religious institutions.

There is no evidence whatsoever to warrant differential exclusion of counsellors from government subsidy. Registration is a risk issue, not a skills issue. Counsellors have the same public risk issues as psychologists. The qualification level of a counsellor is commonly similar to that for so-called general psychologists as many academic programmes offer both degrees. Clearly a government-endorsement of counselling via MBS would have immediate workforce implications.

Counselling careers might provide a much-needed 'escape route' to the aspiring 'provisional psychologists' who justifiably sense they may never be able to pass the notorious arbitrary and bizarre 'case study' requirements that create the bottleneck at the end of a long, expensive registration process. Unlike courses in Law and most university courses, registrants are not given 'past exam' questions or 'model answers'. Instead they are given long lists of supposed 'criteria' they have to demonstrate with no indication of the weighting, wording, length, supporting references, or rationales. It is open to subjective interpretation. The examiner can claim something is missing in the report when it is clearly there. There is no meaningful direct appeal process as it has to go through a 'supervisor'. This ignores that it might have been a

supervisor failing in the first place.

It would serve no public interest for such examiners to have any role in continuing so-called 'competency' assessment. Psychology is nothing like Dentistry, in which there are specific visible procedures to be learned, new chemicals and tools, and fine manual skills. Psychology is notoriously open to subjective assessment and abuse of process. It is beyond the scope of this submission to comment on similar provisions in Psychiatry beyond noting that the ACCC has long taken an interest in anti-competitive restrictions by medical colleges and their AHPRA boards.

Professional development requirements for psychologists in particular are wholly disproportionate to any possible benefits to their clients or themselves. Psychologists as health professionals are scarcely more required to administer emergency procedures such as first aid than any other members of the public. They commonly work in clinics where nurses and doctors are available and walk-in practices ought not to be any more at risk than a law office or other commercial practice. The 10 annual hours of peer consultation plus 20 hours of other CPD are touted as though this was keeping us with an ever-changing field. It has created a training and CPD industry. The usual bleat for rural and regional areas is to provide more resources to meet this contrived 'need' rather than reduce it to a workable number in the first place. NSW solicitors, by contrast, only need complete 10 CPD hours annually. Law is by definition a genuinely-changing field, unlike psychology.

Provided they met the same Police and other checks as eligible Allied Health providers, provisional registrants fed up with working for free and trying to pass mysterious case studies might drop out and find a rewarding career as a Counsellor rather than as a Psychologist. Many may have enrolled for that reason in the first place -ie- 'helping people' through talk therapies, rather than the mundane IQ-testing and other activities of some Psychologists.

The MCA is mindful of the costs and impact of seemingly minor changes to the MBS and any other government regulations. As its co-author Prof AJ Frances said of the Diagnostic and Statistical Manual, *".. it's very easy to change the definition of a mental disorder by just tweaking it the tiniest little bit and all of a sudden you'll have millions of new patients. If you add a new disorder and it's at the very populous boundary between normality and mental disorder you invent 10 million patients overnight." (2005)* … *"We have a medical system that couldn't've been conceived of more brilliantly by an enemy of the United States... (2013)* Single-line changes to the MBS could overnight wipe out or create entire classes of providers and 'mental disorders' and 'treatment' industries. But that is the rationale for market forces to be involved rather than government fiat.

If consumers became aware that most board-endorsed clinical psychologists were said to have no specialist qualifications (Hyde, 2015, Cahill, 2018) - how would they justify a gap fee? Consumers might well regard the differentiation as a deceptive trade practice, particularly when patients are gambling with their own reputations by conceding a 'mental disorder' in order to be eligible for MBS.

Consumers might also have similar concerns about seeing a psychiatrist. MBS eligibility assumes patients have attended for concerns about 'mental disorder'. But sometimes this has been inferred by their doctor or even by a spouse, court order, friend, co-worker – or opponent. Sometimes they are not seeking a treatment but actually seeking a report for a court or other authorities that they do <u>not</u> have a mental disorder. The duopoly position of clinical psychologists and psychiatrists allows them to have patients 'over a barrel' in terms of gap fees. Patients may be forced to attend these instead of counsellors or general psychologists in order to satisfy a requirement or get a report of some sort, such as for Centrelink or NDIS.

Define the field of activity reserved for licensed or certified professional practitioners;

There are many underpaid and unpaid providers in the mental health sector. As previously noted, Lifeline relies on volunteers. Also in this category are many provisional psychologists putting in thousands of 'work experience' hours. These substantial groups often have negative incomes- ie, they pay to work. The only way many can accrue enough hours to be eligible to apply for registration is to work for free, while paying for their own offices, insurances, and petrol if they are required to be mobile.

No existing research, nor to our knowledge, even 'yet to be done' research does or could support this hierarchy. The research results have long been available. There is no scientific support for this differentiation, but rather a consistent refutation. Research results reliably show that unpaid untrained unregistered mental health providers, called 'paraprofessionals' in the literature, can perform as well as, and sometimes get better results than mental health professionals (reviewed by Durlak, 1979, 1981, Hattie, 1984). In the 60s Carl Rogers' colleagues explored personal factors as determinants of psychotherapeutic outcomes. Genuineness, empathy, concreteness, and respect were therapist attributes thought to be more influential than psychology school orientations (Truax, & Carkhuff, 1967). In the next decade Hogan (1979) reviewed studies to date that had equated professionals with paraprofessionals. Meta-analytic comparisons from within the profession, starting with yet another 'citation classic' (Smith & Glass,1977), found *"Few important differences in effectiveness could be established among many quite different types of psychotherapy.*

Many submissions have been made to the MBS task force about the limits to number of sessions eligible for funding. This is yet another area where some evidence is actually available and sometimes contradicts the claims: for example studies reviewed by Hattie (1984) comparing paraprofessionals with professionals that showed if anything a better outcome over a longer period of sessions in favour of the paraprofessionals.

Some studies focus on differences between existing practitioner levels; for example 'general versus clinical psychologists'. These ignore the comparison between both of these professional groups and the untrained competition. By ignoring control conditions of either no treatment or paraprofessional sessions, these studies fail to consider whether the entire edifice, including psychiatrists, might be questionable.

It should be noted that whatever of such research applies to the allied health professions should be seen to apply to the medical practitioners in the mental health sector as well. Psychiatrists are able to offer as much as 160 sessions per year to a single patient. Modern psychiatry can no longer claim any distinct difference from the other mental health professions in terms of talk therapy. Their differentiating feature was once Freudian psychoanalysis and has always been physically invasive treatments such as drugs, ECT, insulin coma and psychosurgery, some of which have since been abandoned. They also claim that they take a greater responsibility for differential diagnosis and management of medical conditions in persons presenting with mental health symptoms. But the latter consideration would really only apply at the diagnostic stage and for emergency care.

If persons required continuing medical observation that is a role for a mental health hospital facility. In community settings if, as is widely touted, the first line of treatment should be talk therapies and exercise, there is therefore a major market distortion if a psychiatrist is paid many times the hourly rate of an allied health professional for delivering essentially the same type of talk therapy, meditation, or merely monitoring someone.

The MBS tacitly acknowledges this lack of differentiation with a single list of therapies identified as evidence-based, presumably applicable to psychiatrists, clinical psychologists and Allied Health. The focus on evidence-based therapies means psychiatrists and clinical psychologists are no more likely to be more proficient in these therapies than other health practitioners.

There is no evidence or logic suggesting that a TAFE-level trained counsellor would be unable to perform the same sorts of 'focused psychological strategies' as registered Allied Health practitioners. These are what they might learn in a TAFE course. Indeed, the Australian Counselling Association (ACA) and Psychotherapy & Counselling Federation of Australia (PACFA) acknowledge a Certificate in Cognitive Behaviour Therapy (CBT) obtained in a 4-day workshop.

That is correct – 4 days, not 4 years, to learn the most highly-supported of the talk therapies.

“ ...disadvantaged groups, such as individuals from very low socioeconomic backgrounds and people residing in remote areas because they may have more difficulty in accessing services which could improve their mental health”

Proposals such as put forward by the Australian Psychological Society (2018a) to the MBS Review to limit psychologists with general registration to persons with “mild to moderate disorders” will desolate psychology practices. More supposedly severe or chronic cases were to be referred on to Board-certified psychologists, with the following logic:

“Within psychology, one endorsement area (Clinical Psychology) was identified by the Government when the Better Access Medicare items were first introduced to meet the standard required to provide treatment services to individuals affected by the more severe, complex and chronic mental health disorders.”

This met with APS member backlash from thousands, brought to the attention of the MCA from membership and social media. The potential effects of changes proposed to the MBS echoed those known to MCA so we quote from correspondence from a Reform Australian Psychological Science group from within the APS:

“To illustrate: I live and work in a community of approximately 20 000 people, and I receive additional referrals from surrounding towns. We have 4 part-time non-endorsed psychologists and 1 full-time clinical psychologist, who specialises in chronic pain management. My waiting list varies anywhere between 1 and 3 months at any time. Likewise, the waiting list of the clinical psychologist varies between 1 to 3 months. Under the APS 3 Tier model, and according to the data cited above my caseload will be reduced by 90%. Those clients will need to be referred on to the clinical psychologist who, as already pointed out, has a wait-list of 1-3 months now, or to our already stretched community mental health service. There are 3 other non-endorsed psychologists who will have to refer their clients on as well. The most likely scenario is that, with our caseloads reduced by 90%, the non-endorsed psychologists in this community will be forced to close our businesses, further reducing access to services. Clients in need of intervention

will be forced to wait for extended periods of time, travel at least 100km to see another psychologist for timely care (at their own expense), or utilise Telehealth. Telehealth is an excellent facility, but it does not solve the problem of access, given that 90% of referrals will still need to be serviced by only 40% of psychologists." (Cahill, 2018)

Recent media presentations have attempted to make a case that the more severe cases warranted special highly-skilled teams, but that is a straw-man argument. GP referrals to general psychologists in private practices would rarely be for treatment for the severe psychiatric disorders that would have traditionally been seen in the locked wards of an asylum. There is no evidence for these supposed advanced skills. There may be a case for the acute facility itself because of its resources, drugs, restraints and custodial protections but that is not an argument based on any proof of the supposed skills of the staff therein, whether medical or allied health.

Separation of the market functionally into discrete professional activities

A simple proof of the political rather than scientific logic is the apparently arbitrary equation under MBS items of different Health disciplines all deemed to be eligible to provide the same list of 'focused psychological strategies'. Mental health nurses, social workers, occupational therapists, GP medical doctors, and psychologists supposedly all come from different disciplinary backgrounds. Yet they all offer services from the identical list of services, which was updated by the Australian Psychological Society as a supposed (2018c) review of evidence-based psychological interventions. Ironically, the APS has always listed its recommended fees for clinical psychologists as exactly the same as for other psychologists, including counselling psychologists. There is no logical or scientific justification to exclude a Counsellor classification to provide from this same list of focused psychological strategies. It is an arbitrary restraint of trade.

Psychology originated as a science like Anthropology or Economics. It was deemed a health profession and registration was introduced allegedly 'in the public interest'. The rationale for registration was that miscreants were in a position to do harm. Only if registered could they be 'struck off ' instead of battled at common law.

Clearly, the onus of proof from both the scientific and legal perspective on the MBS policy-makers and the registered health professionals drawing MBS money is to show why some tiers should be differentiated and remunerated exponentially higher than the existing voluntary class of mental health service providers and generic counsellors for doing much the same things. This also applies to psychiatrists.

Particularly questionable are the gatekeeping roles which demand lengthy, expensive 'supervised' post-graduate activities, and create an underclass of 'provisional psychologists'. In many cases across the health sector these programs have become artificial and onerous. They drain public funds while at the same time restricting supply of highly-trained and experienced persons from entering the market. The ACCC has queried this with medical colleges.

Even ignoring the legal Consumer and Competition onus of proof imperative, there is not a mere lack of evidence for the superiority of these psychotherapies over generic talk methods. There is an overwhelming amount of contrary evidence. Parallel to the negative results for psychotherapy overall from Eysenck in 1952 and Smith and Glass in 1977, Hogan in the 1970s reviewed studies to date that had equated professionals with paraprofessionals. A multitude of studies have followed (reviewed by Durlak, 1979, 1981, Hattie, 1984) and the conclusions have almost always been the same. Mental health professionals have never demonstrated any superiority over untrained persons.

Artificially Expensive Diagnostic Services

The same can be said for mental-illness diagnoses. Meehl (2013), widely cited in psychology and science textbooks, demonstrated convincingly, even in the pre-computer era (Meehl, 1954), that statistical methods based on tests could outperform trained experts in the mental-health and other sectors in diagnostic accuracy. In a well-known follow-up Goldberg (1968) showed that even when the clinicians were given the advantage of seeing the results of the actuarial computations to incorporate into their own judgements they could not match the actuarial results. Despite much outcry from clinicians this has never been refuted and has been repeated in other sectors. So there was never any scientific justification for a government-endorsed diagnostic hierarchy in the mental health sector.

Tests used for assessment for qualification for NDIS or Centrelink benefits are commonly specified for a particular standard. If an IQ score is to be use as an intelligence measure it is essential that practitioners have common standards or the scores are meaningless and/or people could shop around trying to get a particular score from different providers. A Wechsler series kit can cost around $3,000 and there are different ones for different age groups. Compared to a hospital unit or dental practice a set up for a psychologist is probably modest and within small business ranges. However for rural and regional areas the numbers of clients served might not justify such purchases. This results in long waiting lists and travel to better-equipped centres.

Some of this is unnecessary. Much clinical testing such as cognitive assessment does not need 'the latest' version as the

scores can easily be transposed with tables to approximate the current test score and in neuropsychological testing it is the contrast between scores that is the focus rather than the magnitude of scores. The issue commonly becomes more one of (dis)honesty in interpretation, for example in contested insurance cases, than the sensitivity of the tests. If AHPRA complaints become a weapon spurious complaints can arise over a practitioner's supposed 'out of date' tests when it ought to be a matter for proof whether this made even the slightest difference in an objectively-administered assessment. These costly tests add little value compared to the abuses from restricted use.

The same applies to medical diagnoses. The hierarchy of mental health 'gold standard' assessment commonly defaults to psychiatrists. This is more of a legal than scientific convenience as demonstrated decades ago by Meehl (1956, 2013). It is the same with death certificates. Any lay person might be able to see that some accident victims strewn along the highway are clearly dead but the law requires a medical doctor to pronounce the judgement. Psychiatry has never demonstrated any superiority of mental illness diagnosis since Meehl's day. The EEG and PET scans seen on TV documentaries are not used in clinics. Clinicians rely on interview and questionnaires, as they did in Meehl's day.

Contrived Restrictions on Therapeutic Practices

It is hard for the mental health sector to demonstrate that its more invasive treatments such as prolonged medication can even beat placebo. The overall figures for all types of interventions in the mental health sector do not justify any sort of highly stratified fee hierarchy, whether physical or talk therapy. Given the lack of any demonstrated support for highly paid mental health professionals to outperform partly trained so-called paraprofessionals there seems little reason to exclude or not embrace some of the more recreational types of intervention. For two decades it has been clear that basic physical exercise has mental health benefits, and in a well-known study (Blumenthal, 1999) adding a psychotropic drug into the mix only weakened the effect of the overall treatment of exercise alone (Babyak, 2000). Various forms of recreation made into therapy such as art, drama and music therapy have a long history in mental health institutions. Generic counselling, provided it is not flavoured with some bizarre religious, guru, or so-called motivational cult underpinning, could make an equal claim to highly paid psychotherapies.

In 2018 a public media campaign attempted to claim a 'groundbreaking' finding that 'the drugs work': *"Oxford University study … found pills were up to 113 per cent more likely to tackle depression than no treatment at all — despite previous claims that they did not work."* - a clear response to the public interest generated by consistent negative findings such as a meta-analysis by Kirsch et al (2008). However, the source article in Lancet (Cipriani et al, 2018) specifically mentioned this history of negative findings: *"Depressive symptoms tend to spontaneously improve over time and this phenomenon contributes to the high percentage of placebo responders in antidepressant trials." ... short-term benefits are, on average, modest. ... We did not cover important clinical issues that might inform treatment decision making in routine clinical practice (eg, specific adverse events, withdrawal symptoms ..."*

Tellingly they noted *"drugs tended to show a better efficacy profile when they were novel and used as experimental treatments than when they had become old,"* an echo of the old medical placebo adage: *"Use the new medicines while they still work."*

The supposed 'new' evidence in this widely-publicised study of Cipriani et al (2018) had an obscure table on page 150 of their 289-page supplementary appendix. The figures had to be computed by the reader to come to the rounded average effect size of SMD=.3, which had been virtually the same figure obtained by Kirsch (2008), prompting media coverage "the drugs don't work". Subsequent publications ranged as high as Numbers Needed to Treat (NNT) of around seven or eight, meaning several are given an invasive drug so that one might benefit. And that is a big 'might' as there was no information as to whether meeting the threshold actually had clinical significance. Also scorned was the fact that the doctors writing the Cipriani meta-analysis article were relying on third-hand information from ghost-writers. One of the authors (Ioannidis, 2018) distanced himself some of the press claims that had been made about the study. Other of their own colleagues (Moncrieff, 2018) queried whether the changes on the rating scales used had any clinical significance. The source studies meta-analysed are commonly *"ghost written": "physicians and scientists agree to sign on even if they may not be intimately familiar with the underlying data or relevant research '…it was common practice for pharmaceutical companies to approach him and his colleagues with requests to review and sign on as primary authors to company studies'."* (US Senator Grassley, 2010). In other words the authors of the source articles, let alone the meta-analysers, may not have actually seen the patients or even the case files or raw data.

The Cipriani et al (2018) authors had been careful to mention that talk therapy might be similarly beneficial but "because of inadequate resources", not always available. Lest the promoters of CBT think this justifies its government-endorsement there are estimates of a NNT of nearly 4 for CBT (Cuijpers, 2016). So, again this could be interpreted as saying that for every patient getting a measurable change there might be 2 or 3 patients who do not. CBT has bloated to a grab-bag of sub-treatments and is not without unwanted side-effects even if they are likely less than with long-term psychotropic drugs. However, when multiplied by thousands of practitioners and adding in some of their gap fees this can amount to a considerable amount of money.

The onus of proof of all this is not that some unfunded group such as MCA, Productivity Commission, or even the MBS Taskforce should be forced to review the statistics in countless journal articles (the Cipriani article claimed to review 522 trials with 116,477 participants). Consumer law requires that a public benefit must be demonstrated by the proponents of the treatments.

Impose restrictions on the ownership and organisation of professional practices.

The Psychology Board of Australia (2015) has defined *"Practice means any role, whether remunerated or not, in which the individual uses their skills and knowledge as a registered psychologist in the profession. Practice in this context is not restricted to the provision of direct clinical care. It also includes using professional knowledge in a direct, non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on safe, effective delivery of services in the profession."*

The wording is not confined to "*direct clinical care"* but any non-clinical role. This is clearly a gag on critics of the sector. Any psychologists who left direct clinical care but raised questions about the sector as MCA is doing with this submission could be deemed to be muzzled for taking *"roles that impact on safe, effective delivery of services".* Critics of scientific fraud in the sector are commonly accused of putting the public at risk, for example when lobotomies were criticised. One NSW Minister referred to a whistle-blower in the mental-health sector as a "grub". An AMA spokesperson called consumer advocates "maggots in the meat".

Traditionally psychologists had a lot of training in what they term 'rats & stat's' with a heavy emphasis on testing, often in the vocational and education sectors rather than health. There is only a contextual relationship to the health sector -ie- some worked in clinics. For example, psychology courses rarely if ever contained any training in emergency procedures, as would be expected for other health professions.

A damning proof of scientific and market distortion is a report that the majority of those who are currently Board-endorsed as 'clinical psychologists' do not even have higher degrees in clinical psychology (Hyde, 2015):

"Due to the grandfathering process some years ago, more than 40% of endorsed clinical psychologists do not have a Masters or Doctorate. Many have no more than 4, and some as little as 3 years of university training … "(Cahill, 2018).

By contrast some counsellors, provisional psychologists, and volunteers may have such higher degrees including PhDs and years of experience in the mental health sector, yet no access to MBS. From a consumer perspective there is neither reason nor justification for this. This differentiation of practitioners could be argued as " *misleading or deceptive, or likely to mislead or deceive"* (s 18 of the ACL).

By what logic can a practitioner likely to be less-qualified be portrayed as more-qualified? This was precisely the issue investigated by the NSW Ombudsman (Moss, 1995), who described psychologists' registration as "a rubber stamp" for the privileged 'grandfathers'. Yet eligibility bottlenecks prevent many experienced and qualified people from delivering paid service. A 50 year old trying to register can appear as though they must have done some misdeed, as with a 50yr old suspiciously driving with an L-Plate. Some of the provisions for registration have the effect of leaving them unpaid for years with little prospect of ever breaking even over the expensive (as much as $37,000/yr) training. This does not even take into account the opportunity-cost of having left other careers because they wanted 'to help people', nor the detriment to the public in areas where there are not enough services. In particular, these are rural areas.

Conduct regulations

Limit the fees which professionals may charge or require the application of fee scales for particular professional services

In the mental health sector there are dramatic differences in remuneration for similar or the same procedures between different disciplines. This artificial scientific and professional hierarchy is reinforced by governments through:

- Medical Benefit Schedule hierarchical fees
- Public Service job levels
- AHPRA registration categories, Board-endorsements, and competency assessments
- Legal case law precedents such as criteria for an 'expert witness'

For delivery of essentially the same services, patients and the government can be charged on the order of nearly 3 to 1

in terms of bulk-billed fees, for example, the Allied Health Focused Psychological Strategy of $84.80 versus for Psychiatry, $221.30. The differential in patient fees is even higher when psychiatrists add gap fees of up to $200 that many consumers are not in a position to dispute. The psychiatrists are able to offer many more sessions than Allied Health practitioners. The fee gaps are even wider in court proceedings where supposed expert witnesses in mental health can be hired to comment on insurance claims and child custody arrangements.

MCA notes that proposals have been made to extend the use of provisional registrants and so-called 'psychological assistants' on a similar logic to *"using nurse practitioners to perform a range of functions formerly restricted to medical practitioners has enabled the delivery of some health services at lower cost without increased risk to patients."*

MCA cautions that applied to Psychology, this would lead to exploitation. Psychology is not analogous to Nursing. A nurse is not an apprentice doctor. They cannot simply convert to being a doctor. They would be starting their university course from scratch. A Psychology graduate working as a counsellor, by contrast, might have every expectation of becoming registered to provide full services. Indeed, counsellors have professional associations but are ineligible for MBS. Many become 'provisional psychologists' and pay $150/hr to their 'supervisors' for sessions over several years. So-called 'assistants' might be easily tempted to themselves register as provisional psychologists. It is concern that the APS draft (2018) had called for endorsement of "psychodynamic" therapies for medical benefits with little specificity of the actual supposed underlying this, for example Freudian or Jungian and others. The potential for costs and entrapment of psychodynamic registrants was exposed by Richard Noll as:

"... a multilevel marketing pyramid, with … Jungian Analyst status essentially equivalent to a distributorship that can be bought.... The usual patient of a Jungian Analyst is always a possible trainee whose economic input into the system is potentially significant. Money, perceived power, and perceived spirituality, all flow to the few certified Jungian Analysts in the elite at the top of this pyramidal economic system". (Noll, 1994)

The APS fee structure has equated fees between all types of psychologists for decades. All APS psychological 'recommended fees' are the same hourly rate, irrespective of so-called specialities or board-endorsements. This acknowledges that psychologists do not always work in the Health sector. Many have PhDs. Some are scientists who see animals rather than humans or work in industry. It also reflects the long-standing scientific findings of no outcome differences attributable to training. The difference is maintained artificially by funding requirements rather than science.

Prohibit certain kinds of advertising, promotion or solicitation of business by professional practitioners;

The press is quick to jump on what it sees as misallocation of public funds with headlines like: *"Exclusive: animal whisperers, yoga and soul counselling classes are all being billed to taxpayers .."*. Yet the MBS appears to allow the higher tiers of the remuneration scale such as psychiatrists and clinical psychologists to run meditation practice (yoga) in the form of 'mindfulness training' at a price far higher than the market for such activities outside the health sector (noting that mindfulness is borrowed from Buddhist meditation which is public domain.) Admittedly, the policy states that: *"It is expected that such treatment would include, but not be limited to: shorter term psychotherapy; less frequent but long term psychotherapy; pharmacological therapy; cognitive behaviour therapy."* The " *but not be limited to"* clause gives wide scope and "160 occasions in a calendar year" at $156.15 per session could legally add up to $24,984 per annum for a single patient.

The abuse of payments for training psychoanalysis has been described as 'psychic pyramid selling' and 'an intellectual Ponzi Scheme'. Trainees are encouraged to spend years paying out at $150+/hr for treatments for themselves in the patient role, tempting them to get medical referrals to claim this as a 'necessary treatment' for their own claimed 'mental disorder'. This is a well-known misallocation of funds, but the failure to monitor requirements for trainees' therapy and ensure they are justified and reasonable will perpetuate this misdirection of government monies.

The evidentiary base for psychotherapy does not justify exclusions or a fee hierarchy based on training. A prominent current example is Eye Movement Desensitization and Reprocessing (EMDR) which is now commonly advertised as a qualification and service by Board-certified clinical psychologists. It is of concern to the MCA that the Australian Psychological Society appears to have so far proposed this practice for Medical Benefits (Australian Psychological Society, 2018b). The APS is now calling for a second round of updates to the submission but if approved by MBS it would have given an apparent government authorisation for this. Yet any patient can do a web keyword search on "EMDR quack" and will find scathing reviews. Even the popular psychological science press has deplored this as "pseudoscience" and "quackery":

- Scientific American: *"More than 500 brands of psychotherapy exist, with new ones springing up on a nearly monthly basis. Although a handful of these neophyte treatments have been tested in scientific studies, it is anybody's guess whether the others actually work. … Few psychological treatments have been as widely*

*heralded as EMDR. Some EMDR proponents have called it a "miracle cure" and "paradigm shift," … psychotherapists proudly list their certifications in EMDR on their Yellow Pages advertisements … Yet not a shred of good evidence exists that EMDR is superior to exposure-based treatments that behavior and cognitive-behavior therapists have been administering routinely for decades."(*Arkowitz & Lilienfeld, 2012)

- Psychology Today: *"Eye movements, the new part that EMDR brings, are unnecessary and do not contribute anything to the health and well-being of clients.…there is the downstream effect of pseudoscience. When the public is exposed to quackery, this often generalizes to a lack of confidence and trust in psychologists and science. They no longer turn to psychologists for help."* (Kashdan, 2014).

Specify professional and ethical standards to be observed by, and disciplinary procedure to apply to, professional practitioners.

The onus of proof to demonstrate public benefit is on the professional who is seeking to exclude others. In decades of seeking statistical support or relying on anecdotal evidence about occasional breaches of ethics they have usually only found the opposite.

When registration of psychological practices was initially considered by the NSW Department of Health in 1996 and reviewed (1999) : *"Submissions calling for the restriction of additional titles such as counselling or psychotherapy have been noted by the Department.* ***However, very little material was provided demonstrating the risks of injury to patients from counsellors or psychotherapists.*** *The* ***benefits of such a restriction are likely to be marginal****. Prescribing additional titles such as counsellor or psychotherapist under the Act for exclusive use by psychologists is likely to significantly increase any competitive advantage which exists under the current Act for psychologists. Non-psychology trained practitioners would not be able to use the titles unless they undertook additional training in psychology to become registered, notwithstanding that* ***their current training may be adequate for the services*** *that they offer. Alternatives, such as information campaigns that highlight the benefits of dealing with registered practitioners are likely to be far more effective. Therefore, the Department rejects the need for restrictions on additional titles."* [MCA highlights in bold above]

By contrast, where information of "injury to patients", including deaths, had been the subject of complaint they were sometimes about highly-qualified Health Department and University practitioners. There were parliamentary claims of "cover up" and calls for an inquiry. Royal Commissioner Slattery (1990) thus recommended that a Professional Conduct Division of the Supreme Court was needed to allow Common Law to function in cases of abuse of psychological methods rather than self-regulation or even a Board-certification system: *"The publishing of codes of conduct, test standards, and guidelines for the use of tests has proved inefficient in ensuring acceptable standards of practice... the previous system, despite its many merits, did not prevent, in Australia or elsewhere, the use of assessment and treatment techniques of dubious value.."* (Vol. 13, p. 297).

But little of this was heeded. MCA members complained to the Ombudsman about selectivity/lack of enforcement by the then-new NSW Psychologists Registration Board, who wrote: *"I have rarely dealt with a body which appears to have such a limited understanding of its administrative responsibility and so little capacity for self-assessment."* (Moss, 1995)

These concerns have never been put to rest. A current legal case based on the Slattery Royal Commission issues, reputed to have been the longest-running saga ever covered by the Sydney Morning Herald, has resurfaced 30 years later. An ABC author in 2018 mentioned medical issues that had been well covered by the 1983 Parliamentary allegations and subsequent 1990 Royal Commission. But the court judgement on defamation of the medical practitioner has effectively forced the defence to go back to taws and actually prove from scratch the allegations which had been made in the 70s-80s when the patients were still alive (Bachelard, 2018).

Coerced Psychiatric Labelling

The current MBS eligibility provisions induce labelling of persons as having 'mental disorders' as defined by ICD-10. This clearly tempts people who might otherwise be seeking a non-health service such as guidance, mentoring, marital advice, social work, industrial or legal advice to use the MBS funding to get 'free' subsidised consultations with a professional person. In rural areas clinics may be the only counselling professionals. But it also gives them a potentially stigmatic lifetime label as 'mentally disturbed'. Efforts to 'normalize' mental illness have only served to make this labelling seem more plausible. A high price for the bulk-billed service might be paid if they are ever turned down for a job, child custody arrangement, gun ownership, power of attorney or insurance claim on the basis of a documented mental disorder.

Notoriously the funding can tempt persons enrolled in lengthy, expensive training programs such as psychoanalysis to

abuse the MBS system to pay their trainers. Instead of seeing the general public they make more money counselling each other. They need only a referral from a GP to begin claiming extended consultations with a psychiatrist and the taxpayer ends up spending many times the hourly rate that a university educator would have received for the same level of educational service by labelling it a health intervention. The trainer can do a double dip with the MBS money of several hundred dollars an hour plus a 'gap' training fee - commonly $150-$200/hr on top. No doubt they can justify this $400+ an hour income at the dinner table if they have an in-law who works as a barrister or Big-6 accountant, but if this were ever investigated in a public inquiry the irony and scale of such activity might not impress the taxpayer.

Complaints about violations are likely to only catch the most vulnerable aspirants. High-end practitioners are given almost unlimited discretion in the services offered so it would be hard to even make a case as to why a $400 an hour psychiatrist should be discouraged from offering what is essentially a training or 'talk & yoga' session under *" but not be limited to"*, given the public acceptance of the benefits of psycho-education and mindfulness therapies.

Should there be any changes to mental illness prevention and early intervention by healthcare providers? If so, what changes do you propose and to what extent would this reduce the prevalence and/or severity of mental illness? What is the supporting evidence and what would be some of the other benefits and costs?

"early identification and treatment can make a huge difference. … because mental illness at a young age can affect schooling and other factors which influence opportunities over a person's lifetime — moreover, most mental illnesses experienced in adult life have their onset in childhood or adolescence"

The clichéd calls for "early identification" are a trap. They would be standard public health goals in many areas of medicine. MCA warns that extrapolating this to mental health, however, is dangerous and invites exploitation. Adolescents in particular have been the targets of 'bounty-hunt' mental-illness labelling in order to obtain government subsidy.

Prof aj frances , former diagnostic & statistical manual co-author, warned *"there were suggestions [of using] DSM-V for psychosis risk - the idea that we could predict psychosis and prevent it was the thing that got me started on on this crusade because it seemed to me that there was no more dangerous thing we could do than pretend we could predict psychosis and treat it with medication that would be harmful. it turns out that only one in 10 people identified to be at risk for psychosis actually goes on to have psychosis - and that may be a high number. so you'll be misidentifying nine out of 10 to pick out the one who really needs your help. there's no effective treatment. the studies that have been done so far show no effective treatment preventing psychosis. and here's the hooker - in the hands of the people making the suggestions, that intervention would be a psychosocial intervention that might be helpful for anyone - no harm done. but in the real world the kids would be getting antipsychotic medication*

The dangers of deceptive claims for early intervention were made most clear in Australia in October 1992 when *Four Corners* hosted by Andrew Olle aired concerns about medical companies attempting to register in Australia. The Texas Senate Inquiry into these firms had been covered by UK company Thames Television. An 'early detection' bounty-hunter paradigm had been exposed for such practices as "soliciting students at school and paying government employees for referring patients"

The Texas Senate Inquiry heard testimony such as *"They, they had suggestions like schools, uh hospitals, uh counselors, anyone that you knew of that might run across a patient or a person who was a potential patient that would need help, especially during uh, the holiday season when, when there would be you know, people alone and, and need someone to talk to"*. (former hospital staff member to committee chair, October 25, 1991) . *"I was given a detailed explanation of how other psychiatrists had been made rich and that this could be done for me if I would go along with his program. Quote, where are your loyalties? You know, I mean, if you're, if, if we're gonna give you a patient and make you $15,000 just for not having to do a damn thing but writing your name and admitting him to the hospital for me under major depression, [will you say] yeah, sure, I'll admit him?* (psychiatrist testimony, November 12, 1991) in Glumm and Johnson (2001). They were referring to an 'extra $300,000/yr' for referring children to the facility, then discharging them on the day the fee subsidy expired.

It was largely because of response to the ABC TV show that there was a subsequent review and rejection of the applications, such as from WA Health: *"In my view the following scenarios are not unrealistic: Hospitals will solicit direct referrals from GPs for payment of a bounty and then trade favours with specialists to look after them in private hospitals. Payment of emergency room staff in public hospitals to divert promising patients to the private system Multiplication of programs run by clinical psychologists. Expansion of ineffective in-patient programs in Psychiatry and medicine. There are many medical conditions where the level of discretion over admission is high as demonstrated by our own analyses in recent years in WA country hospitals. ..."* (WA Health Minutes March 1993, obtained by Brian Martin, Uni of Wollongong)

There is a massive cost to society of labelling young people as 'mentally disordered". It is a stigma they will carry for

life. Attempts to 'normalize' and accept mental illness only make it more likely to be believed. The assumed trade-off by supposed 'treatments' is highly controversial. Any who make such claims should present their alleged 'science' to the ACCC to authorise exemption from trade practices scrutiny. That is the law.

Conclusions

The importance of this questioning of the evidence-bases to the Productivity Commission is clear: Only competition and consumer legislation can reverse the onus of proof away from critics and direct it onto those proposing market restrictions. Continuing these trends will decrease productivity. Distortions in the hundreds of millions of dollars, depriving many consumers of services, are not merely based on a lack of evidence. They are refuted by “classic” solid evidence that contradicts the claims and assumptions made by the practitioners and those with vested interests in the hierarchy. The latter can even include consumer spokespersons with 'lived experience' who are led to believe they are entitled to 'the best' and who want 'the latest' scientific evidence-based services - as peddled to them by experts with a conflict of interest to be paid for by their 'best mate with very deep pockets' – the taxpayer.

Contacting MCA

The MCA authors of submissions and those who have provided information and cases are in a precarious position presenting information.

The persons who have authored this MBS submission and provided information to the MCA do not wish to be publicly identified by name or region as they are in a vulnerable position for reprisal particularly if they are seeking registration or employment. They are happy to communicate directly and identify themselves to the MBS Task Force and provide further information if desired

This has a double effect. An anonymous MCA author cannot cite this submission among their 'publications' on a CV, while the academics most likely to provide rebuttals and to question the MCA submission get to bolster their careers. Over the years this creates a gross imbalance that can misdirect policy.

Review of the entire Mental Health Sector remuneration as required by the Competition and Consumer Act 2010 and The National Competition Policy is long-overdue.

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