Submission to the Productivity Commission re Mental Health

Research has revealed that the mental health indicators over the last 2-3 decades have failed to improve, despite billions of dollars being spent primarily on psychiatric services. Clearly, something is wrong.

1) **Health and Medical Services**.

Psychiatric responses to people's emotional problems, disturbed and disturbing behaviour tend to be predominantly biological, ie. psychiatric drugs such as antidepressants, and Electro Convulsive Treatment (ECT). Most practicing psychiatrists now rely almost exclusively on these intervention approaches, usually referred to as 'biological psychiatry', as opposed to psychological or psycho-social approaches as taken by psychologists and social workers (note: some few psychiatrists still practice social psychiatry). Most GPs are now also prescribers of psychiatric drugs, and are therefore also practicing biological psychiatry, but without extensive training in either psychology or psychiatry.

Biological psychiatric services are generally synonymous with 'the medical model', ie. a medical frame of reference from which to make sense of distress, troubling and troublesome behaviour. As such, they refer to psychological and social problems in living as "illnesses" with "symptoms". The assumption, for the most part not supported by scientific evidence, is that psychiatric conditions are brain disorders. There remains no consistent or compelling evidence that the vast majority of psychiatric disorders have a brain basis (Rose 2019; Moncrieff 2009). This includes but is not limited to experiences referred to as:- depression, anxiety, bi-polar disorder, schizophrenia, psychosis (other than drug induced psychoses), personality disorders, substance abuse disorders, gambling disorders, post-traumatic stress disorder, conduct disorders, ADHD and ADD, etc.

The psychiatric conceptualization of problems in living does not have universal acceptance within the mental health sector. There have long been criticisms of the medical model, as early as the late 19th century, but more recently from the early 1960's (Szasz 1961). The very concept of 'mental illness' is viewed as an arbitrary medicalization of what are essentially psychological, interpersonal, social, economic and political problems. In recent years, the Division of Clinical Psychology of the British Psychological Society (BPS) has been forthright in its criticism and rejection of the medical model of psychiatry in a range of policy statements and publications (Div. Clin Psych 2013). The general critique of the psychiatric treatment of such issues has widespread support in the mental health sector. While some people feel well served, many other people with lived experience often view themselves as victims (or 'survivors') of the psychiatric system in which they have often been incarcerated and forcefully 'treated' against their will; treated as though they were 'disease' entities, rather than as human beings with problems in living; compelled to take psychiatric drugs, which are known to be neurotoxins (on average, resulting of 20 years less of life for long term users); forced to undergo ECT, which is known to so damage the brain that it results in memory loss (Rose 2019). No other medical specialty arouses such controversy, resistance or volume of patients who view themselves as either victims or survivors.

The critique of biological psychiatric services has gained momentum in recent years, with an enormous amount of academic and popular publications detailing the conceptual, philosophical, practical, neurological, legal and ethical problems associated with it. The breadth of these critiques is too extensive to cover here, however it is noteworthy that many of the most vocal critics are psychiatrists themselves, usually those practicing psycho-social approaches to psychiatry rather than biological approaches. Many of the critics are highly regarded professors of psychiatry, such as Professor David Healy (2004), and Professor Joanna Moncrief (2009), both in the UK. American psychiatrist Dr Peter Breggin (1991) has been a vocal critic of biological psychiatry for decades. In Australia, prominent psychiatrists who also critique the medical model of biological psychiatry include Dr Jon Juredini (S.A), and Dr Nail McLaren (Qld). Many other psycho-socially oriented psychiatrists, both in Australia and abroad, also disagree with biological psychiatry.

Amongst all of the problems typically discussed with biological psychiatry, the damaging effects of psychiatric drugs on many people stands out (Healy 2004). It is clear that there is a large range of differing responses by people to the same drug. Where one person may swear that a particular antidepressant saved their life, another person will claim that the same drug was responsible for them trying to *take* their own life. How can this wide variance in outcome be explained?

The answer lies in the science of pharmacogenomics. This is the scientific study of the inherited capacity to break down (metabolise) and expel various chemicals. When applied to psychiatric drugs, pharmacogenomics explains the role of a specific group of liver enzymes (the CYP450s, the amounts of which we inherit from both parents) in the expulsion of drug chemicals. We all differ in our loading of these specific liver enzymes, whose only role is to metabolise and expel drugs which effect the functioning of the brain (psychoactive substances). This includes all psychiatric drugs such as antidepressants, as well as nicotine, caffeine, cannabis, alcohol, amphetamines, psychedelics, opiates, etc. Within the small collection of CYP450 liver enzymes, we can be either:- *poor metabolisers* (with virtually none of the required enzymes); *intermediate* metabolisers (a semi loading of the enzymes); *adequate metabolisers* (a full loading of the enzymes); or *ultra-rapid metabolisers* (more than the full loading). In regards to any particular drug, the poor or intermediate metobolisers can be expected to experience adverse side effects (either quickly or over time), while the adequate and ultra-rapid metabolisers can be expected to not suffer these. That 60% of people take themselves off SSRI antidepressants within the first few weeks suggests that the inability to break down and expel the chemicals in the drug is a relatively common experience.

When not being well metabolised and expelled, the chemicals build up to a high concentration in the blood supply and adversely affect the brain. The results can be worsening depression, anxiety and panic; intense agitation; urges to self-harm; increased suicidal feelings, ideation, and behaviour; hypomania and mania (often then misdiagnosed as ‘bi-polar); and even psychosis. Where prescribers are not aware of pharmacogenomics and the reality of adverse effects of the drugs, they can often be tempted to increase the dosage level; add different psychiatric drugs to the cocktail, eg. valium, mood stabilisers, even anti-psychotics; and to misdiagnose the increased distress and confusion as being evidence of more and more psychiatric disorders, such as bi-polar disorder, generalised anxiety disorder, personality disorders, and sometimes psychosis. The

typical response to each of the new diagnoses is more psychiatric drugs. *As a result, some people simply spiral downwards as a result of their engagement with the mental health system.*

Psychiatry often claims to be practicing a 'bio-psycho-social' approach, however in reality, this is seen to be untrue (Rose 2019). The main psychiatric interventions provided by psychiatrists in the current Western world are biological, ie. drugs and ECT. Standard biologically oriented psychiatry only pays 'lip service' to psycho-social factors, with little if any interest in the psychological or social experience and realities of their patients. Drugs remain the predominant treatment.

- Over 4 million Australian's are on a psychiatric drug including 110,697 children under the age of 15. Children and young people have under-developed CYP450 metabolic systems- how many of these children and young people are made worse as a result of psychiatric drugging? How much of the youth suicide and disability rate can be attributed to this inability to adequately metabolise psychiatric drugs which prescribers see fit to prescribe them, regardless of their immature metabolic systems?
- Nearly 5,000 Australian children aged two to six are on the ADHD drug methylphenidate (Ritalin, Concerta) while the TGA has not approved its use for those younger than six. How many of these children and young people are made worse as a result of psychiatric drugging? How much of the youth suicide and disability rate can be attributed to this inability to adequately metabolise psychiatric drugs which prescribers see fit to prescribe them, regardless of their immature metabolic systems?
- More than 49,000 children aged 2-16 are on antidepressants, although the TGA does not authorize antidepressant use in depression in those under 18. How many of these children and young people are made worse as a result of psychiatric drugging? How much of the youth suicide and disability rate can be attributed to this inability to adequately metabolise psychiatric drugs which prescribers see fit to prescribe them, regardless of their immature metabolic systems?
- As of 15th December 2017 there were 41,317 adverse drug reactions reported to Australia's TGA linked to psychiatric drugs, 1,439 of these deaths.
- There are now 67 psychiatric drug warnings issued by Australia's drug regulatory agency. These include to warn of the risk of hallucinations, increased blood pressure, agitation, akathisia (inability to remain motionless), aggression, life threatening heart problems, addiction, suicidal ideation and possible death.
- Spending has increased from $6.9 billion in 2010-11 to 9.1 billion in 2016/17, a nearly 32% increase in just 6 years.
- The prescription rates of psychiatric drugs has increased by hundreds of percentages in the last 30 years.
- In the same time-frame, the mental health indicators have shown a worsening, not an improvement.

As per much of the research and literature pertaining to the potentially damaging impacts of psychiatric drugs for some/many people, it is my contention that the radical increase in prescriptions of psychiatric drugs in the last three decades is a major factor in the worsening of mental health indicators in this country. Many people in the general population are poor or

intermediate metabolisers- these people will suffer adverse effects of common psychiatric drugs, such as commonly prescribed antidepressants. As a result, many will further deteriorate to the point of becoming more disabled by their emotional problems. Some become so adversely effected that they become actively suicidal (note: suicide is only the tip of the misery ice-berg. For every person who attempts suicide because of an adverse effect of the drugs, there are dozens who feel so wretched that they can barely continue to function). Others experience an increase in anxiety and panic states, which can also become disabling, preventing participation in education, training and employment.

In the absence of wide-spread pharmacogenomic testing (which is commercially available, giving the person information about which drugs their system is likely to cope with and which they are unlikely to cope with- creating a rational basis for prescription choices), and in the presence of wide-spread prescribing of psychiatric drugs (eg. by psychiatrists, GPs, paediatricians), it is no wonder that many more people have become psychologically disabled, have committed uncharacteristic acts of violence as well as self-harm and suicide. These problems are now at an almost epidemic proportion- this was not the case prior to the introduction and wide-spread prescribing of drugs such as Selective Serotonin Reuptake Inhibitor (SSRI) antidepressants in the late 1980s. These problems have radically escalated since SSRI antidepressants entered the market and became amongst the most widely prescribed drugs in our society. Prozac was merely the first and best known of these class of drugs.

Recommendations:

a) The government conduct an earnest review of psychiatric services for their i) efficacy, and ii) for the iatregenic damage which is caused to patients as a result of biological psychiatry. Findings from such a review guide government policy on mental health policy and expenditure.
b) The government fund pharmacogenomics testing via the PBA as a mandatory step prior to the prescription of all psychiatric drugs so that a rational basis can be established.

2. Mental Health Workforce.

Most mental health practitioners in Australia are psychologists who are registered with the Psychology Board of Australia (PBA) to provide mental health services. Over the last 15-20 years, the Australian Psychological Society (APS) came under the influence and leadership of one type of psychologists, ie. clinical psychologists. These mostly academic clinical psychologists came to occupy the leadership positions in the APS, as well as the PBA. There appears to have been a concerted political effort to enhance the position of clinical psychologists only. The most efficient means of doing this, it would appear, was by engineering a false narrative which disparaged the competencies of all other psychologists (most of whom are not clinical psychologists). When the Howard government introduced the Better Access to Psychologists and Psychiatrists program, the APS wanted to include only clinical psychologists in the program. The then Minister for Health saw the potential which a ‘ready-made’ psychology workforce had to service the mental health needs of the general public, and therefore included all registered psychologists in the Better Access program as mental health service providers.

Melbourne University researchers (Pirkis et al 2011) evaluated the Better Access program, and provided evidence that:- registered and clinical psychologists both provide services to people in moderate to high need categories; both registered and clinical psychologists undertake the same work with clients, providing the same services; both registered and clinical psychologists achieve outcomes with clients which are comparable with the best international standards of psychological care. That is, there were no demonstrable differences between the clients, the quality and the nature of the services provided, or the outcomes between different types of psychologists- all did the same work, with the same clientele, achieving the same impressive results. Despite this evidence, and in the absence of any evidence showing differences, the Medicare subsidies for services provided by clinical psychologists are nearly 50% more than the Medicare subsidies paid for services provided by registered psychologists. There is simply no evidence that can support such a differential in subsidies.

Note: the main difference claimed between those now deemed clinical psychologists and those now deemed registered psychologists is that clinical psychologists are said to undergo a masters degree in clinical psychology as their 5^{th} and 6^{th} years of training; whereas registered psychologists undergo a two year on the job internship as their 5^{th} and 6^{th} year of training. Both training pathways have their advantages and disadvantages- there is no research evidence to indicate that either results in superior practitioners. In fact, the only available evidence (Pirkis et al 2011) points towards there being no differences. However, contrary to the rhetoric, around 42% of those now deemed clinical psychologists have *no masters or doctorate degree* in clinical psychology at all, but were simply 'grandfathered' into the status by virtue of belonging to the APS College of Clinical Psychologists- a choice that was open to all psychologists in the past. And many registered psychologists do have masters degrees and PhDs in psychology.

The psychology profession in Australia has been wracked by division and conflict as a result of this arbitrary defiance of the research evidence. Clinical psychologists within the APS and PBA continue to push the advantage of clinical psychologists. If permitted to continue, this will result in the exodus of highly competent, experienced and skilful psychology practitioners leaving the mental health sector. The Australian public will suffer as a result, via fewer skilled and experienced practitioners being available to meet their needs. They will be replaced by fewer, young inexperienced clinical psychology graduates who are simply not equipped to meet the public's needs. The public will suffer in terms of more poorly treated mental health problems, more extreme levels of disability and more suicides if registered psychologists are forced out of the mental health workforce. The APS and PBA are complicit in this state of affairs.

The Better Access program was reduced in scope when client's allowance for counselling sessions were reduced from 18 to 10. International research demonstrates that it takes around 20 sessions of psychological therapy to adequately address most mental health problems, such as experiences referred to as depression and anxiety (the most common presentations). Prior to this reduction, Pirkis et al (2011) had demonstrated the high level of effectiveness of the Better Access program in terms of client outcomes. Any research now purporting to demonstrate a lack of efficacy of the program is simply reflecting the deleterious impact of reducing the sessions from 18 to 10. It is commonly feared that this reduction of sessions is simply a strategy designed to justify the elimination of the Better Access program altogether. This would be an unmitigated disaster for the Australian public, were it to occur. Psychology has been demonstrated to 'work'.

Removing interventions that work, such as the Better Access program, in order to replace them with more psychiatry and psychiatric drugs will simply compound the problems described in section one of this submission.

There are several prominent biological psychiatrists who have acted as outspoken critics of the Better Access program- Patrick McGorry, Ian Hickie and John Mendoza. These have been the most influential in providing advice to successive Ministers for Health in regards to mental health policy over the last 20 years. They are now disparaging Better Access psychologists to take the focus away from the Productivity Commission's findings that despite many billions of dollars being spent (primarily on psychiatric services and products, like paying psychiatrists $380 per 45 minute consultations, and subsidising psych drugs), the mental health indicators have got worse over the last 25 years, not better. Their advice and policy direction has demonstrably failed miserably- but rather than take responsibility they are blaming Better Access psychologists (whose services have only ever been a minor part of the mental health spend). Their attacks on Better Access psychologists are nothing more than a strategic diversion away from the facts of the matter. Biological psychiatry, which they are vigorously advocating, has failed to help the Australian public- in fact, the Productivity Commission figures suggest it has harmed the public.

Hickie is arguing in many media outlets that the Better Access program has failed to increase accessibility for the public. He is suggesting, rather, that the funds should be diverted into Public Health Networks (PHN's) and private mental health 'hubs', such as his Headspace centres. However, there is simply no evidence to suggest that this would increase accessibility for regional or rural people. It will still be a matter of service providers having to be near those in rural and remote areas. From my experience of having worked in the British National Health System several years ago, which utilise this 'hub' approach, I am confident that private practitioners are more likely to make psychological services accessible in community locations than PHN's or 'hubs'. Private practicing psychologists tend to work in the communities in which they live, which is spread across the population (Note: it is only clinical psychologists and psychiatrists who tend to provide services only in the wealthier urban areas; this is not the case for registered psychologists or social workers providing services under the Better Access program- Pirkis et al (2011).

Hickie is also arguing that there is a quality problem with the Better Access program, ie. registered psychologists are failing to provide high quality care for those with moderate to severe problems. The only relevant research, conducted by Pirkis et al (2011) demonstrated very clearly that registered and clinical psychologists in the Better Access program provide services for people with moderate to severe problems; and obtain outcomes which are comparable with the best international standards. Any data which contradicts this is simply the result of having reduced the amount of sessions from 18 down to 10 per year. International research shows very clearly that most psychological problems require around 20 sessions for a positive impact. The Medicare Review Mental Health Reference Group (MHRG) has recommended bringing the Better Access program in line with the international research which supports more sessions for those in more need. Most consumers in the Better Access program do not require an extensive amount of sessions, but those in most need do. The MHRG recommended extending the amount of sessions for those in need. If this is acted upon by the government, it is likely that any

negative research findings will turn around and again reflect the benefits of those in most need having more sessions (as was the case when Pirkis et al (2011) did their research (when consumers were able to access 18 sessions per calendar year).

Psychology has been demonstrated to 'work'- 80% of people with a particular problem who are receiving psychological help are doing better than those with the same problems but not receiving help (Duncan & Miller 2000). Pharmaceutical psychiatry has not been demonstrated to 'work' (Moncrieff 2009; Rose 2019). The inefficient spend in mental health is not on the relatively small amount of funds that go towards psycho-social help, but on the much larger part of the pie that goes on biological psychiatry (private psychiatrists being paid $380 per 45 minute consultation, in-patient biological psychiatric treatment, and psychiatric drug subsidies).

The APS has been literally inventing the false narrative for the last two decades (suggesting that registered psychologists are not adequately trained to provide clinical services). Prominent psychiatrists like Hickie, McGorry, Mendoza etc are simply using this APS-made fabrication in order to remove psychologists from the sector, and to have the funds diverted to their psychiatric programs and services. These psychiatrists and their organisations have all been in receipt of funds from multinational pharmaceutical companies. I suggest that this presents an undue influence of pharmaceutical companies on successive Ministers of Health and mental health policy and funding in this country. This influence continues to this day.

Recommendations:

a) The federal government support an ACCC case against the APS and PBA for anti-competitive activities in their promotion of clinical psychologists and barriers to registered psychologists in their provision of mental health services.
b) The federal government conduct an investigation into the undue influence of pharmaceutical companies and their lobbyists (prominent psychiatrists) on mental health policies and funding.
c) The federal government accept the recommendations of the Medicare Review Mental Health Reference Group to expand the Better Access program so that those in most need will be able to obtain more assistance from registered psychologists, social workers and clinical psychologists equally.
d) The federal government remove the inequities in subsidies between clinical psychologists, registered psychologists and social workers- so that service consumers are able to access the practitioner of their choice without being financially penalised.

3. Prevention and Early Intervention:

Issues of early intervention regarding mental health need to be balanced with the potential social damage which can be done to people, especially children and young people, through stigmatisation. As long as the psychiatric system of classification (eg. as seen in the American Psychiatric Association's Diagnostic and Statistical Manual- DSM) is the dominant language used in regards to psychological problems in living, social stigma against people to whom the psychiatric labels are applied will remain a persistent reality (Rose 2019).

The stigma is inherent to the classification language, which differentiates between people in a categorical manner, ie. people are viewed as being 'schizophrenic' or not; 'bi-polar' or not; 'depressed' or not. The reality is that all experiences which are (poorly) captured under those terms fall on a continuum, and do not exist in discreet categories. The psychiatric labelling system creates a false 'us and them' perception, with those viewed as 'them' being perceived as qualitatively different to 'us', ie. 'them' are more unstable, more unpredictable, more dangerous to self and others; less desirable, less reliable, less trust-worthy. According to this system, 'we' typically would not want our children to marry one of 'them', due to the dehumanising and disparaging manner in which psychiatric labelling puts people into deficiency categories. Such stigma will exist as long as the psychiatric labelling system is prominent, despite community education efforts to reduce stigma. It is analogous to the obvious fact that dehumanising racism will still exist as long as slavery exists.

Early intervention programs which have gained prominence in Australia, such as psychiatrist Patrick McGorry's early psychosis program, run an extreme risk of damaging the self-concepts of young people who are viewed as being at risk of psychosis. It is well demonstrated that psychosis, along with most other forms of psychological problems in living, results from psychological trauma (Moncrieff 2009). This can be in the form of overt abuse experiences (sexual, physical assault), but also from developmental trauma in which children are exposed to damaging attachment styles with parents. Socio-economic status is known to have a strong relationship with experiences referred to as psychosis. People in lower socio-economic groups, experiencing more poverty, negative biases, lower expectations, fewer job opportunities etc, experience heightened psychological stress from a young age, and are more likely to be assessed as suffering from psychosis than their better-off counterparts. As such, it seems cruel and unjust to target these already suffering young people for early detection of psychosis, when the psychosis is generally a reflection of social disadvantage. Their identities can be further ruined by stigmatisation that goes along with the label of psychosis, and their brains damaged with anti-psychotic drugs (Breggin 1991).

The only biological psychiatric treatment for psychosis are anti-psychotic drugs. These are known to result in a form of brain damage (Tardive Dyskenesia) in many people who are on the drugs for more than just a few years. People on anti-psychotic drugs have a life expectancy which is on average 20 years shorter than people not on anti-psychotic drugs. These drugs are viewed as neurotoxins- essentially, poisons to the brain (Breggin 1991). This is the intervention which psychiatric early psychosis detection programs result in. Not only is it not possible to accurately predict who will become 'psychotic' and who will not (given that such labels have very little scientific validity or reliability to begin with), it is socially and neurologically damaging to those so designated (Rose 2019).

Given what is known about the social causes of psychological problems, it makes sense to target prevention efforts at those social determinants. All forms of social disadvantage are relevant here. These include:- poverty; restricted options and opportunities in life due to lower socio-economic status; culturally/socially inappropriate educational experiences which alienate certain groups in society; racism; sexism; stress which results from all these forms of disadvantage, which result in poor life choices regarding substance abuse, and poor parenting behaviours. Such problems manifest in trauma responses in those suffering them, and subsequently manifest in

experiences and behaviours which are then viewed as evidence of mental health problems. Essentially, social-cultural-political-economic problems manifest as individual mental health problems (or more accurately, our individualist Western culture makes sense of these manifestations in terms of individual problems in living). As such, *genuine prevention* lies in the area of addressing social-political-economic disadvantage with social change efforts. This requires a macro-level analysis and suite of interventions. In a humane society, such a focus also needs to be joined by a micro-level of support, as people are suffering now and cannot go unsupported while waiting for macro-level change to occur. The political will for such macro level change is often absent amongst policy decision makers.

Micro-level support entails providing psycho-social assistance those who are suffering from the individual manifestations of macro-level problems in a non-stigmatising, non-blaming, non-damaging manner. This goal is simply inconsistent with the medical model and biological psychiatry, with its emphasis on stigmatising labelling and drug & ECT intervention. Psycho-social help and support come in many forms, from peer support, community development aimed at overcoming social isolation, self-help and mutual support movements, through to supportive counselling and intensive psychotherapy. A range of psycho-social practitioners can provide these roles, along with people with lived experience.

Early intervention needs to operate in a non-stigmatising manner, ensuring that the cost to the consumer of involvement with a mental health professional does not entail damage to their self-concept, nor ongoing negative treatment from service providers and society in general. The Medicare Review MHRG has advocated that Medicare subsidised services be made available for early intervention with people who are not yet suffering from established problems in living, but are vulnerable to doing so. Personal counselling and support is able to meet this need, and can ensure that problems are addressed early in the experience rather than waiting until they become chronic and intractable. Expenditure made at the early intervention stage will prevent much higher levels of expenditure at later times.

In consultation with other professional groups as well as people with lived experience, the BPS Division of Clinical Psychology have created the Power, Threat, Meaning Framework as a non-medical model, non-stigmatising approach to working with people suffering from emotional problems in living, troubled and troubling behaviour. This psycho-social approach presents an evidence based alternative to psychiatric labelling, psychiatric drugging and forced incarceration and treatment. It seamlessly leads to psycho-social intervention styles which are strengths based, trauma informed, empowering and respectful of service consumers. This Framework is being enthusiastically embraced in the UK, as well as Europe and other parts of the world.

<u>Recommendations:</u>

a) The federal government cease funding early psychosis intervention programs which are psychiatric in nature.
b) The federal government boost funding to the Better Access program, enacting the recommendations of the MHRG pertaining to early intervention with people who are not yet suffering from a ‘disorder’.
c) The federal government adopt the Power, Threat, Meaning Framework as a model for psycho-social intervention and support for all federally funded mental health programs.

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