POST *DRAFT REPORT* SUBMISSION TO THE PRODUCTIVITY COMMISSION FROM THE AUSTRALIAN NATIONAL OFFICE OF THE INTERNATIONAL ORGANISATION, THE CITIZENS COMMISSION ON HUMAN RIGHTS

23 January 2020

BACKGROUND OF THE CITIZENS COMMISSION ON HUMAN RIGHTS

The Citizens Commission on Human Rights is a non-profit organisation which was established in 1969 by the Church of Scientology and the late Dr Thomas Szasz, Professor of Psychiatry, as an independent body to investigate and expose psychiatric violations of human rights and to clean up the field of mental healing. CCHR offers a free public service to those who have been harmed in the psychiatric industry and it is an international organisation with headquarters in Los Angeles.

The main task of CCHR has been to reform mental health and preserve individual's rights in line with the *Universal Declaration of Human Rights*. In Australia CCHR was instrumental in uncovering and bringing to the attention of NSW authorities the lethal drug and electroshock (ECT) practice known as "Deep Sleep Treatment" used at Chelmsford Private Psychiatric Hospital. And it helped achieve the NSW Royal Commission into Deep Sleep Treatment in 1988 and the Queensland government inquiry into the psychiatric ward, Ward 10B, at Townsville Hospital in 1990.

More recently CCHR conducted education campaigns to protect children from the trauma of restraint, the harm of electroshock and psychosurgery in various states of Australia where mental health acts were under review. The World Health Organisation has stated, "There are no indications for the use of ECT in minors, and hence this should be prohibited by legislation." [1]

This included in W.A. where a draft Mental Health Bill proposed to allow children of any age, to be able to consent to sterilisation if a psychiatrist determined they had the "capacity to consent." No further consent was needed from anyone including parents or a Tribunal. The Bill also proposed to allow for children aged 12 to be able to consent to electroshock and psychosurgery — again if the child was considered to have the capacity to consent as determined by a psychiatrist with a Tribunal giving final approval. No parental consent would have been needed at any stage and a clause in the bill allowed for parents to be excluded from the Tribunal hearing. CCHR launched an education campaign to inform parents and the general public including placing half page ads in the main and community newspapers, bulk mailings and many other actions.

As a result, there was worldwide condemnation on these issues, with over 1,000 submissions received by the WA Mental Health Commission. Not only was the proposal to allow children to consent to sterilisation dropped, but sterilisation was completely removed from *the Mental Health Act.* In addition, the age at which a child could consent to electroshock and psychosurgery was lifted to over 14 years of age. CCHR continued to educate the public and the psychosurgery ban was then lifted again to under 16 years. The new act with these changes was implemented on 30th November 2015.

Internationally CCHR is responsible for many hundreds of reforms gained through testimony before legislative hearings, its own public inquiries into psychiatric abuse and its work with the media, law enforcement and public officials.

While CCHR does not provide medical or legal advice, it works closely with and supports medical doctors and medical practice. Medical drugs and scientific tests are essential for treating and curing disease but the same cannot be said of psychotropic drugs and treatment which can seriously adversely affect vulnerable children and adults.

SUBMISSION

1. CCHR fully supports better healthcare for children and adults but wants to ensure that funding is not going to be poured into a bottomless pit with consistently declining conditions for vulnerable children and adults.

2. The *Productivity Commission's Report on Government Services 2019,* reveals that in 2016/17 results were appalling:

    - 14.9% or 14,781 of those who were admitted to psychiatric acute inpatient services were re-admitted to acute wards again within 28 days. [2]
    - 40.9% of children aged 0-17 discharged from a psychiatric ward/facility did not significantly improve.
    - 44.6% of children aged 0-17 discharged from community care did not significantly improve.
    - 62.8% of children aged 0-17 discharged from ongoing community care did not significantly improve.

3. Spending has increased 31.8% in the past six years ($6.9 billion in 2010/11 to $9.1 billion in 2016/17). Where are the results from this increased spending as would be evidenced by declining numbers of children and adults requiring assistance?

4. How psychiatry "diagnoses" someone affects not only the person, their family and friends but also the money spent by both Federal and State Governments. If the diagnosis is not scientific and the treatments not proven to work, then no amount of money thrown at the system will improve it.

5. While mainstream medicine deals with diseases such as malaria, bronchitis, hepatitis and heart disease all which have exact, identifiable physical causes, psychiatry deals with "disorders". Disorders are names given to undesirable feelings and behaviour for which no exact physical causes have been isolated. These mental disorders are frequently referred to as "illnesses" or "diseases" but they are not the same thing. This difference sets psychiatry far apart from the usual practice of medicine.

6. Psychiatry's main "diagnosis manual" used in Australia, the *Diagnostic and Statistical Manual of Mental Disorders* itself states there are no scientific tests. As of 10 January 2020, Medicare Benefits Schedule is still using *DSM-IV* and the Pharmaceutical Benefits Scheme uses DSM-5. Examples in the DSM manuals include:

    DSM-IV for Schizophrenia: "No laboratory findings have been identified that are diagnostic of schizophrenia" (p.305).
    DSM-IV for ADHD: "No laboratory tests, neurological assessments or attentional assessments have been established as diagnostic in the clinical assessment of Attention Deficit/Hyperactivity Disorder." (pp. 88,89)
    DSM-5 for ADHD: "No biological marker is diagnostic for ADHD" (p.61)

DSM-5 for schizophrenia: “Currently there are no radiological, laboratory or psychometric tests for the disorder” (p.101).

This means that unlike in normal medicine a “diagnosis” is completely subjective with no scientific basis to justify the prescribed treatment. More and more money is spent by parents, the person and state and federal governments as the real cause of the person’s problem is not found and rectified, the child or adult continues to suffer unnecessarily and in some cases they die.

7. *There are no objective tests in psychiatry — no X-ray, laboratory, or exam finding that says definitively that someone does or does not have a mental disorder.” “I mean, you just can’t define it.”* — Allen Frances psychiatrist and former DSM-IV Task Force Chairman.[3]

8. “*Unlike physical illness, we can’t rely on blood tests, brain scans or other biological tests. As a consequence of this lack of diagnostic accuracy, our field relies purely on observation.”* — Bernard Baune, Professor & Head of Psychiatry at University of Adelaide.[4]

9. *“There are no laboratory tests, such as blood tests or scans, to determine if you have ADHD.”* — Royal Australian and New Zealand College of Psychiatrists.[5]

10. *“Making lists of behaviours, applying medical-sounding labels to people who engage in them, then using the presence of those behaviours to prove they have the illness in question is scientifically meaningless. It tells us nothing about causes or solutions. It does, however, create the reassuring feeling that something medical is going on,”* — John Read, former senior lecturer in psychology, Auckland University, New Zealand. [6]

Proposals for Infants & Children in the *Draft Report*

11. As the Australian Institute of Family Studies 2018 report indicated, “The diagnostic systems used in Australia are still being debated. Critics argue that they pathologise normal human experiences, decontextualise mental health difficulties, lack scientific validity, and are culturally insensitive.” Further, “Emerging evidence suggests that certain mental health conditions may be over diagnosed in children. Numerous converging factors are thought to contribute to potential over diagnosis, including the influence of the pharmaceutical industry.” [7]

Infants & Toddlers in the *Draft Report*

12. CCHR is extremely concerned and believes the below is the truth based on evidence in the *Draft Report* and other mental health arenas, that the proposal to expand screening of young children including 1.25 million children aged 0-3 for mental illness will lead to more children being diagnosed and put at risk of being prescribed a potentially dangerous psychotropic drug. This is not better health care for our babies, infants and toddlers.

13. Psychiatric screening is the use of a highly subjective checklist usually based on the *DSM* or *DC:0-5* (for children aged 0-5 years) in order to diagnose a child or adult with a "mental illness." From these screenings and subsequent referrals of identified children, infants and children toddlers can be "diagnosed" and prescribed stimulants, antidepressants and or antipsychotic drugs, placing them at risk of ill-health and potentially dangerous side effects—some even deadly.

14. To say that a "social and emotional well-being check" which is proposed in the *Draft Report* to be done by nurses and maternal nurses in Community Health Centres, is not screening for mental illness is semantics and misleading.

15. Terms such as "mental health" or "emotional health" are now used rather than resorting to use of "mental illness/mental health terminology." Examples include:

16. In the minutes of a meeting of the Mental Health Expert Working Group that were set up to advise the Australian Federal Government, it stated: **"Professor Oberklaid also stressed the need to get messages about children's emotional and social well-being right, and to find the right language in which to talk about these issues, rather than resorting to use of mental illness/mental health terminology."**[8]

- "Emerging Minds," which promotes mental health for infants and children and receive federal government funding, states, "Child mental health can also be referred to as the child's social and emotional well-being."[9]

- One of the Commission's points of reference in its *Draft Report* is, "Zero to Three," an organisation that relies upon *DC:0-5, the Diagnostic Classification of* ***Mental Health*** *and Developmental Disorders of Infancy and Early Childhood*.[10] In other, words, so-called psychiatric disorders in children, which the manual says includes **difficulty sleeping, tantrums, losing track of a favourite stuffed animal and hyperactivity.**[11]

- Further, "The current revision, *DC: 0–5*, was substantial" and: expanding the number of diagnostic categories and clinical disorders from previous versions." This includes such "disorders" as "Overactivity Disorder of Toddlerhood" and "Disorder of Dysregulated Anger and Aggression of Early Childhood."[12]

- The Australian Association for Infant Mental Health now promotes where training on how to use *DC:0-5* can be done.[13] Workshops using this manual train individuals in the "development of diagnostic classification of mental health disorders" (aka mental illnesses).[14]

- $11 million was allocated for the failed and scrapped in 2015, Expanded Healthy Kids Check (a physical check that was expanded to include screening for mental health). The *Draft Report* now proposes to use the Guidelines from this failed Expanded Healthy Kids Check to screen 3-4 year olds. The Department of Health stated about this expanded check screening:

"Intervening early means building strong and resilient children, and avoiding behavioural or mental health issues that can persist for the rest of a person's life. Internationally renowned experts are telling us **there is a growing body of evidence showing that you can identify kids with (or at risk of) conduct disorders or poor development very early – from three years old."**[15]

17. **The *Draft Report* states the following about screening, diagnosis and treatment:**

- "The definition of infant mental health is still a matter of debate among experts, although more formalised approaches to **diagnosis and treatment** are being developed and implemented." [Volume 2, p.652]

- **"But additional screening and support tools can be valuable in prevention of mental illness or early intervention where it is required."** [Volume 2, p.650]

- "**Consistent screening of social and emotional development** should be included in existing early childhood physical development checks to **enable early intervention."** The *Draft Report* defines what early intervention programs are: They "assist a child, young person or adult through the early identification of risk factors and/or the **provision of timely treatment** for problems that can alleviate potential harms caused by mental illness." Treatment for mental disorders can include psychiatric drugs. [Volume 1, p.2, 186]

18. **Infants and toddlers are already prescribed psychiatric drugs in Australia.**

In 2007/08 there were 53 Australian infants under one year old on antidepressants and antipsychotics (306 in total aged 0-3 on a psychiatric drug).

By 2015 there were a staggering 7,817 children aged 2-6 years on psychiatric drugs in Australia including 1,459 children on antidepressants when no antidepressant is approved for use in children under 18 in Australia for depression).[16]

The Department of Health no longer provides the numbers of children on psychiatric drugs by age, under 6.

19. Yet there have been 67 psychiatric drug warnings issued by the Therapeutic Goods Administration (TGA) including to warn of the risk of increased blood pressure, hallucinations, life-threatening heart problems and even death.[17]

20. **Psychiatric drug side effects in infants and toddlers reported to the TGA include**:

- A 1-year-old boy on the antipsychotic chlorpromazine suffered involuntary upward deviation of his eyes.

- A 2-year-old girl on the antipsychotic droperidol suffered severe hyperextension of the neck.

- A 3-year-old girl on Ritalin had involuntary muscle movements described as lip-smack tongue protrusions.[18]

21. With "emerging mental illness," or "at risk", psychiatrists claim they can predict future mental illness by the use of a checklist of arbitrary questions. How unscientific is this? One example is Headspace's Identification of young people at risk of developing psychosis which reveals a staggering 82% to 90% will not go on to develop psychosis within a year of "diagnosis." Despite this, the premise is that they should be treated now.[19]

22. Depending on the state the infant or toddler lives in, most children receive the current physical check around 8 times before they turn 3 years old. This could mean that the child could be subjectively screened each time for mental illness and be at risk or referral for a diagnosis which would again be based on a subjective checklist. At which point a potentially dangerous psychiatric drug could be prescribed. [20]

"Expanded Healthy Kids Check" Proposal in the *Draft Report*

23. As mentioned above, psychiatry has already attempted to screen 3 year olds in the past between 2012 and 2015, with the expansion of a physical check called the Healthy Kids Check to include screening for "mental illness" of 3 year olds. The expanded check was trialled at 8 Medicare Locals and scrapped in 2015 due to immense public criticism from the public and professionals.[21] [PCDR Vol 2, p. 657 & 656]

24. The Australian Institute of Family Studies 2018 report states: "The federally funded 'Healthy Kids Check,' aimed at screening 3–5 year olds for signs of psychosocial and development problems, was defunded after three years, but not before generating considerable debate within both popular and academic forums (e.g. Newman, 2012; Prior, 2012). And the early intervention strategies of the nationwide Early Psychosis Prevention and Intervention Centres (EPPIC) have attracted ongoing criticism, with, for example, prominent United States (US) psychiatrist Allen Frances (2011, paragraph 4) declaring them "a vast and untried public health experiment that will almost surely cause more harm to children than it prevents." [22]

25. **Responses from professionals to Expanded Healthy Kids Check 3 year old screening included:**

    - Psychiatrist Allen Frances who was the DSM–IV Task Force Chair, said the screening of 3 year olds was "reckless" not evidence based and could lead to an explosion of false diagnoses that would see youngsters overmedicated and labelled with mental illness.[23]

    - The doctor's magazine, the *Medical Observer* conducted a survey of GPs in 2012 and found that two thirds of GPs disagreed with the expanded Healthy Kids Check with a quarter believing it would lead to mis-diagnosis with more psychiatric drugs and a further 41% said the scheme was a waste of money.[24]

- Child psychiatrist Dr Jon Jureidini, said he was “relieved,” that the proposal for the 3 year old check had disappeared.” [25]

26. CCHR filed a Freedom of Information Act request with the Productivity Commission this year that shows the Commission and the Mental Health Inquiry personnel do not have a copy of the failed and scrapped 2015 Enhanced Healthy Kids Guidelines now proposed to be used in the *Draft Report* to screen 3-4 year olds.[26] The *Draft Report* erroneously says that the Enhanced Healthy Kids Check was never rolled out. However, the *Medical Journal of Australia* reported it was trialled at 8 Medical Locals.[27] [Volume 2, p.658]

27. These discrepancies are currently unexplained. How can the Commission propose the use of these Guidelines if they’ve apparently not read them?

28. The *Draft Report* states, “There is no adequate data to assess whether the increased focus on infant emotional well-being in the past has had a substantial effect on young children and their families.” Despite this complete lack of evidence it is proposed to expand screening accompanied with more demands for even more money. [Volume 2, pages, 653, 658].

Early Childhood Centers and Schools in *Draft Report*

29. The *Draft Report* says early childhood education centres and schools act as the gateway for students and families to the mental health system. However, this usurps the role of schools: to be places of education, not clinics. Instead, already overworked teachers are being expected to be an adjunct to psychiatry, screening students for mental health problems and to refer them for a diagnosis. [p. 662, 659 of PCDR, Vol. 2]

30. Screening checklists for children above the age of 4 years old, include such questions as has trouble sleeping, wants to be with you more than before, is afraid of new situations, fidgets and squirms, distracted, acts as if driven by a motor, does not listen to rules, avoids schoolwork and homework, and refuses to share.[28]

31. At the staggering annual cost of up to $1.65 billion, a full time “Well-being” teacher is proposed in the *Draft Report* for each public and private school who will be responsible for student’s mental health and organising referral lines to mental health services in the community. And it is proposed that teaching regulatory authorities mandate that teachers devote time each year on mental health education. If implemented, all of this will lead to more children on ADHD drugs, antidepressants and antipsychotics. [660, 661, 689, 675 of PCDR, Vol 2]

32. We already have a serious problem with Australian children being given antidepressants.

33. There were 101,174 children under 17 on antidepressants in 2017/18, a 34 % increase in just 4 years, despite the fact they are not approved for children under the age of 18 for depression as previously stated. A further 107,000 children were on ADHD drugs in 2017.[29]

34. There is no evidence in the *Draft Report* that any of psychiatry's "treatments" were looked at as a reason for the failing mental health system. Treatments including psychiatric drugs need to be looked at or the system will continue to fail and children and adults will continue to suffer. As is evidenced by this inquiry, there have been very little results for the $9 billion spent annually.

Conflicts of Interest

35. There is no evidence in the *Draft Report* that conflicts of interest between psychiatrists, mental health support groups and pharmaceutical companies has been investigated. This is an area which drives up the use of antidepressants and other psychotropic drugs. No-one responsible for advising governments, involved in writing medical guidelines, conducting inquiries or doing anything that affects entire populations with potential conflicts of interest should take part in these activities. They must be excluded.

36. There are concerns that pharmaceutical kickbacks have gone unreported after changes made in 2015 to Australia's system of self –regulation by Medicines Australia as one study demonstrates:

37. ***"These changes allowed for reduced reporting of spending on food and beverages at events and for sponsored healthcare professionals, with the result that over a third of previously reported industry funding on healthcare professionals is now hidden.***

38. ***"This study demonstrates the limitations of a self-regulatory system, which can be quietly changed in such a way as to reduce overall public reporting of industry funding in the healthcare sector."*** ─ Dr. Lisa Parker from the University of Sydney co-author a paper published in the *British Medical Journal Open.*[30]

39. Pharmaceutical funding on free drug samples and funding for research are not reported as they are in the US and UK. Advisory Board meeting funding also needs to be disclosed in Australia.

40. **The Royal Australian and New Zealand College of Psychiatrists (RANZCP):** Their 2017 Annual Report, lists Janssen, Lundbeck, Pfizer, Merck Sharp and Dohme, Servier, Otsuka and Teva Pharma as supporting their activities.[31]

41. **Professor Ian Hickie** received funding from Bristol-Myers Squibb to establish an Australia wide GP training program in depression called SPHERE. The organisers of this training bragged on their website that Pfizer's funding of this GPs training helped restore their antidepressant, Zoloft, to the number one product in the market in Australia. [32]

    Prof. Hickie has served on professional advisory boards convened by the drug industry in relation to specific antidepressants made by Bristol Myer Squibb and Eli Lilly. He has led projects funded in part by Bristol Myer Squibb, Pfizer, Eli Lilly, Wyeth and Servier.

In 2013, Prof. Hickie has also received travel support from Servier and Astra Zeneca and in the area of paid educational seminars/resources has declared the involvement of 4 drug companies.[33]

42. **Professor Patrick McGorry** has received unrestricted grant funding from drug companies, Janssen-Cilag, Eli Lilly, Bristol-Myers Squibb, AstraZeneca, Pfizer and Novartis. He has acted as a paid consultant for and has received speaker's fees and travel reimbursement from all or most of these companies. He has also received honoraria for consulting and teaching from Roche, Lundbeck, Janssen-Cilag, Eli Lilly, Pfizer and Astra Zeneca.[34]

43. **Headspace Centres:** Prof. McGorry founded the youth mental health centres "headspace" and he is a well-known advocate of "early intervention" treatment for mental disorders. This involves treating those "at risk" of psychosis, i.e. they don't have it now but could get it. How non-scientific is this? Essentially it is an arbitrary list of behavioural symptoms, which psychiatrists claim can predict the onset of "psychosis." Often predicted at age 12-14 years old, psychiatrists can then "treat" the adolescent to "prevent the disorder." headspace's "At risk evidence summary" estimates 82% to 90% will **not** go on to develop psychosis within a year of diagnosis. Psychiatrist Allen Frances, who chaired the committee who produced the diagnostic manual for psychiatry (DSMIV) warned that Prof. McGorry's Early Psychosis Intervention Centres do not have a reliable early diagnosis tool.[35]

44. Despite this and many other warnings, the premise is that youth should still be treated now. Potentially dangerous antipsychotics could be prescribed as part of this "treatment."[36] There are 109 headspace centres around Australia. 15 of these operating based on Prof. McGorry's Orygen Centre's early psychosis model.[37]

45. Prof. McGorry's Orygen Centre currently directly operates 4 of the 27 headspaces in Victoria.[38] Orygen has been funded by drug companies Eli Lilly, AstraZeneca, Janssen-Cilag and Bristol-Myers Squibb.[39]

46. An independent evaluation report released in 2015 of McGorry's headspace centres revealed that of the 26,058 evaluated 12-25-year-olds seen by headspace, only 13% had a "clinically significant improvement," 29% had no change and an unacceptable 24% either declined or significantly worsened. Consultation costs ranged from $136 to $1,000 per visit.[40] Despite this between October 2018 and January 2019 the Australian federal government gave $208 million to headspace. [41]

47. Psychiatrists Professor Ian Hickie and Patrick McGorry both declared they had no conflicts of interest when they were part of the Mental Health Expert Working Group which was advising the Minister for Mental Health on reforming mental health in Australia in 2011.[42] The forms filled out did not stipulate pharmaceutical company funding as a conflict of interest, instead they asked for conflicts that "appear to influence proper consideration or decision making." Nowhere is it more important than at the Federal Government level that Conflicts of Interest Forms are comprehensive. [43]

48. **Psychiatric advocacy groups**: While there are people who genuinely want to help others in these groups, as far as psychiatric advocacy groups are concerned, pharmaceutical funding of these groups raises concern about the influential role this can play in setting health policy.

49. ***"There is no doubt that industry funding can distort the patient voice."*** ─ Dr Ray Moynihan, Bond University Queensland.[44]

50. ***"The way we think about disease is being subtly distorted by ostensibly independent players, including patient advocacy groups, who are largely singing the tunes acceptable to companies seeking to maximise markets for drugs and [medical] devices***." ─ Professor Lisa Bero, University of Sydney.[45]

51. A cursory review of several psychiatric advocacy groups reveals the following:

52. **Australian ADHD Professionals Association (AADPA):** The 2018 president of AADPA (Prof. Mark Belgrove) has previously received a research grant from Eli Lilly, an educational grant from Shire, and has spoken at meetings sponsored by Janssen-Cilag, Shire and Eli Lilly. The 2018 vice president (Prof. David Coghill) has received research support from Shire and Vifor-Pharma, and payment for Advisory Boards/speaking from Shire, Eli Lilly, Janssen-Cilag, Medice and Novartis. Committee member Roger Paterson has received speaker's fees from Janssen, Eli Lilly, Novartis, Shire and Servier, and is a paid Advisory Board member for Eli Lilly and Shire.[46]

53. **Mental Illness Fellowship of Australia (MIFA):** MIFA has received funding from Janssen[47], makers of antipsychotic drugs such as Risperdal.[48] The organisation received $7400 from Janssen for a 'Parliamentary Friends of Mental Illness' dinner in 2017[49] ; $33,318 for Schizophrenia Awareness week activities, education and awareness events for parliamentarians and participation in a mental health advisory board in 2016,[50] and $47,394 for a public awareness programs in 2015.[51]

54. **SANE:** received $23,000 from Janssen in 2017[52], $74,750 in 2016[53] and $91,900 in 2015. In 2014, the organisation listed AstraZeneca, Eli Lilly and Pfizer as supporters[54], with Pfizer providing $30,000 over 2013/2014.[55].

55. Failure to declare conflicts of interest threatens public trust. The integrity of medical guidelines has been shaken with high profile exposure of bias and conflicts, both in Australia and the US, which have brought untouchable bastions of authority into disrepute.

56. Consumers are already highly attuned to conflicts and bias in what is being markets and sold to them aided by the internet.

57. Authoritative advice loses credibility when the consumer discovers an undisclosed conflict of interest. They value transparency and openness and demand this, in order to make valued decisions.

58. The simplest method to counteract conflicts of interest it to make it mandatory they are disclosed.

Alternatives, Informed Consent: Providing Real Help

59. CCHR has long been an advocate for competent non-psychiatric medical evaluation of people with mental problems. Undiagnosed and untreated physical conditions can manifest as “psychiatric symptoms”.

60. The California Department of Mental Health Medical Evaluation Field Manual states: “Mental health professionals working within a mental health system have a professional and a legal obligation to recognize the presence of physical disease in their patients...physical diseases may cause a patient’s mental disorder [or] may worsen a mental disorder….” [56]

61. In general medicine the standard for informed consent includes communicating the nature of the diagnoses, the purpose of a proposed treatment or procedure, the risks and benefits of the proposed treatment, and informing the patient of alternative treatments, so they can make an informed, educated choice.

62. Psychiatrists routinely do not inform patients of non-drug treatments, nor do they conduct thorough medical examinations to ensure that a person’s problem does not stem from an untreated medical condition that is manifesting as a “psychiatric symptom.”

63. They do not accurately inform patients of the nature of the diagnoses, which would require informing the patient that psychiatric diagnoses are completely subjective (based on behaviours only) and have no scientific/medical validity (no X-rays, brain scans, chemical imbalance tests to prove anyone has a mental disorder).

64. All patients should have what is called a “differential diagnosis.” The doctor obtains a thorough history and conducts a complete physical exam, rules out all the possible problems that might cause a set of symptoms and explains any possible side effects of the recommended treatments.

65. There are numerous alternatives to psychiatric diagnoses and treatment, including standard medical care that does not require a stigmatising and subjective psychiatric label or a mind-altering drug. Governments should endorse and fund non-drug treatments as alternatives to potentially dangerous psychotropic drugs.

66. Children and adults have problems in life, and they need help with their problems. Is a child having problems at school because they need tutoring, has their eyesight and hearing been tested, are they getting enough sleep and exercise as well as eating properly? Are they having problems at home or school with peers or teachers or are they simply high IQ and bored?

67. The cause of the problem can greatly vary from child to child and adult to adult. A thorough investigation is vital. If a child is being abused, bullied or has problems at

home, a psychotropic drug, electroshock or forced psychiatric treatment will never solve the problem.

68. For children and adults who are seriously unwell and need care, hospitals/wards need to be turned into places of proper care. They need access to medical assistance and tests, a safe and restful environment where they are not threatened with forced treatment so they can return home as happy and healthy children and adults.

69. This is not only sound financial judgement; it is sound mental health as well.

Summary & Questions

70. The *Draft Report* states**, "Despite the rising expenditure on healthcare, there has been no clear indication that the mental health of the population has improved."**

71. For years experts have said there is inadequate or no accountability for the money spent on mental health.[57] Despite the lack of accountability, funding continues to soar, has reached over $9 billion annually and still the psychiatric system has not improved.

72. No other industry would be allowed such a poor performance for money invested. In contrast, money given to other areas of medicine shows noticeable progress, such as improving survival rates from cardiovascular disease over the past 20 years.[58]

73. With psychiatry having no real workable humane solutions, a continual cry for more funding and the lack thereof being blamed as the cause of the problem, proven solutions that help and don't harm must be implemented. **The existing money must be spent on solutions that do work.**

74. There are many medical professionals in Australia who genuinely help children and these should be the people and services that receive funding to assist children with problems. Accountability does not mean that the government is just informed by the mental health service that: "The funds were spent on the development of long-term screening," for example.

75. Accountability means providing a full break up of **exactly** what the funds are for, proven results in helping children and adults. This is extremely important considering the actual number of government and non-government mental health organisations receiving funding.

76. It is not sound economic practice to continue to increase funding where a lack of improvement and ineffective solutions that can harm are forthcoming.

77. **To rectify conflicts of interest:**

78. **A) federal law is passed so that all monies received or given by pharmaceutical companies are declared publicly including amounts and exactly what the money was used for including research funding.**

Criminal fines implemented if this is not adhered to.
B) Comprehensive "Declaration of Conflicts of Interest" forms to be filled out by everyone involved in the writing of a medical guideline, advising governments, conducting inquiries and other similar actions. These forms must stipulate that present and past pharmaceutical funding is required to be declared.

C) Anyone with conflicts of interest or potential conflicts of interest be excluded from these activities.

79. **Government funding should only be given to those mental health services that have been held accountable, report their results once a year and are actually producing results.**

80. **When a child or adult presents at a psychiatric hospital or is having problems, before any treatment is given, they are first:**

    A) Given a searching, competent physical check up to discount any underlying, physical condition as the cause of the child or adult's mental condition.
    B) Before any child or adult is "diagnosed," and treated. If this is done many would not need admitting or treating.

Questions of the Commission

81. Can the Commission please explain the discrepancy between the *Draft Report* stating the Heathy Kids Check was never rolled out and the *Medical Journal of Australia* stating it was trialled at 8 Medicare Locals?

82. How can the Commission propose the use of the Expanded Healthy Kids Check Guidelines if they've apparently not read them?

83. What is the result of the $11 million previously spent on the Expanded Health Kids Check?

84. The rising statistics of psychiatric child drugging are the cold hard facts. They show there is more drugging of infants and children. Has the Mental Health Inquiry's Commissioners obtained the current statistics for the numbers of babies and infants on psychiatric drugs in Australia and investigated the prescribing to 0-3 year olds?

85. Has the Commission determined if those placed on psychotropic drugs had been screened or diagnosed with a disorder from *DC: 0-5*? Has it investigated the reasons for why all National Mental Health Strategies to date, by the very nature of the Productivity Commission's Mental Health Inquiry existence, have failed?

86. Has the Commission investigated the Adverse Drug Reports of psychotropic drugs filed with the TGA and prescribed to young and adult Australians, and whether existing, especially government funded youth programs, have apparently not stemmed the tide of youth emotional problems?

87. Will the Commission categorically state that its recommendations do not endorse the psychotropic drugging of those aged 0-3 and that it was never intended to imply this?

88. Does the Commission intend to investigate conflicts of interest with pharmaceutical companies as a reason for increased costs?

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[1] *WHO Resource Book on Mental Health, Human Rights and Legislation,* World Health Organisation, 2005, p. 64.
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