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Productivity Commission Inquiry into Mental Health,
elaboration on oral comment on the Draft Report
Public Hearing, South Australia, 5 February 2020

Thank you [Commission] for inviting us to this consultation and paying our respects. My name is Tom Benjamin (PhD) . I'm a registered psychologist and adjunct medical school lecturer but I'm today representing MCA, the longest-running Medical Consumers Association in Australia, founded in 1976 by my University of New South Wales colleague Dr. Erica Bates. MCA wrote the original Patients Bill of Rights.

My consumer involvement stemmed from my research into experimental treatments in psychiatry, extended even to people without psychiatric illness, as Dr Bates warned way back then: *"everyone in the community becomes a potential patient .. in need of preventive psychiatric intervention."*¹ I personally was appointed as a Research Officer to investigate alleged deaths and cover-ups² and was delegated powers similar to a Royal Commissioner under the NSW Public Hospitals Act³ to report to the Royal Commission "into Mental Health Services", re-badged as ".. into Deep Sleep Therapy"⁴. Denied a hearing, I was vulnerable to attacks from all sides amid allegations that my own report had been covered up⁵ , so to exhume my reputation I made public presentations on radio, TV, and to professional and community groups, which is how I came in contact with MCA.

Our detailed references were submitted but today we've printed out for you a summary of consumer protection considerations, tabled, which I highlight

- *A draft report presenting one fait accomplis option is not acceptable.*⁶
- *The most important policy option is the no-regulation option. Ask yourself honestly: What would happen if we didn't introduce any new form of regulation?*
- *Regulation is a last resort.*
- *The Australian Competition and Consumer Commission (ACCC) is our principal legislative weapon*⁷
- *Registration of these professions should be removed unless there is overwhelming evidence for retention.*⁸
- *Parliament has set up a mechanism .seek authorisation. and obtain immunity from Court action*⁹
- *Cartels are immoral and illegal because they not only cheat consumers. They're destroying other businesses by controlling services to the point where honest and well-run companies cannot survive, destroying consumer confidence in an entire sector.*¹⁰

These words should all sound familiar. They're not MCA's words. I'd just read out current government policy *"Intended to be read by every member of the Australian Public Service — from*

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- 1 Bates, E. & Gestalt Institute of Melbourne Collection (1977). Models of madness. University of Queensland Press, St. Lucia, Qld. p. 21
 - 2 Collins, P. (1987) "medical atrocities ... shadowy and sinister medical experiments ... a large-scale cover-up, a string of deaths, a secret internal inquiry" NSW Parliament. Hansard. 3 March
 - 3 NSW Public Hospitals Act 1929, Sec. 11 (4) and former Sec 12
 - 4 Slattery, J (1990) Royal Commissioner. New South Wales Royal Commission into Deep Sleep Therapy
 - 5 Ragg, M (1990) Collins warns of cover-up risk. The Australian. 5 December; Slee, J. (1991) Doctors sue when doubts are raised. Syd Morning Herald. Jan 11; Voumard, S (1994) Ban psychosurgery: ALP call. Syd Morning Herald. 7 Oct
 - 6 www.cuttingredtape.gov.au;
https://www.pmc.gov.au/sites/default/files/publications/Australian_Government_Guide_to_Regulation.pdf
 - 7 Hawke, R. (1991) Building a Competitive Australia, Prime Ministerial Statement, 12 March
 - 8 Premiers and Chief Ministers Meeting. (1991). Communique 21-22 November, Adelaide
 - 9 Fels, A (1997) "Can the Professions Survive under a National Competition Policy?" - The ACCC' view. Australian Competition and Consumer Commission Joint Conference - Competition Law and the Professions 11 April.
 - 10 Australian Competition and Consumer Commission <https://www.accc.gov.au/publications/cartel-conduct-how-it-affects-you-and-your-business>

the most junior member of the policy team to the departmental secretary.” That same Ministry that wrote your terms of reference cautions you in the following words: “Are you trying to manage a public health issue that has suddenly taken on a life of its own? Be careful not to be distracted by the symptoms of a problem or media interpretations of it. It’s natural for media or lobby groups to focus on controversial or emotive aspects of potential policy decisions, but is the cost of regulating in proportion to the real-world risk?”¹¹

The proposals in your draft Report have resurfaced time and again - 2005¹² ..2011¹³., and the results have already been described to you as “catastrophic”¹⁴. The draft proposals have potential to make things worse and ‘wreck the economy’. Again, these are quotes from others, not MCA. You have many warnings among your hundreds of submissions and your own earlier reports. The fundamental underpinning of the video on your website that 1 in 2 have a supposed mental illness history is light years away from the submissions you’ve received that the true incidence of serious mental illness calling for help is more like the traditional 3%¹⁵. So who is representing ‘the other 97%’ ?

The dire warnings about “bounty hunters” are from US Congress¹⁶ and ‘wrecking the economy’ from Dr. Alan J Frances. You likely know of him, as he wrote the book. This is the book - the Diagnostic And Statistical Manual Of Psychiatry. He came out of retirement to warn about the dangers of diagnostic inflation and over-hyped treatment¹⁷. Dr Frances pointed out the dangers of reliance on those with ‘lived experience’ of illness: “*There is no constituency for normal*”

The Commission expressed reservations that in their experience the ACCC had only limited jurisdiction over cartel conduct in the health sector. MCA had submitted as an example that the Royal Australasian College of Surgeons (RACS) had bowed to the law and sought authorisation (A90765) for accrediting hospitals, selecting, training, examining trainees and assessing overseas-trained surgeons. The ACCC calls the health sector ‘a new priority area’¹⁸ but Commissioner Alan Fels said “Governments have been reluctant to take strong action...” and Commissioner Graeme Samuel said that health ministers told them “to back off”.¹⁹ The current Minister for Health wrote to MCA stating he did not want to “burden” the ACCC while your inquiry was underway.²⁰ So it’s still “back off”.

The ball is in your court. As a consumer group our punchline as in our written submission is: an ACCC inquiry. The evidence now available to the Productivity Commission does not in any way support a \$500,000,000/per day of savings. The proposals are much more likely to wreck the economy. False psychiatric labels on hundreds of thousands if not millions of Australians can create a pill-popping intergenerational underclass of people identifying themselves as having a mental disorder, a get out of work free card. I already see such people in the clinics.

11 Australian Government Guide to Regulation op cit.

12 Productivity Commission (2005) Australia’s Health Workforce Research Report January 2003, 22 December 2005 <https://www.pc.gov.au/inquiries/completed/health-workforce/report/healthworkforce.pdf>

13 Senate (2011) Inquiry into Commonwealth Funding and Administration of Mental Health Services

14 Submission: Comments from other interested persons #23 to Productivity Commission

15 Consortium of Australian Psychiatrist-Psychologists. Submission #260 to Productivity Commission; Raven, M. (2019) Submission #390 to Productivity Commission.

16 US Congress (1992) The Profits Of Misery : how inpatient psychiatric treatment bilks the system and betrays our trust : hearing before the Select Committee on Children, Youth, and Families, House of Representatives, One Hundred Second Congress, second session, hearing held in Washington, DC, April 28., Washington :U.S. G.P.O. <https://babel.hathitrust.org/cgi/pt?id=umn.31951d00282733c&view=1up&seq=2>

17 Frances, A. (2015) Former Chair, Task Force for the Diagnostic and Statistical Manual (DSM-IV) YouTube, the overdiagnosis of mental illness. <https://www.youtube.com/watch?v=yuCwVnzSjWA>

18 Sims, R (2015) Priorities 2015:Medical and health Conference: Committee for Economic Development of Australia. 19 February. Sydney

19 Quoted in Medow, J. (2016) Consumer watchdog ACCC urged to investigate cartel claims against surgeons. Sydney Morning Herald. September 23

20 Hunt, G. (2019) Minister for Health, letter to Medical Consumers Association. 18 September

Evidence submitted points toward suicide rates made worse²¹, higher costs for placebo-level treatments²², waiting lists, excessive psychiatric labelling, removal of stigma making false positives seem acceptable, prescription drug problems²³, mass unemployment, unsustainable mental health workforce, with no savings from prevented illnesses.

Our Solution? - The ACCC. Although you have section 52 barring false or misleading evidence, *“the decision of a Court is in every important respect sharply contrasted with the edict, however benevolent, of some hidden authority, however capable ... there is no opportunity to test by cross-examination such evidence as may be received nor for the parties to controvert or comment on the case put forward by their opponents... it is manifest that an opinion so arrived at differs by the whole width of the heavens from the decision of a Court.”*²⁴. The structure of the mental health sector workforce should be subjected to a full ACCC inquiry. The ACCC can reverse the burden of proof onto cartels making extreme claims rather than those questioning the claims.

The 2011 Senate inquiry heard identical proposals and concerns. The Opposition criticized the inquiry process. They're now the government. The debate was heated - over 1000 submissions. They were warned against early detection and the multi-tiered stepped-care model back in 2011. The damage has already begun.

As for the essence of consumer protection: What if expensive water tests out as tap water? or worse, our tap water is contaminated? By analogy in the mental health sector we have at the unlicensed end cults and illegal drugs. At the regulated end we've had prescription drugs, psychotherapies, lobotomies, deep sleep, electromagnetic and electroconvulsive therapies. In the middle we have free services such as counselling by Lifeline, a supermarket remedy, or a harmless sugar pill placebo. Some regulated treatments have been banned and we hear on ABC and 2GB that prescription drugs are killing more than the illegal ones²⁵. So the traditional consumer concerns are: the high priced pill, which may be covering up risks, actually has no better outcome than a sugar pill.

That is the evidence before this commission. We need to clarify. The fallacy of so-called 'evidence-based treatments' is not that they don't work. The problem is the opposite: Everything sort of 'works', including the placebo. There are hundreds of new psychotherapies each year. Maybe they work. But so does generic counselling done by unregistered, minimally-trained, unpaid persons²⁶. So why pay \$300 a glass for tap water – or a sugar pill?

Endorsement of junk science so-called 'evidence-based' services that share common elements yet don't beat placebo precisely fits the ACCC definition of cartel behaviour: *“... stifling innovation and protecting their own inefficient members. Cartels steal billions of dollars in Australia and abroad from businesses, taxpayers and ultimately from consumers.”*²⁷

While MCA has submitted our support for expansion of counselling services, we caution that there is no evidence whatsoever for over-credentialing of such new services as this will do nothing to curb the cartel excesses in this sector for supposed 'public protection'. Strictly vetting, credentialing and accrediting highly-qualified counsellors will in practice only make the cartel a bit

21 Burgess, P, Pirkis, J, Jolley, D Whiteford, H & Saxena, S (2009) Do nations' mental health policies, programs and legislation influence their suicide rates? An ecological study of 100 countries. Australian and New Zealand Journal of Psychiatry Volume 38, 2004 - Issue 11-12 Pages 933-939

22 “we are still not aware of a single convincing demonstration that the benefits of psychotherapy exceed those of placebos for real patients.” Prioleau, L., Murdock, M., Brody, N. (1983) An analysis of psychotherapy versus placebo studies. Behavioral and Brain Sciences, , Vol.6(2), p.284

23 Medhora, S (2017) Pharmaceuticals officially more of a problem than illicit drugs, report finds. ABC. 19 December <https://www.abc.net.au/triplej/programs/hack/misuse-of-pharmaceuticals-on-the-rise/9271046>; and 2GB radio

24 Hewart, Lord Chief Justice of England (1929) The New Despotism. Ernest Benn Ltd

25 Medhora, S. (2017) Pharmaceuticals officially more of a problem than illicit drugs, report finds. ABC JJJ. 19 December; Peters, N (2017) Prescription drugs deadlier than illegal drugs. 2GB Radio. Dec 19, 2017

<https://www.2gb.com/podcast/prescription-drugs-deadlier-than-illegal-drugs/>

26 Refer to MCA's written submissions re: paraprofessionals op cit.

27 ACCC. cartel-conduct-how-it-affects-you-and-your-business op cit.

larger, as the ACCC Commissioner warned: “Members of the professions often present the view that rules prohibiting anticompetitive conduct should not apply to them as the conduct complained of has the purpose of protecting the public. ... 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)”²⁸. The APS and departments of health had for decades resisted any registration of psychology²⁹ as there had never been evidence that this would protect the public. Registered practitioners were in a stronger position than the unregistered to do harm and exploit vulnerable clients and trainees. The testimony is invariably supply-sided and at best anecdotal.

The statistics common in journal articles will hail a treatment as being successful if it has an NNT as low as four. NNT is number needed to treat. It refers to the number of people who would need to be exposed to the treatment for one person to benefit. Where else in the health or any other sector would such ratios be tolerated? Would you tolerate this in dentistry? Let's imagine Clint Eastwood as a dentist saying to you: “I know what yer thinkin'. I've already drilled three people this morning. Only one of you will get better. So you' gotta ask yourself one question ‘Am I feelin' lucky?. Well are ya?”

NNTs in drug trials are commonly higher than four, sometimes as high as 9 to 15. So as a consumer group we have to ask: ‘Who is speaking for the other eight persons?’ Eight receive a potent drug and a lifetime psychiatric label so one might get lucky. And the prize may only be a rating on a tick box scale as having shown some statistical improvement, but “*unlikely to indicate significant clinical change for the majority of young people*”³⁰. Who's representing the 8 false positives handed out for every one that might be detected? MCA can't. They can't even represent themselves. They don't yet know this will happen.

Often the statistical improvement is not even clinically detectable. Researchers recently reported that adolescents “*do not show a clinically significant change even after receiving the best available guideline-recommended treatment*”³¹. On the front page of the most influential adolescent study its recommended treatment “*did not differ from placebo on any measure*”³².

Childhood detection becomes even scarier. The Commissioners have asked why we view early detection as illogical. I gave the analogy of a famous athlete like Serena Williams³³ who would have shown athletic ability at a very young age. That would not tell us whether it would be tennis she would specifically continue in later life. She might well have taken up something quite different, even outside the athletic area. Anyone can easily trace back retrospectively for early signs. But ‘the arrow of time’ points only one way. We can't predict adult behaviour from early childhood. The most common disorders listed by the Australian Bureau of Statistics were for Post-Traumatic Stress and episodes of anxiety and depression³⁴. These would arise from the circumstances of adult life. They would not be predictable, let alone preventable, from early childhood decades earlier. Even if there were a reliably detectable genetic predisposition, the triggering adult circumstances might not arise.

28 Fels, A (1997) "Can the Professions Survive ... op cit.

29 Cooke, S.(2000) A meeting of minds: the Australian Psychological Society and Australian psychologists, 1944-1994; Australian Psychological Society; Lean, A. (1996) Review of the Psychologists Act. NSW Health

30 Headspace (2012) Evidence Summary: Using SSRI Antidepressants and Other Newer Antidepressants to Treat Depression in Young People: What are the issues and what is the evidence? December <https://headspace.org.au/assets/download-cards/ssri-v2-pdf.pdf>

31 Parker AG, Markulev C, Rickwood DJ, et al. Improving Mood with Physical Activity (IMPACT) trial: a cluster randomised controlled trial to determine the effectiveness of a brief physical activity behaviour change intervention on depressive symptoms in young people, compared with psychoeducation, in addition to routine clinical care within youth mental health services: a protocol study. *BMJ Open* 2019;9:e034002.

32 March J, Silva S, Vitiello B; TADS Team. (2006) The Treatment for Adolescents with Depression Study (TADS): methods and message at 12 weeks. *J Am Acad Child Adolesc Psychiatry*. Dec; 45 (12):1393-1403.

33 Reference to Ms Williams is purely because she is a famous athlete recently in Adelaide for the Aus Open.

34 Australian Bureau of Statistics (2018) One in five Australians has a mental or behavioural condition. Media release 12 December.

As for spotting families at risk I mentioned to the Commissioners that anyone can spot demographic distress. Poverty can be detected just by looking at people or their environment: *“bad scents have become a generational way of life ... the smells of these places, which are characterized by poverty, decay, crime, malnutrition, and disease”*³⁵. It doesn't require a \$300/hr PhD clinician. As a former Policy Officer in the NSW Education Department I would commonly arrive at Head Office having heard about disadvantaged schools in the morning press and talk shows. My colleagues were clearly well aware of the issues as it was our job to assess them. And the schools knew which families had problems. The solutions would be socio-political rather than clinical.

The Commissioners were concerned that the press had interpreted their intentions for psychosocial interventions, for example as *“...misconceptions and factual errors that are evident in your article of 2 January 2020 titled “1.25 million Australian 0 to 3 year olds at risk of dangerous psychiatric drugs” ... This is not, as your article wrongly suggests, an attempt to screen for “mental illness”. The Productivity Commission does not recommend or suggest that the check should be linked to referring children to a mental health professional, providing children with a diagnosis or enabling increased use of psychiatric drugs.”*³⁶

I replied that it had not been merely the recent press who had expressed concerns but months before this MCA in 2019 had submitted to you³⁷ authoritative international warnings about the likelihood that your report would be taken as a 'green light' to drug prescription in this age group, for example, Dr AJ Frances, Chair of Task Force Diagnostic and Statistical Manual (DSM-IV) warned in 2015 *“...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 ...”*³⁸

I mentioned that just this week my university colleagues, who are investigating prescription drugs in childhood and adolescence and had presented concerns to the International Overdiagnosis in Medicine Conference³⁹, had passed between us recent articles showing Prozac has already been trialled on under-2 year olds.⁴⁰ Whatever the rationale or need in such cases, we were pointing out that it is not a mere prediction that such drug prescriptions might arise, but observations of contemporary practices and the history of prescribing trends, spawning headlines such as: *“Thousands of Toddlers Are Medicated”*.⁴¹ Even mild non-endorsements from government are taken as a 'green light' for expansion of clinical practices.

One reason for the default to drug treatments is the contrived trade restriction on delivery of non-drug alternatives such as cognitive behaviour therapy (CBT) and the Common Elements Treatment Approach (CETA). These can be delivered by non-mental health providers with a minimum of training. We have seen online CBT courses for as little as \$20. These therapies work well by following a manual. The caste system of the health professions is the main barrier to mobility in providing such services. The 'crisis' propaganda that we dare not leave anyone 'at risk' pressures the sector to 'do something', invariably leading to drug prescription: *“Because CBT resources are in limited supply, ... provision of FLX as monotherapy for MDD in adolescents will remain highly*

35 My reference to “smell” in public hearing was to observations such as <https://themarginalized.com/2010/01/28/smells-the-suburbs-and-the-slums/>

36 Letter from Productivity Commission to CCHR <https://www.pc.gov.au/inquiries/current/mental-health/correction-letter-mental-health.pdf> 14 January 2020

37 MCA submission to Productivity Commission 2019

38 Dr Frances, A. (2015) op cit

39 <https://www.preventingoverdiagnosis.net/>
<https://2454211.mediaspace.kaltura.com/category/Preventing+Overdiagnosis/146828052>

40 Farzadfard, S Ashrafzadeh, F Toosi, M Majd, H Shahabifar, M (2019) Efficacy of treatment with Fluoxetine in children with breath-holding spells. International Journal of Pediatrics; Walsh M1, Knilans TK, Anderson JB, Czosek RJ (2012) Successful treatment of pallid breath-holding spells with fluoxetine. Pediatrics. Sep;130(3):e685-9. doi: 10.1542/peds. 2011-1257.

41 Schwarz, A. (2014) Thousands of Toddlers Are Medicated for A.D.H.D., Report Finds, Raising Worries. New York Times, May 17

relevant”⁴² Given that CBT and CETA are cheap to administer and taught from manuals in weeks, not years or decades, it is appropriate for consumers to ask for an ACCC investigation the mystery of why these should be expensive or in “limited supply”.

Evidence has been put to the Commission that it is difficult enough to predict specific future adult psychiatric conditions, even as extreme and overt as psychosis, at the end of teenage, 18 years old (“*There is no evidence to show that intervention at onset (commonly 18-25 years of age) reduces morbidity into adulthood.*”⁴³), yet we are being promised that we can do better than this by predicting and treating people as soon as they’re born. A decade from now eugenicists will testify that that’s too late. DNA can assign your psychiatric label before you’re born. Again, this is hardly a prediction as this very month *New Scientist* hailed genetic research that “.. *many mental health problems appear to share an underlying cause, something researchers now call the “p factor”*”⁴⁴

And the 0-3 year old false positives haven’t even been born yet. They’ll have no say in it. But you can bet the other kids in the school yard will have plenty to say about them if they find out about their ‘mental illness risk’ or ‘p-factor’ labels. These labels will have nickname taunts like “Hey, Peefack”. And their own future children will already now have a ‘genetic predisposition’ and ‘family history’ of mental illness. The label sticks. Reducing stigma only makes it seem credible. Dental patient isn’t like mental patient.

While the Commission has forcefully indicated that it had no intention of increasing the “*attempt to screen for “mental illness”*”⁴⁵, there are massive commercial incentives for ulterior motives. I reminded them of the 1992 ABC Four Corners incident cited in MCA's written submissions in which a company had sought to implement in Australia the practices of “bounty hunting” of ‘mental illness’ labelling children to send them to psychiatric hospitals⁴⁶. The bureaucracy had attempted to block the documentary⁴⁷, but once it aired the state parliaments quashed the deals. We pointed out that the Commission had received submissions from current psychiatrists alerting them to such excesses re-surfacing here⁴⁸.

I cited to the Commission my personal experience as an expert witness in court cases in which the mental illness label had been used as a weapon -ie- A casual interview mention by a person making an insurance claim that “I think a cousin had ADHD” had evolved over several formal psychiatric reports from “family history of mental illness” to prior “history of mental illness”. The claimant didn’t even know that a psychiatrist had labelled them as having a mental illness history. The industry slang for such sanctioned fraud is “chop doctor”: a paid-for ‘expert opinion’ that can chop an insurance claim.

The two-tier stepped care caste system⁴⁹ is already decimating the mental health workforce. Restricting extreme conditions to advanced skills sounds logical, but that’s general medicine. It’s never been shown to apply in the mental health sector. Submissions to this committee show there is no evidence whatsoever for difference in outcomes in any mental health conditions attributed to training, and the training is becoming very costly, up to \$30,000 a year for a course. It has always been a closed shop. Back in 1963 we read that there were 50 applicants for 8 places⁵⁰. Evidence to the committee is that the situation has not and will never improve. Some speak about “advanced psychological therapy” restricted to clinical psychologists and psychiatrists - Except no one has invented a new way of talking. The results for decades have shown these psychotherapies don’t beat

42 March et al (2006) op cit.

43 Consortium of Australian Psychiatrist-Psychologists. Submission #260 op cit.

44 Jones, D (2020) A radical idea suggests mental health conditions have a single cause. *New Scientist*. 22 and 25 January. <https://www.newscientist.com/article/mg24532660-500-a-radical-idea-suggests-mental-health-conditions-have-a-single-cause/>

45 Letter from Productivity Commission to CCHR op cit.

46 ABC Four Corners (1992) Patients Held Hostage. Script Title No: 217219 19 October

47 Martin, B https://www.bmartin.cc/dissent/documents/health/nme_battle.html#Four%20Corners

48 McLaren, N. Submission #044 ; Overservicing in Psychiatry Submission #513

49 There is no mobility between the professions; each would have to start from scratch to switch professions.

50 Cooke, S.(2000) op cit

each other or placebo⁵¹.

The greatest anti-consumer irony of stepped-care is that the most expensive therapies will become those which have long shown themselves to be the most over-priced and ineffective compared to 'spontaneous remission' (doing nothing) or placebo. In line with ACCC Commissioner Fels warnings, consumers unacquainted with textbook and learned journal psychology will be peddled the impression that there are supposedly 'advanced' psychotherapy skills that must, for their supposed 'protection', be restricted to high-fee psychiatrists and clinical psychologists. This goes against nearly a century of evidence to the contrary. The self-styled, over-priced, ineffectual pseudo-elite will be further entrenched, draining resources: "... *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.*" ⁵² These are almost the same words as the ACCC: "*honest and well-run companies cannot survive, destroying consumer confidence in an entire sector.*"⁵³

The other damage of stepped-care categories is confusion. When a referral walks through our door we have no way of predicting they might be classed as moderate to severe, or 'what if I think they're one of the 97% who don't have a serious mental illness?'. 'Ooo - we might fear that we'd get in trouble with AHPRA for refusing to treat or supposedly exceeding our skill level'. The GP is put in a similar position. They get paid more to write a mental health treatment plan for me than I get to do the treatment. Do they risk an audit if they refer to the general allied health practitioner, let alone a counsellor? So their safe default is to give them a psychiatric label for life, refer to clinical psychologists and psychiatrists, irrespective of their waiting lists, high price, psychiatric labels, placebo-level pseudoscience, and probable drug prescription.

And does anyone seriously think that I'd sit in the clinic, unpaid, to act as a referral agent, passing people on to the waiting lists of my colleagues? I will close shop. That's not a prediction. That's my 'lived experience'. I was offering bulk-billed services in a regional and rural area. They are also an indigenous clinic. I closed my two practices to move to South Australia. The town I left behind is now surrounded by bushfires. I can't help. That town is ineligible for general psychology teleservice, but before leaving I recruited volunteers who were highly qualified, one with a PhD, who would have been quite happy to replace me in the role. They had in fact been working for free and certainly would have charged little more than the gap fees that some other practitioners charge and patients wouldn't have required a psychiatric label. But thanks to the onerous artificial AHPRA requirements they remain un-registered. Some are unemployed and they've virtually left the mental health sector. So I doubt that I will be replaceable. So, government money? for whom? The nearest mental health practitioner is a mental health nurse with a waiting list 20 km away. I'm told that the ECT machine is 'running hot' and has a queue for it. So there's your mental health service. The APS warned you in 2005 that "*The potential for 'telemedicine' in the mental health area is limited. It carries the danger of over-reliance on use of prescription drugs as a ready electronic means.*"⁵⁴

And our lived experience here in Adelaide? A patient might shell out \$175 for a 7 minute specialist visit: \$1500 an hour. But they'd be happy to be a false positive diagnosis to find they didn't have cancer. These high fees trickle down into the mental health system as opportunity costs. Psychiatry commonly claims they have trouble convincing medical graduates to take up psychiatry because of

51 Cooke, S.(2000) op cit referring to Eysenck, H. J (1983) The effectiveness of psychotherapy: The specter at the feast. Behavioral and Brain Sciences, , Vol.6(2), pp.290-290

52 Arkowitz, H. and Lilienfeld, S. (2012) EMDR: Taking a Closer Look - Can moving your eyes back and forth help to ease anxiety? Psychology Today. August 1, 2012 <https://www.scientificamerican.com/article/emdr-taking-a-closer-look/>; Kashdan, T (2014). Why Are Deepak Chopra & EMDR Important for Science and Life?Pseudoscience wastes time, resources, and leads to public skepticism of science. Posted Feb 07, <https://www.psychologytoday.com/au/blog/curious/201402/why-are-deepak-chopra-emdr-important-science-and-life>; Eysenck, H. J. (1952). The effects of psychotherapy: an evaluation. Journal of Consulting Psychology, 16(5), 319-324. Eysenck, H. J (1983) The specter at the feast. op cit.

53 ACCC. cartel-conduct-how-it-affects-you-and-your-business op cit.

54 Australian Psychological Society (2005) submission # 118, p. 62) to Productivity Commission Position Paper: Australia's Health Workforce <https://apo.org.au/sites/default/files/resource-files/2005/09/apo-nid1906-1182636.pdf>

the more attractive working environment and fees in other specialties. This is one cartel level reinforcing another.

Contrast that with a patient referred to me, stressed or bullied at work. Symptoms have to be disproportionate to the stress to meet mental disorder criteria so this one might be one of 'the other 97%'. Our busy clinic has a highly-trained psychotherapist counsellor. She's not yet had a single referral. I get the referrals because I'm registered with Medicare. I rang Medicare and they advised it would be "illegal" for me to pass that "other 97%" patient on to the counsellor. This afternoon I have patients on the book, she again has none: unsustainable. As the APS warned in 2011 "*Many patients have little choice but to use the funded (and hence cheaper), less well-trained practitioner.*"⁵⁵ So much for your proposed peer workers and low-intensity therapy coaches.

We have millions of people around Australia on these mental health treatment plans the APS described as 'false pretences'. Your own 2005 workforce report said "*the skills of many health workers are not being used to full advantage. .. because of various systemic impediments*". Submissions now call this 'catastrophic'. Thousands of counsellors out of business. The sector runs on the back of volunteers. Your very own web site says '*if you need help ..contact.. lifeline*' -ie- Talk to an unpaid volunteer, not a government service, not a \$254 an hour so-called 'advanced' psychotherapist with a waiting list, but a volunteer, someone who is paying to go to work.

Back in 2005 you noted "*Pro bono training services are an important contribution*" "*large increases in undergraduate intakes ... exacerbating these pressures*", calling for "*greater use of explicit payments*"⁵⁶ These volunteers are recruited with ads mentioning counselling careers ("*What's in it for you? ... Potential career opportunities*"⁵⁷). When these new grads see psychologists and others forced to close shop due to these procedural barriers these Lifeline volunteers who are putting in their thousands of hours of unpaid placement hours will start to realise that there's no actual career path waiting for them. When they exit the sector to get a real day job you'll be left with a couple of \$200 an hour practitioners with a waiting list. And they, like me, prefer the beach lifestyle rather than locating to the rough, tough areas of need in the region, who will have to drive an hour to see them.

I mentioned to the Commission that no business could expect to survive if a competitor was encouraged to set up next door, subsidised with a taxpayer-guaranteed \$220 per visit for every one who walked in their door, and with a license to offer potent legalised drugs. It's hard to picture the economy surviving such a scenario, which is one of the reasons for Dr AJ Frances' warning that "*We have a medical system that couldn't've been conceived more brilliantly by an enemy of the United States. Our medical industrial complex is a brilliant conception if you wanted to destroy our economy and it's working exactly to do that.*"⁵⁸

The Committee asked about cultural reform and I replied that Dr Thomas Szasz had been asked that very question at a talk he gave us at University of NSW a few decades ago. He laughed and replied it would take the combined powers of Jesus, Muhammad and Buddha to make any dent in psychiatric hegemony.

Our recommendation is that this entire mental health workforce edifice should have presented its case for existence to the ACCC, "*our principal legislative weapon*". ACCC Commissioners have called for it. It is long overdue. The Ministry that commissioned you has warned "*there are a relatively small number of situations that justify direct government intervention in the form of regulation. Is the cost of intervention greater than the potential gain?*"⁵⁹

55 Crook, A. , Fazande, M. (2005) APS Response To ProductivityCommission's Position Paper "Australia's Health Workforce" <https://www.pc.gov.au/inquiries/completed/health-workforce/submissions/sub118/sub118.pdf>

56 Productivity Commission (2005) op cit

57 <https://www.lifeline.org.au/south-east/recruitment-south-east-sa>

58 Frances, A. (2013) Plenary. Preventing Overdiagnosis. Dartmouth, 26 September. <https://www.youtube.com/watch?v=sMBeIENDqT4>

59 Australian Government Guide to Regulation op cit.