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Productivity Commission Inquiry into Mental Health

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Update to MCA Submissions #19 and #41 per Opportunity for further comment on the Draft Report.

Concerns: MCA believes that the historical and recent evidence now available to the Productivity Commission justifies a prediction that the proposed early detection paradigm will prove to be counter-productive. There is no reason to expect suicide rates to decline. A likely outcome is higher costs, excessive psychiatric labelling, prescription drug problems, unsustainable workforce, with no savings from prevented illnesses. The scale of the mental health labelling of entire generations of Australians may affect the entire workforce and economy.

Solution: MCA believes that government reliance on public inquiries and commissions is fatally flawed because these cannot reverse onus of proof onto those making proposals. The well-funded provide the bulk of say-so evidence, without cross-examination. The Australian Competition and Consumer Commission was specifically established to address these issues. The structure of the mental health sector workforce should be subjected to a full ACCC inquiry before any proposals are implemented.

Specific information requests

With regard to the Productivity Commission (PC) specific information requests, below is a summary table of MCA concerns. The submission and appendices elaborate on our reasoning and the evidence.

promising	5.1 low-intensity therapy coaches as an alternative to psychological therapists
promising	19.2 personal care days for mental health
promising	25.2 proposed indicators to monitor progress against contributing life outcomes
concerns	3.2 out-of-pocket costs for mental healthcare
concerns	5.2 mental health treatment plans
concerns	14.2 incentives for dsp recipients to work
concerns	18.2 what type and level of training should be provided to educators
caution against	Reform area 1: prevention & early intervention for mental illness & suicide attempts
caution against	3.1 education activities that support mental health and wellbeing
caution against	17.1 funding the employment of wellbeing leaders in schools

MCA Submissions

We refer to our 3/Feb//2019 *“Preliminary reading, our Submission #19 and its attachment, and our Comments from other interested persons #44.*

The Productivity Commission Draft Report (DR) has confirmed our concerns expressed to you in our initial pre-reading submission of 3/Feb//2019 *“Preliminary reading for Medical Consumers submission”*. Shortly after our submission, Dr Melissa Raven in her *submission #390 “Productivity Commission inquiry must include fact-checking”* made similar warnings:

“Unfortunately, the Productivity Commission inquiry is likely to be presented with many supposed facts that are inaccurate. Furthermore, some of those inaccuracies will seem trustworthy, because

of their provenance, coming from respected experts and organisations, and citing authoritative sources.”ⁱ

In the months since, new evidence has been published relevant to your information requests [brackets] and our pre-reading headings *[italics]* as follows:

[Early childhood Reform Objective: Better use of childhood services to identify and enable early intervention for social and emotional development risks; State and Territory Governments should put in place strategies to reach universal levels of screening for perinatal mental illness for new parents.]

Detection fallacy: seductive concepts such as 'early detection' have no scientific basis and historically have resulted in financial incentives for abuse

It is illogical to expect that early detection of supposed risk factors en masse in the very young will predict, let alone prevent, the sorts of mental disorders these same persons might commonly present decades later in adult life. Lumping 24 year olds in as ‘young persons’ makes this a tautology rather than a prediction about their adult mental health as they are already adults and possibly parents themselves.

Submission #260 advised the PC that “ .. *No evidence exists that is robust enough to justify removal of acute and longer-term bedded services for people with SMI in favour of primary prevention (prior to onset of disease), early detection (also known as secondary prevention) and early intervention strategies. These strategies have largely failed to show enduring benefits. ... There is no evidence to show that intervention at onset (commonly 18-25 years of age) reduces morbidity into adulthood.*”ⁱⁱⁱ

Logically, intervention at age 0-3 would have even less connection with adult morbidity. 2019 is at least the third time we’ve been led down the road to ‘early detection and intervention’, described internationally as “headhunting” in schoolsⁱⁱⁱ and “Australia’s reckless experiment”.^{iv}

- The DR is in 2019 resurrecting these concepts for “*1.25 million 0 to 3 year olds ... to incorporate social and emotional wellbeing ... Identification of children at risk .. for students and their families to access help.*”
- In 2011, the ‘mental health and wellbeing check’ for 3- and 4-year-old children’ was widely criticized.^v
- In our Submission #19 we had mentioned the 1992 ABC Four Corners’ exposé that derailed an attempt to bring to Australia a US private psychiatric corporation early detection programme “*accused of abducting patients and illegally detaining them against their will ... placing referral representatives in public school counselling services*”.^{vi}

After much effort, we have been able to obtain access to the transcript of that TV broadcast, excerpts from which we are attaching as Appendix 1. The second Appendix is excerpts from the US Congress (1992) testimony on which it was based, for example:

“Adolescents for us was our big money winner. So, we did target adolescents. We actively had a group in our referral network that they would go out and meet with all the junior highs and the high schools. Then when we added the children's program, we put a new group in there that went out and hit the elementary schools. We would do such things as we would pay for counselors in the school. We'd pay the school district for the counselor and put him out in the school and then our marketing

people would be in constant contact with those people. We also got a lot of our adolescent referrals through the juvenile authorities. So, we were big in marketing to juvenile authorities.”^{vii}

This is not some ‘old American problem’. Our own governments of the day had tried to quash the ABC broadcast. It was largely because of outcry response to the broadcast that the corporation was blocked. A 2018 review of our own Australian Headspace showed the same sorts of potential for schools to use the mental health system as a tool for non-clinical purposes:

“Some (20%) of the young males identified the importance of ensuring referrals from schools were managed appropriately, and that available mental health services are not “overadvertised”. An example was provided of general poor behaviour at school leading to a mental health referral from school-based staff. This was seen by several young males as potentially damaging likelihood of future engagement. Referral to services in this context may appear punitive rather than facilitative. ‘It is like, if you get suspended for something small with anger, like overreacting a little bit, they will say, “Go to headspace”. They will just refer you. That’s why a lot of kids don’t like it because high schools, pretty much, are basing it straight off that.’ Young male, focus group 12–17 years” “^{viii}

The 1992 hearings exposed the issue of running up “*an excessive amount of therapy each day, sometimes as many as eight hours, even though school age patients are supposed to be receiving academic instruction too. On one particular day, she received \$482.00 worth of “projective testing,” and \$482.00 worth of psychological evaluation; and five additional hours of group therapy at a cost of \$80.00 per hour for a total of \$1,364.00 worth of testing and therapy in one day. Her \$625.00 a day semi-private room brought the grand total for that one day to right at \$2,000.00. This is not just unreasonable, it’s outrageous and it’s fraudulent. I urge you to consult mental health experts in your communities and ask them whether it’s possible to conduct that much testing and therapy in one day. I also brought with me a copy of this paperback book, Broken Toys/Broken Dreams, which can be purchased for \$10.95 at any bookstore. I presume a hospital that buys large quantities can get it at an even lower cost. The teenager we have been talking about was charged \$84.00 for her copy. Her bill showed a \$42.00 charge for an \$11.00 book, not just once, but two times.*”^{ix}

A quarter century later, submissions to the PC from Australian psychiatrists sound almost identical to the issues exposed by Four Corners : “*Compounding the matter, the private hospitals offer extra services, mostly run as day-, week- or month-long courses addressing a specific issue. For example, there may be a course run for people named as victims of sexual abuse, or another directed at the spouses or children of the patient population. Courses have to be approved but, once registered on the schedule, it is a matter entirely for the treating psychiatrist whether the patients or their families attend. As long as the forms are completed and the course is approved, no questions will be asked. This is true of courses consisting, for example, of twenty days of six hours each, costing from \$20,000 per attendee. Thus, a course with say eight people would yield the organisers at least \$1300 per hour, possibly a lot more.*”^x

“*... these psychiatrists and their private hospital had previously been taking a large number of referrals, providing treatment at an average cost of somewhere between \$5,000-10,000 per patient, not including the many courses they ran each year (they do not release their figures). This meant they were taking at least \$1million a year; probably a great deal more. ... sending the great bulk of patients to hospital where they would be prescribed heavy doses of drugs and ECT. After some weeks or months in hospital, they would be discharged but this was just the first step on the well-known path through the “revolving door” of the mental hospitals.*”^{xi}

These issues are perennial. MCA foundation president Dr Erica Bates commented 42 years ago on this exact attitude in Australia back in the 60s and 70s: “*Part of the preventive psychiatric attitude is that expert services should be given, not only to those who are already ill, but also to the*

seemingly healthy: hence, everyone in the community becomes a potential patient and is regarded as being in need of preventive psychiatric intervention.^{xii}

“The beauty of the psych hospital is the fact that you can get into them relatively cheap. ... The other situation is you’ve got a tremendous cash flow. The cash flow starts almost immediately. ... We were a for profit company looking for the bottom line.”

Chairwoman Schroeder: And so you had a wide net spread looking for anybody who could pay?

Mr. Durrett: I personally, even as the controller of the hospital, I had to make five cold calls a week out in the community and out in the surrounding area to try to drum up additional referral networks that we could use. Everybody in the hospital had a certain number of cold calls that they had to make.^{xiii}

[Reform area 1: prevention and early intervention for mental illness and suicide attempts; recommendations to improve early detection of risk factors for mental ill-health, expand early intervention] Treatment fallacy

Even making the ill-supported assumption of detectable “risk” on mass scale in young children, what is the supposed “help”? Submission #260 noted: *“As for primary prevention strategies, for SMI such as schizophrenia and other psychotic disorders, there is no known mechanism by which to prevent onset of disease”*.^{xiv} As for the more common conditions said to be a PC focus, Australian authors¹ from across the child & adolescent mental health sector stated in October 2019: *“Recent evidence from meta-analyses of randomised controlled trials (RCTs) have shown the effect sizes of both CBT [Cognitive Behaviour Therapy] and antidepressant medication are smaller than previously reported. This suggests that many young people either fail to respond or do not show a clinically significant change even after receiving the best available guideline-recommended treatment delivered in controlled trials”*^{xv}

This has been the pattern for years. The Treatment for Adolescents With Depression Study (TADS) funded by the National Institute of Mental Health has been influential, with thousands of citations and possibly millions of drug prescriptions written in Australia and internationally. The TADS recommendations have echoed through Australian treatment guidelines for adolescent depression. Specifically, it has been used to justify prescription of Prozac to adolescents and use of CBT as the actual front-line treatment. The TADS 2004 article had concluded *“... given incremental improvement in outcome when CBT is combined with medication and, as importantly, increased protection from suicidality, CBT also should be readily available as part of comprehensive treatment for depressed adolescents.”*^{xvi}

Yet these authors noted that *“CBT did not differ from PBO [placebo] on any measure.”*^{xvii}

The rationale for using the combination [COMB] of Prozac [FLX] and CBT was described as follows: *“Despite the fact that suicidality improved markedly across all of the treatment conditions, suicidal events were twice as common in patients treated with FLX alone than with COMB or CBT alone, perhaps indicating that CBT protects against suicidal events. ... Because CBT resources are in limited supply, the TADS suggests that providing access to CBT may be especially valuable for adolescents with a personal or family history of suicidality. While we wait for evidence-based psychotherapy to more become widely adopted, provision of FLX as monotherapy for MDD in adolescents will remain highly relevant to those who wish to accelerate response. Given the small FLX attributable risk of a suicidal event, many patients and providers may wish to begin with CBT alone to avoid any risk of antidepressant-induced suicidality, especially when favorable prognostic*

1 Victoria University, University of Melbourne, National Centre of Excellence in Youth Mental Health, University of Canberra, Canberra, headspace, National Youth Mental Health Foundation, University of New South Wales, Black Dog Institute,

factors are present ... only advancing to medication when the response to CBT is deemed inadequate.”^{xviii}

So, as with decades of earlier negative evidence, we are advised to begin with a front-line ‘treatment’, CBT, that ‘did not differ from placebo on any measure’. CBT is artificially in ‘limited supply’ because of anti-competitive trade restrictions by provider lobbies. A CBT course can be purchased for as little as \$20 online or a 4-day workshop. There is no prerequisite. Government-sponsored CBT treatment manuals and worksheets are freely available. But because of the artificial so-called ‘limited supply’ of CBT, “while we wait for evidence-based psychotherapy”, we ‘advance’ to Prozac.

We will never get such ‘evidence-based psychotherapy’ as the research has already been done and replicated for decades and psychotherapy has barely beaten placebo. Nor is it likely that human nature will change or that someone can invent a new way of talking in talk therapy.

So ‘while we wait’ for the improbable we ‘advance’ to Prozac, the famous “Military’s Secret Weapon” from the cover of Time magazine^{xix}: “*If Prozac can make you feel better even if you are not depressed, why shouldn’t we all be taking it?*”^{xx}. It should be no surprise that it might make an adolescent feel a bit privileged to be told their parents are part of the problem and be invited to take such a popular adult drug, long before they would be eligible to legally buy a cigarette or alcoholic drink. Even with such advantages it marginally beat placebo. And because Prozac was associated with slightly higher suicidality it is recommended that CBT, which did not beat placebo on any measure, should be given because ‘*CBT protects against suicidal events*’.

This surprising logic might be dismissed as ‘an old American study’ except that recent Australian replications since have shown no additional benefit from adding Prozac to CBT^{xxi}.

Prescription drugs are now publicly conceded to be killing more Australians than illicit drugs.^{xxii}

There is Australian and overseas evidence that suicide rates rise following introduction of ‘suicide prevention’ programmes.^{xxiii}

[Info req 5.2 mental health treatment plans; 19.2 personal care days for mental health]

Forced labels: artificial conflation of diverse medical consumer groups as so-called ‘mental health’ or ‘mental illness’ groups creates an illusion of a ‘crisis’ or ‘epidemic’. Medical Benefits and campaigns to ‘normalize’ mental health/illness tend to reinforce this.

We welcome the DR consideration of “req 19.2 personal care days for mental health” as an alternative to having to concede to ‘mental ill-health’ or ‘mental disorder’ under 5.2 *mental health treatment plans*. Such labels can actually pass to the next generation in contexts in which their children may have to concede in a court dispute or tick a box when applying for something: ‘family history of mental illness’. The labels, rather than saving the economy millions of dollars, might as likely add to the intergenerational underclass of unemployed who regard themselves as ‘disabled’ with supposed mental illness ‘a disease like any other’, particularly if they are seen as needing drugs. The alleged stigma for common mental health problems disappeared decades ago^{xxiv}, so reducing ‘stigma’ will only make false positive labels seem more credible.

Arguments that these will not be mental health checks or psychiatric labels ignores the DR specific mention of “screening for perinatal mental illness for new parents”. Persons seeking, advised to seek, or sent for supposed ‘help’, once labelled as ‘at risk’ would be likely to attend a GP. To avail themselves of ‘free’ counselling or other treatment they would require a Mental Health Treatment Plan (MHTP). To sign a MHTP is to officially accept a diagnosis of a ‘mental disorder’.

The labels are tolerated because of such media reporting of the DR as : *“one in two Australians will be affected by mental ill-health including anxiety and depression and up to a million people don't get the help they need”*.^{xxv} MCA has consistently warned about the lack of onus of proof required in public inquiries for such figures to be relied upon unchecked. Compare that ‘one in two’ (50%) with the Submission #260 estimate of those who experienced a ‘serious mental illness’ each year as 3% of the population^{xxvi} , and these are likely to remain much the same people in the next census, not an increasing group. Nor is this anything new.

The entire underpinning of an alleged new crisis and people needing help had largely been based on suicide rank orders, numbers who access MHTPs to get an MBS rebate, and a single phrase from the Australian Bureau of Statistics (ABS) : *“perceived they had an unmet need.”*^{xxvii} Dr Raven (Submission #390) had pointed out to the ABS that its own Survey had actually found that 90% of ‘at risk’ people rejected a need for treatment, and the ABS was obliged to publicly correct this to *“10% perceived that their need for counselling was not met.”* Note - that is counselling, with no mention of drugs, much less ECT. The correction was submitted as #390 to the PC^{xxviii} and the DR now put it quite differently: *“... most people manage their health themselves .. “*

The RANZGP s has reported for some years that mental health is the #1 reason people attend a GP.^{xxix} But this is nothing new. Our MCA Foundation President Dr Erica Bates commented four decades ago that *“General practitioners say that between 20 and 50% of their patients show psychiatric problems and ask for a sedative, tranquilizer, or hypnotic.”*^{xxx} This never meant that such people should be confused with the ‘serious mental illness’ groups.

The perennial question is whether ‘mental disorder’ labels should attach from these millions of GP visits, let alone from early detection of ‘risk’ in children who have no say in the matter. Labelling is currently forced to be the case to qualify for subsidies under MBS Mental Health Treatment Plans. The Australian Psychological Society (APS) had warned the ACCC long ago about this: *“By restricting consumers wishing to access psychological services to the narrow mental health domain, there is a danger that not only will patients be forced into a mental health model, which may not be appropriate, but that some of this information that has been collected under false pretences, and may be accessed and used with potential negative consequences.”*^{xxxi}

[Info req 14.2 incentives for dsp recipients to work] clearly follows a medical model. It assumes the supposed ‘mental illness’ arises from within the person and is a barrier to them participating in work. The corollary is that if ‘prevented’ or ‘cured’ they will then contribute. The cause & effect can easily be the reverse: lack of employment opportunity contributing to mental ill-health, as acknowledged in *[Info req 25.2 ...contributing life outcomes]*

People declaring themselves mentally- disordered from workplace physical injury, bullying, sexual harassment, corruption, whistle-blowing, and discrimination may not be avoiding or ignoring work opportunities. To the contrary, their malaise may stem from not being allowed to work. This a ‘dispute’ rather than a ‘stigma’. The employer refuses to let them resume work or to transfer them to other duties for some other reason. The mental illness label becomes a weapon in the dispute rather than a concern for welfare.

Commonly these so-called ‘incentives’ to work turn out to be threats to remove subsidies, making them contingent on work-seeking. Even on the unrealistic assumptions of work availability and receptive employers there may well be nothing that people with serious mental illnesses would have to contribute to the workforce. This has been apparent for decades. Physical disability associations made MCA aware that sometimes their entire team of sheltered workers could not compete with the

process-work output of one or two able-bodied workers. These groups tend to be highly-motivated and acutely conscious of limitations.

Even voluntary work in the current employment climate is competitive. Much volunteer work is skilled and sometimes dangerous. Even a charity Op Shop requires applicants to be able to lift certain weights and interact with customers. Seriously mentally ill people with psychoses and personality disorders by definition may be disruptive and could well endanger and lower productivity of co-workers, negating any contribution.

[Info req 17.1 funding the employment of wellbeing leaders in schools; 18.2 what type and level of training should be provided to educators] *long-standing evidence contradicts the need for any hierarchical structure of 'skills' in 'treating' so-called different 'levels' of 'mental disorder' in the general population.*

The fundamental problem with most interventions is not whether they 'work'. The problem is the opposite - they all work roughly the same, including placebo. The issue then becomes "*Do we have the right to charge patients fees, or get the State to pay us for a treatment which is no better than a placebo?*"^{xxxii} Add to those costs the costs of false positive psychiatric labelling. The PC has been given submissions about restrictions of trade at odds with consumer & competition laws, to charge \$200-\$400+/hr, run up costs with excessive 'programmes', prevent well-qualified potential competitors from registering, and keep patients on waiting lists. These are the sorts of consumer issues that should be addressed by the ACCC.

Research has consistently shown talk therapies do not beat placebo or spontaneous remission even for adults, let alone children. This effectively leaves the default as drug treatment: "*... a psychosocial intervention that might be helpful for anyone - no harm done. but in the real world the kids would be getting antipsychotic medication ...*"^{xxxiii} How is it logical that rearing children on the commonly prescribed speed, major tranquillisers, and Prozac, branded euphemistically as anti-anxiety, anti-psychotic, and anti-depressant, would "*improve lives and slash the estimated \$500m a day cost to the economy*" as touted in PC press coverage? It seems more logical to expect 'drug history' and 'mental disorder' labels to render people less employable and compound the problem.

As pointed out in MCA Sub#19 the reason for the negative findings is nothing to do with lack of funding or skills but simply that human nature hasn't changed. A high level of spontaneous remission is a norm in therapy research.^{xxxiv} The relative ineffectiveness and risks of mental health treatments have been so well known for so long that it had been described in textbooks and APS archives^{xxxv} as *'The Specter at the Wedding Feast: where thousands of psychiatrists, psychoanalysts, clinical psychologists, social workers, and others celebrate the happy event and pay no heed to the need of evidence.'*^{xxxvi}

In line with the negative evidence long noted by the APS and part of their commissioned archive^{xxxvii}, the APS and the NSW Department of Health had consistently rejected any need for psychologists registration, let alone any multi-tiered hierarchy based on assumed specialities or skills. This is in line with *Comments from other interested persons submission #23: "The existing 'state of affairs' in relation to different rebates being offered to consumers of mental health accessing psychologists providing the same services has beggared belief since 2006 (see Pirkis, 2011²),^{xxxviii} however the now infamous Green Paper takes this lunacy to a whole new catastrophic*

2 Pirkis (2011. p.37) showed no significant differences in outcomes between registered and clinical psychologists.

level. This model has additionally been supported by other apparent 'go to' mental health experts in the mental health arena."^{xxxix}

Sub #23 is clearly not renegade malcontent opinion as it is in line with a long history of earlier APS policy and submissions to government inquiries:

"It is frequently incorrectly claimed that the APS originally proposed the two-tier Medicare system, but this is not the case.^{xi} ... For the past ten years the APS has continued to lobby to include more psychologists than clinical psychologists in the top tier: there are still some who object to non-medical professions being included in Medicare ...^{xli} ... What it does is to effectively limit other specialised and general psychologists from providing services to their clients when they are both appropriately trained and, in many cases, have extra training that makes their services more than appropriate. An even greater concern is that around half of all registered psychologists do not have an area of endorsed practice and still provide sound services to clients with both mental health issues and other health disorders."^{xlii}

These issues need not be addressed by the PC as they are entirely appropriate to the ACCC. Australian governments at state and federal levels have for decades regarded competition and consumer law as "our principal legislative weapon"^{xliii}. The official "ACCC view" cautioned that *"Members of the professions often present the view that rules prohibiting anti-competitive conduct should not apply to them as the conduct complained of has the purpose of protecting the public. ... Parliament has set up a mechanism whereby that conduct can continue with immunity from Court action - seek authorisation. That is, demonstrate that the public benefit of that conduct outweighs its anti-competitive detriment and obtain immunity from Court action for that conduct."*^{xliv}

The Royal Australasian College of Surgeons (RACS) for example sought authorisation (A90765) for accrediting hospitals, selecting, training, examining trainees and assessing overseas-trained surgeons.^{xlv} The RACS duly bowed to the law and made its case to the ACCC. This is in marked contrast to the mental health sector, which has never made such a case. All mental health treatments have been questioned by eminent authorities in their own field. Even proponents regularly testify that they do not know how or even whether their treatments work. Nor have they ever justified why the taxpayer is subsidizing and protecting their \$300+ per hour session fees.

[Info req 5.1 low-intensity therapy coaches as an alternative to psychological therapists; 17.1 funding the employment of wellbeing leaders in schools; 18.2 what type and level of training should be provided to educators]

Workforce – current hierarchies create a small highly-paid group with waiting lists and contrived anti-competitive bottlenecks, while a large unpaid or negatively-paid workforce is relied on for frontline services.

MCA welcomes the consideration of "low-intensity therapy coaches as an alternative to psychological therapists". Indeed, the unflattering 'low-intensity' epithet for coaches is unnecessary as psychological therapists of any level or discipline, whether psychiatrists, clinical psychologists, or counsellors have never demonstrated any outcome benefit over placebo, let alone over conscientious so-called 'paraprofessionals'^{xlvi} of the sort who might be attracted to these roles. *"... we are still not aware of a single convincing demonstration that the benefits of psychotherapy exceed those of placebos for real patients."*^{xlvii}

Consideration of the 'coaching' term is welcome as it moves interventions out of the 'sick role'. The term has caught on in the business world. Counselling connotes a deficiency and patronage. Coaching connotes a striving for greater success.

There would seem little risk in using therapy coaches. In our MCA submission #19 we provided references to decades of studies that had compared ‘paraprofessionals’, who could be badged as therapy coaches, with trained psychotherapists, with no proven benefit to the latter. A clear proof of reliance on non-registered paraprofessional can be seen on every government inquiry website, including the PC itself: *If you need help ... Lifeline*. The unregistered unpaid Lifeline volunteers continue to be trusted as the first responders.

MCA has long warned that the role and fee distortions in the mental health workforce warrant an ACCC inquiry. Consumers are being stung for as much as \$200-\$400/hr, with gap fees and wait lists, for therapies that often have long been shown to not even beat placebos. So-called ‘expert reports’ for courts can command thousands of dollars per report. Headspace costs an average of \$339 per session.^{xlviii}

Meanwhile qualified people are denied registration and the first responders remain the unpaid Lifeline and volunteer counselling workforce. They may exodus if they realize their volunteer hours count for nothing and will not further a career. This is unsustainable and some unsubstantiated claims about supposed ‘skills’ arguably violate Consumer and Competition laws prohibiting false promotions. The ACCC has targetted the health sector as its ‘new priority area’:^{xlix}

”Health claims and other benefits: Advertisements for health and medical services, and the benefits they provide, can have a powerful influence on consumers. It is essential that businesses selling health and medical products and services provide consumers with accurate and truthful information so they can make informed decisions. ... After the ACCC expressed concern about the claims, the manufacturer admitted there was no scientific evidence and therefore no reasonable grounds for making the representations.”^l

MCA is relieved that the DR made no conclusion on the highly contentious issues of who should deliver which supposed ‘tier’ of treatment, given the long history of lack of evidence for hierarchies of skills, including psychiatrists. Neither the DR nor the Victorian Royal Commission Interim Report (VRC) endorsed any particular stratification of workforce ‘tier’ roles, leaving an opportunity for an appropriate ACCC investigation.

As to bringing these questionable therapeutic interventions into schools by *17.1 funding the employment of wellbeing leaders in schools*, the school systems claim they are already burdened with too much extracurricular input, interfering with basic education. The problem has been described by education authorities as resistance to taking anything out of the curriculum in order to make room for the new inputs. So everything gets diluted. This proposed new career path overlaps with the existing school counselling roles. School counsellors were burdened for years with having to satisfy dual registration and professional development activities for both teaching and psychology. There is nothing apparent in the new proposals that would add anything that mightn’t be done more cheaply by giving resources and protections to existing staff.

[Info req 3.2 out-of-pocket costs for mental healthcare; 5.2 mental health treatment plans]

This should be addressed by an ACCC sector level inquiry. The Premiers and Chief Ministers *“...agreed that registration of these professions should be removed unless there is overwhelming evidence for retention.”^{li}*

Note that the default premise is not ‘balance of probabilities’, ‘business as usual’, ‘if it ain’t broke..’ or ‘innocent until proven guilty’, but registration ‘should be removed’.

The ‘overwhelming evidence for retention’ as required by the Premiers and Chief Ministers is overwhelming to the contrary. There have been decades of research showing no outcome differences attributable to supposed registered skills or training in the mental health sector.^{lii}

It is impossible to determine market prices for mental health services under the current system. Psychiatrists and clinical psychologists are subsidized massively by the MBS structure. While unregulated guru’s in the sector have survived every attempt at reform and remain free to compete by using whatever trendy neuro- bio- or scien- prefaced theory title that might impress lay consumers, the registered Allied health and self-regulated providers like counsellors pay the price. They are restricted to evidence-based claims and often charge fees in total not much more than the ‘gap fee’ to the higher-subsidised levels.

“... cartels can put honest and well-run companies out of business while stifling innovation and protecting their own inefficient members. Higher prices—cartels artificially inflate costs along the entire supply chain, causing businesses and their customers to pay more than they should.”^{liii}

The fees in the mental health sector are largely contrived and supply-side. MBS medical fees were initially based on existing guidelines and the APS had set up a recommended fee structure based on peer salaries. It has been CPI-adjusted annually.^{liv} Clients and patients have no such CPI-adjustment.

The ACCC has considered, and in some cases prohibited, fee setting agreements: *“ the following would risk breaching the Act if a decision is made between doctors practising through separate entities to: charge the same fee ... increase or decrease fees, agree fees, regardless of whether the agreement is actually put into effect by some or all of the doctors. ... Doctors practising through separate legal entities, or within a legal partnership with at least one corporate partner, are considered competitors for the purposes of the Act. Fee setting in this situation is illegal price fixing”.*^{lv} *“An independent practitioner can’t say “I want to operate as a sole practitioner but I want to agree my fees with other practitioners”.*^{lvi}

A recommended fee leads many to base their gap fees as the difference between their MBS subsidy and the recommended fee. Many then offer supposed ‘discounts’ to people unable to pay. This twisted Robin Hood logic means that far from any charitable motive they are effectively impressing their poorer patients with their ‘generosity’ by stinging their better-off patients for the money. *“However, the ACA Ethics Committee recommends against using a sliding scale. Why? Because it is discriminatory. A sliding fee scale charges people with larger incomes more for the exact same service that is being provided to clients with lesser incomes. Along those lines, it has been argued that a sliding scale can come across as gouging — that you are looking to squeeze as much money as you can out of an individual. That is why you aren’t charged according to income in a physician’s office, at the grocery store, at the gas pump or at the dentist.”^{lvii} “It may feel good to donate services to a particular client, but the psychologist who does so may be overcharging others in order to pay for that charity. It can hardly be called altruistic to donate someone else’s money.”^{lviii}*

Corporate Psychiatry of course has scope to do the same even more shamelessly as demonstrated in the US Congressional Hearings (Appendix 2): *“In the health care Industry, we talk charity care and we talk about contractual allowances and we talk about the patients that we don't receive payments on. In the psychiatric business that is not the case. In almost every case we'll agree up front that if a patient cannot pay for their deductibles and coinsurances, that we'll waive that portion and just collect the insurance benefits. So, if we have a \$35,000 bill and the co-insurance and the deductible is \$2,500, we'll collect \$32,500 on that bill.”^{lix}*

Price should be governed by genuine provision costs and consumer value rather than ability to pay. If artificially-inflated registration, continuing professional development, insurance and other

requirements make service provision uneconomical then that is a matter for the ACCC, as many of these requirements are contrived and unnecessary and should not be borne by consumers beyond market prices.

“Hypothetical scenario—Price fixing You attend a regularly scheduled trade association meeting. Afterwards, during refreshments, you find yourself chatting with a local competitor. The conversation eventually moves to the tightening of margins and profits in recent years. You agree with your competitor that business conditions are much tighter than they have been for quite some time and that things were better in the good old days. No problems here—you are simply exchanging views. Your competitor goes on to say that part of the problem is that the industry participants are ‘cutting each other’s throats’ and that the focus should be on lifting prices and margins. They state that the industry association should concentrate on improving the bottom line for members by putting out a guide on prices. Warning! Where there is an understanding between competitors to use a recommended price list as an industry wide price floor, then a price fixing arrangement has been made. You are non-committal and leave shortly afterwards. Several weeks later, you receive from your competitor an email containing a draft minimum price schedule and saying that most of the suppliers in the state like the idea and intend to use it. Act now! The agreement is clearly to fix, control and/or maintain prices, and would be illegal. You may be implicated if you do nothing, because it could be inferred that you tacitly agreed. You should seek legal advice and report the matter to the ACCC.”^{lx}

This ACCC warning sounds a lot like the regular communications within professional associations in the mental health sector, replete with all the elements such as an annual detailed ‘recommended fee’ schedule and emotive warnings about acting with “unity”.

The default is not to bleat to the taxpayer for more money to meet registration so-called ‘requirements’ but that these ‘should be removed’. The ACCC has acknowledged these contrived barriers for years and some medical bodies have duly followed the law and submitted their case. This has yet to be done for the mental health sector. If it ever comes to pass there will be no case. The evidence is already available and contrary to the restraints of practice.

[Info req 25.2 proposed indicators to monitor progress against contributing life outcomes]

This accurately portrays life outcomes as both cause and effect. Only the discredited ‘chemical imbalance’ proponents would argue that common ‘mental disorders’ arise through some mysterious medical plague independent of social factors. That may be the case for a proportion of the population with the traditional asylum-levels of serious mental illness, but it has little relevance to the common problems presented by walk-in GP patients. So ‘life outcomes’ like unemployment, chronic pain, family discord, and poverty are causes as well as effects of depression and anxiety. But monitoring of these is a monitor of society as a whole.

The focus on suicide can become a misleading indicator as it may reflect too many influences outside the mental health sector. In the likely case that future trends will follow current ones in which suicide rates rise following suicide prevention programmes^{lxi}, suicide as an indicator could make even successful programmes look like failures.

The req “5.1 low-intensity therapy coaches as an alternative to psychological therapists” has some potential for ‘monitoring progress’ as coaching takes the focus away from clinical improvements to more social ‘life outcomes’. Mental health indicators are commonly only at best tick-box rating scales. There are no mental illness bio-markers that can be calibrated against life outcomes. Even

general medicine, with X-rays, DNA and biochemical tests has such limitations^{lxii}, let alone mental health.

The 'positive psychology' movement has some potential for monitoring progress away from the clinical focus but there are limits to what should be expected. Too much reliance will be placed on interventions like CBT when the evidence is misleading. The supposed 'dysfunctional thoughts' that are assumed to be correctable with such talk therapies can be just as elusive and possibly non-detectable as the supposed 'chemical imbalances' assumed to be 'correctable' with drugs and ECT. It is not irrational to be depressed or anxious about unemployment, school bullying, or pain, for example.

Conclusion

Given the updated evidence available to the PC, it seems far more likely that, instead of saving \$500,000,000/day, expenditure and suicide rates will all increase.

MCA believes that only an inquiry that reverses onus of proof, in particular the ACCC, can avoid the problems inherent in the public inquiry route. Quite a lot of information resides in the hundreds of submissions to the PC, but without onus of proof and standing to cross-examine, the political process will remain forever bound to showing the public that they have relied on 'the experts'. These will invariably be those best-funded. There is no money made in critique. There are vast fortunes to be made offering therapies and drugs.

Tom Benjamin

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declared interests: registered psychologist, adjunct university lecturer, expert witness, non-funded

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