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Productivity Commission - Mental Health

Preliminary Submission to Productivity Commission Mental Health Inquiry

background readings

Anticipating an abundance of submissions closer to the April deadline for this Inquiry the MCA offers below a selection of background readings from authoritative sources that may help in assessing submissions.

MCA believes that only an enforcement of existing Competition and Consumer legislation, which places the onus of proof onto those lobbyists who support and propose anti-competitive practices, will bring any improvement in this sector.

This preliminary reading selection provides background for our more comprehensive, fully-referenced, submissions to follow in Feb-March. It covers these points

1. **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 only reinforce this.
2. **Treatment fallacy:** long-standing evidence contradicts any hierarchical structure of 'skills' in 'treating' different levels of 'mental disorder' in the general population.
3. **Detection fallacy:** seductive concepts such as 'early detection' have no scientific basis and historically have demonstrated perverse financial incentives for abuse
4. **Workforce** – current hierarchies create a small highly-paid group with waiting lists and contrived anti-competitive bottlenecks, while a large group of unpaid or negatively-paid people is relied on for frontline services.

1 Forced Labels

Concerns of the Productivity Commission Inquiry regarding *“involuntary incarceration, unnecessary hospitalisation and use of seclusion and restraint”* clearly apply to the Kraepelinian major mood and psychotic illness groups and other serious conditions who require in-patient treatment. These have remained a constant proportion of the population, these days bolstered by illicit and prescription drug users. But those requiring in-patient treatments are nowhere near the figures nowadays cited of *“Almost half of all Australian adults have met the diagnostic criteria for an anxiety, mood or substance use disorder at some point in their lives, and around 20% will meet the criteria in a given year (ABS 2008)”* The medicalizing of anxiety, mood and substance use lumps half the population in with the in-patients as having a 'history of mental illness'. It is worse when the alleged illness is promoted by vested interests as a 'brain disease' or 'chemical imbalance'.

The current Medical Benefits Schedule eligibility provisions encourages labelling of persons as having 'mental disorders' as defined by ICD-10. Campaigns citing ABS figures of alleged high

incidence of mental illnesses are not referring to the Kraepelinian major mood and psychotic illness categories but rather to depression, anxiety and alcohol overuse in the general population. This is termed 'diagnostic inflation'. The MBS clearly tempts people who might otherwise be seeking a non-health service such as guidance, advocacy, mentoring, marital advice, social work, industrial or legal advice to use the MBS funding to get 'free' subsidised consultations with a professional person. But it also gives them a potentially stigmatic lifetime label as 'mentally disordered'. Efforts to 'normalise' mental illness, from lobby groups with vested interests, have only served to make this labelling seem more acceptable. A high price for the bulk-billed service might be paid if they are ever turned down for a job, custody arrangement, gun ownership, or insurance claim on the basis of a documented mental disorder.

Dr AJ Frances, Chair, Task Force for the Diagnostic and Statistical Manual (DSM-IV) "... *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.*

... We can't have experts in an area determine that area. ... These can have a profound impact. Tens of millions of people can be made into patients by the jotting of a pen or the typing of a computer key."

MCA strongly recommends that the Productivity Commission Mental Health team listen to Dr Frances, (2015) on YouTube, such as *the overdiagnosis of mental illness*
<https://www.youtube.com/watch?v=yuCwVnzSjWA>

2 Treatment Fallacy

The Productivity Commission Inquiry seeks "*a more flexible workforce, driven by consumer demand and trained and distributed by competencies rather than professional categories*". The MCA warns that evidence has been available for decades in textbook psychology that there are no proven benefits to professional training in the mental health sector at any level, including the more 'serious' cases. Nor is there necessarily an informed "*consumer demand*" as consumers know only whether they get better, rather than how or why. It is difficult for researchers to demonstrate that treatments beat placebo conditions like 'waiting list controls'. In contrast to many medical or dental conditions, psychological conditions can improve spontaneously with no treatments.

The well-known articles cited below refer to 'talk therapies'. The physical treatments for the more serious cases in the sector such as Insulin Coma, ECT, Deep Sleep, Psychosurgery and Drugs are even more contentious. Nor is there any proof of detection or treatment efficacy in the general population outside the traditional 'asylum' levels of serious mental illnesses requiring custodial care. Application of mental health labels to the wider population is 'diagnostic inflation'.

Nor should these be dismissed as 'old' findings as there are no grand scientific breakthroughs in talk therapy. The levels of training and remuneration should not be glorified as anything more than trade practice breaches of competition and consumer legislation. It is not merely that they have no scientific or clinical basis. Rather, there is evidence and it has been overwhelmingly against need for such anti-competitive regulation.

This also negates any potential value for services to be "*distributed by competencies rather than professional categories*". That there is no evidence for training, competence, or even weeding out incompetence has been duly noted by Australian state government reports over many years: "*may enshrine anti-competitive practices which do not serve the interests of consumers ... no matters resulting in disciplinary action have involved lack of competence. The cost of annual competency assessment cannot be justified.*" (NSW Department of Health, Review of Psychologists Registration Act in 1989).

By Hattie, John A., Sharpley, Christopher F., Rogers, H. Jane *Comparative effectiveness of professional and paraprofessional helpers*. Psychological Bulletin, Vol 95(3), May 1984, 534-541
Used meta-analysis to resolve some of the contentious issues raised in the debate between J. A. Durlak and N. T. Nietzel and S. G. Fisher about the relative effectiveness of professional and paraprofessional counselors. Effect sizes based on 154 comparisons from 39 studies show that clients who sought help from paraprofessionals were more likely to achieve resolution of their problem than those who consulted professionals; moderators of this conclusion were related to experience, duration of treatment, and the manner in which effectiveness was measured. It is concluded that there is substantial evidence that paraprofessionals should be considered as effective additions to the helping services, at least when compared to professionals.

Durlak, Joseph. (1979). Comparative Effectiveness of Paraprofessional and Professional Helpers. Psychological bulletin. 86. 80-92. . *The outcome and adequacy of design in 42 studies comparing the effectiveness of professional and paraprofessional helpers are reviewed. Although studies have been limited to examining helpers functioning in narrowly defined clinical roles with specific client populations, it is argued that the findings are consistent and provocative. Paraprofessionals achieve clinical outcomes equal to or significantly better than those obtained by professionals. In terms of measurable outcome, professionals may not possess demonstrably superior clinical skills when compared with paraprofessionals. Moreover, professional mental health education, training, and experience do not appear to be necessary prerequisites for an effective helping person. The strongest support for paraprofessionals has come from programs directed at the modification of college students' and adults' specific target problems and, to a lesser extent, from group and individual therapy programs for non-middle-class adults. Future studies need to define, isolate, and evaluate the primary treatment ingredients of paraprofessional helping programs to determine the nature of the paraprofessional's therapeutic influence.*

"The frequency with which harm occurs, however, remains open to question. Unfortunately the tendency has been to use anecdotal reports as proof that encounter groups are so dangerous that rigid regulation is needed. Yet a similar array of horror stories could easily be assembled about highly credentialed psychiatrists and psychologists, all of them licensed." Hogan, D The Regulation of Psychotherapists. (1979). A Study in the Philosophy and Practice of Professional Regulation Cambridge, Mass.: Ballinger Publishing Co.

Eysenck, H. J. (1952). The effects of psychotherapy: an evaluation. Journal of Consulting Psychology, 16(5), 319-324. *"A survey was made of reports on the improvement of neurotic patients after psychotherapy, and the results compared with the best available estimates of recovery without benefit of such therapy. The figures fail to support the hypothesis that psychotherapy facilitates recovery from neurotic disorder"*

3 Detection Fallacy

The Productivity Commission Inquiry seeks "prevention" and "early intervention", which would be standard public health goals in many areas of medicine. MCA warns that extrapolating this to mental health, however, is dangerous and invites exploitation. Adolescents in particular have been the targets of 'bounty-hunt' mental-illness labelling in order to obtain government subsidy.

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

The Texas Senate Inquiry heard testimony such as "They, they had suggestions like schools, uh hospitals, uh counselors, anyone that you knew of that might run across a patient or a person who was a potential patient that would need help, especially during uh, the holiday season when, when there would be you know, people alone and, and need someone to talk to". (former hospital staff

member to committee chair, October 25, 1991)

It was largely because of response to the TV show that there was a subsequent review and rejection of the applications, such as from WA Health

"In my view the following scenarios are not unrealistic:

- *Hospitals will solicit direct referrals from GPs for payment of a bounty and then trade favours with specialists to look after them in private hospitals.*
- *Payment of emergency room staff in public hospitals to divert promising patients to the private system*
- *Multiplication of programs run by clinical psychologists.*
- *Expansion of ineffective in-patient programs in Psychiatry and medicine. There are many medical conditions where the level of discretion over admission is high as demonstrated by our own analyses in recent years in WA country hospitals. ..."* (WA Health Minutes March 1993, obtained by Brian Martin, Uni of Wollongong)

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Dr AJ Frances Chair of Task Force Diagnostic and Statistical Manual (DSM-IV) warned in 2015 *"...the idea that we could predict psychosis and prevent it was the thing that got me started on on this crusade because it seemed to me that there was no more dangerous thing we could do than pretend we could predict psychosis and treat it with medication that would be harmful. it turns out that only one in 10 people identified to be at risk for psychosis actually goes on to have psychosis - and that may be a high number. so you'll be misidentifying nine out of 10 to pick out the one who really needs your help. there's no effective treatment. the studies that have been done so far show no effective treatment preventing psychosis. and here's the hooker - in the hands of the people making the suggestions, that intervention would be a psychosocial intervention that might be helpful for anyone - no harm done. but in the real world the kids would be getting antipsychotic medication ..."*

4 Workforce

The Productivity Commission Inquiry seeks *"increased output for the community from a more productive workforce"*. It speaks for itself that the Commission's own website says: *"If you need specific help or advice, you can contact one of the services below: Lifeline Australia..."*. Lifeline relies on volunteers who pay out of their own pockets for training. They have negative incomes; ie, they pay to work. Also in this category are provisional psychologists, for many of whom the only way they can accrue the thousands of hours to be eligible for registration is to work for free, while paying for their own offices, insurances, and petrol if they are required to be mobile. These are the frontline services expected to become *"more productive"*.

Meanwhile many psychiatrists remain unavailable with long waiting lists, *"especially in regional and remote areas, many of which are experiencing shortages"*. Not content with the bulk-billed \$221/hr, some add gap fees of up to \$200 and can claim many sessions per patient. If this is justified by their supposed responsibilities for supervising drug treatments, a medical monopoly granted by law, then the onus of proof under Competition and Consumer legislation is not on critics of such treatments but rather those who have called for the legislation that underpins the monopoly. Prescription drug overdoses and addictions are a major current concern in the legislatures of Western countries so it is illogical to automatically assume that current practices are protective of the public: *"Prescription drugs used to manage pain, anxiety and depression are killing more West Australians than meth and heroin combined."* (*The West Australian Thursday, September 28, 2017*) ... *"No area of the United States is exempt from this epidemic—we all know a friend, family member, or loved one devastated by opioids,"* (*Center for Disease Control, Principal Deputy Director, 2018*)

Competition and Consumer legislation would allow the medical profession to make a case for exemption from scrutiny. Professor Fels' (1997) gave the 'ACCC view' that *"Members of the professions often present the view that rules prohibiting anti-competitive conduct should not apply to them as the conduct complained of has the purpose of protecting the public. ... But if there is*

something that is anti-competitive and it really is for the patient's benefit or client's benefit that is, for the public's benefit (as distinct from being a private benefit for the doctors/lawyers etc) - then Parliament has set up a mechanism whereby that conduct can continue with immunity from Court action - seek authorisation. That is, demonstrate that the public benefit of that conduct outweighs its anti-competitive detriment and obtain immunity from Court action for that conduct.” [Prof. Fels' underlining].

In other words, MCA is merely calling for enforcement of existing law.

The devastating implications of many proposals to set up tiered structures based on the scientifically-fallacious notions that more 'serious' levels of 'mental disorder' justified more supposedly specialised and skilled 'board-endorsed' practitioners was summarised by one of the APS reform groups:

“To illustrate: I live and work in a community of approximately 20 000 people, and I receive additional referrals from surrounding towns. We have 4 part-time non-endorsed psychologists and 1 full-time clinical psychologist, who specialises in chronic pain management. My waiting list varies anywhere between 1 and 3 months at any time. Likewise, the waiting list of the clinical psychologist varies between 1 to 3 months. Under the APS 3 Tier model, and according to the data cited above my caseload will be reduced by 90%. Those clients will need to be referred on to the clinical psychologist who, as already pointed out, has a wait-list of 1-3 months now, or to our already stretched community mental health service. There are 3 other non-endorsed psychologists who will have to refer their clients on as well. The most likely scenario is that, with our caseloads reduced by 90%, the non-endorsed psychologists in this community will be forced to close our businesses, further reducing access to services. Clients in need of intervention will be forced to wait for extended periods of time, travel at least 100km to see another psychologist for timely care (at their own expense), or utilise Telehealth. Telehealth is an excellent facility, but it does not solve the problem of access, given that 90% of referrals will still need to be serviced by only 40% of psychologists.” (Cahill, L (2018) Reactions to the APS Medicare MBS Submission. Reform Australian Psychological Science –'RAPS'. <https://reformaps.org/reactions-to-the-aps-medicare-mbs-submission/>

Even ignoring the overwhelming evidence that training has no correlation, sometimes negative correlation, with outcomes in mental health, the current system doesn't actually even have the supposed higher levels of training:

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

(Cahill, 2018, citing Hyde, J I (2015) Australian Clinical Psychology Association (ACPA) to Australian Government Department of Industry Tracking Code: 66FRVA Skilled Occupation List (SOL) 2015-16<https://industry.gov.au/Office-of-the-Chief-Economist/SkilledOccupationList/Documents/2015Submissions/ACPA.pdf>