Submission to the Select Committee into Mental Health and Suicide Prevention

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I have been a registered and practicing psychologist since 1988, having obtained training in the form of a B. Arts Degree (psychology & sociology), a Post Graduate Diploma in Counselling Psychology, two years internship during which I underwent supervised training, and a PhD in clinical health psychology. To date, I estimate that I have worked with somewhere between 5,000-10,000 clients during the last 33 years as a psychologist.

The link between antidepressant drugs & suicide.

Despite routine statements that it should not be the case, the prescription of psychiatric drugs (primarily antidepressants) is usually the first line treatment option offered to Australians suffering from depression and. Despite clear research evidence that antidepressant drugs are not effective for mild to moderate depression, most prescriptions for antidepressant drugs are made out to people reporting mild to moderate depression. Despite clear research evidence that antidepressant drugs increase the rates of suicidality and suicidal behaviour, antidepressant drugs continue to be the main form of treatment which sufferers of depression are offered.

Just two years before I began my career as a psychologist, the 'new generation' antidepressant Prozac was released, the first of the Selective Serotonin Reuptake Inhibitors (SSRIs.) SSRI antidepressants were promoted on the basis of a chemical imbalance theory. The drug was created decades earlier, but shelved due to its uses being unknown. By the 1980s, neurology research had revealed that the brain chemical, serotonin, was relevant for a range of experiences such as mood and social behavior, appetite and digestion, sleep, memory, and sexual desire and function. Serotonin is merely one of hundreds of neurotransmitters, the levels of interconnectedness of which are still beyond the comprehension of current neuroscience. Most neurotransmitters play a wide range of functions in the brain and impact on many different biological systems. When the drug companies learnt that serotonin had a relationship to mood, the *marketing* executives (note: not the research scientists) decided to brand SSRIs as *antidepressants*, and literally created the theory that depression resulted from not enough serotonin in the brain. With billions of dollars poured into promoting the theory, their marketing strategy was hugely successful- the serotonin deficiency theory quickly became *the* conventional wisdom in regards to depression. Every talk-back radio host, every health editor, every 'well informed' person just *know* that not enough serotonin causes depression. This conventional wisdom has seen the prescription rates of antidepressant drugs, not just SSRIs, skyrocket in the last decades by hundreds of percentages. Before Prozac, depressed people were twice as likely to be treated with psychotherapy/counselling than with antidepressants. Today, for every one person receiving psychotherapy/counselling for depression there are four people taking antidepressant drugs. What is the point of trying to deal with your problems psychologically when you've been led to believe that you are suffering from a brain disorder, requiring a pill?

UK Professor of Psychiatry, Dr David Healy obtained the 'hidden' data set from the clinical trials pertaining to SSRI antidepressants. In order to obtain approval for the release of SSRIs onto the market, the pharmaceutical companies had kept hidden unfavourable results, publicly releasing on the favourable results. When Professor Healy obtained the hidden date via various freedom of information acts around the world, he conducted the statistical analysis with the entire data set, and concluded that SSRIs result in an increase in suicidality, not a decrease. Healy (2004) states that his research demonstrates a *seven fold* increase of suicidal ideation and the doubling of completed suicides for people on SSRIs (when compared to equally depressed people not on SSRIs).

Perhaps being aware of the problems associated with antidepressants, the Howard government made significant efforts to increase access for Australians to psychological care. "Although the Howard government hoped the program (Better Access to Mental Health) Health would result in a decline of taxpayer-subsidised antidepressants, the number of prescriptions written in Australia for these drugs since 2006 has increased by 382,738 to more than 12 million last year" (Editorial- The Age, June 20th 2010). Clearly, the problem is getting worse, not better.

My involvement with GPs dramatically rose with the introduction of Medicare rebates for psychologists introduced in November 2006. Suddenly, more than half of my private practice case load were GP referrals, as GPs are the 'gate-keepers' to these rebates via mental health care plans. Prior to this, most of my clients were either self-referred, or referred by Employee Assistance Programs as part of employee entitlements. As such, most of my previous case load was with people who had not come to me via a medical pathway, however since late 2006 at least half of my case load derives from a GP referral. This increase in GP referrals has given me more experience in what appears to be conventional medical responses to such issues as depression and anxiety. It has also given me the opportunity to work more closely with many GPs and to see that for the most part, these are caring professionals who are genuinely well intentioned.

While not maintaining any statistics on the issue, my estimate is that around 75% of people referred to me by GPs come already having been placed on antidepressants, usually SSRIs, and often benzodiazepines or mood stabilizers in addition. The overwhelming majority of these people present with symptoms which clearly suggest either the early stages of negative side effects, or an established pattern of the same, depending on how long they have been on the drugs. Around 60% of people placed on antidepressants find the side effects so intolerable that they do not continue on them beyond the initial few weeks (Healy 2004). The other 40% typically present with many of the following symptoms, eg. worsening depression, anxiety and panic attacks; increases in suicidal ideation, and sometimes self-harming behaviour; psychological as well as physical agitation, and often increases in substance use to counter this; mania and hypomania, reflected in reports of 'out of control' behavour that 'just isn't *me'*; sexual dysfunctions; insomnia as well as lethargy; nightmares and terrors; electric shock like sensations in the head, as well as a myriad of other odd physical sensations, including

new chronic pains (medically inexplicable), nausea, dizziness, headaches, tinnitus, bowel and digestive system abnormalities.

Many of the 40% of patients who remain on these drugs have been suffering on them for years, lacking the confidence to defy their physicians recommendations and withdraw. This lack of confidence is usually bolstered by experiences of failed attempts to withdraw themselves, often 'cold turkey' or at least too quickly, resulting in terrifying withdrawal effects. To compound the problem for these sufferers, they tend often to respond to medical cues and invitations to view these symptoms as resulting from a worsening of their condition, eg. depression, rather than attribute them to the symptoms of the drugs. When a sincere and respected physician authoritatively tells a patient that the drugs *can't* be creating these symptoms, a significant part of the population are prone to believe them, now more vulnerable due to their increased suffering. People who are suffering tend to be vulnerable to the influence of those in credible positions of authority, even if just out of sheer desperation. The greater the suffering, the greater the vulnerability to this influence. As such, the sense of despair and hopelessness deepens and a vicious downward spiral can be created.

If this is all so apparent to me as a psychologist, why is it not so apparent to intelligent and conscientious GP's? This question has puzzled me greatly. To date, I have settled on the explanation that when many of the current crop of mid-career physicians were embarking on their careers in medicine, the SSRIs were being heralded as the new 'wonder drug'. Commencing my own career in psychology during the same era, I remember wondering if I had not just been made redundant by this advance in pharmaceuticals. This concern was only stemmed by my reading in the early 1980's of Peter Breggin's book 'Psychiatric Drugs and their brain disabling effects'. The marketing of the SSRIs drugs in the late '80s was so effective that few members of the public could have remained ignorant of them, and they had not yet been around for long enough for the industry claims of 'no SSRI side-effects' to have been proven false. The promise of relief from emotional suffering was now as close as the doctors prescription pad. Due to the effective marketing and the plethora 'good news stories' in popular media, the placebo effect was in full force. (The placebo effect was well demonstrated by Kirsch 2009). The pharmaceutical marketing reinforced everyone's confidence, especially the prescribing doctors confidence, that the ultimate answer, in the shape of a pill had been found.

Placebo effects are one matter, with the evidence in regards to the SSRIs calling into question the legitimacy of the very term *anti*depressant. Were the SSRI story to end there, merely with the placebo findings, one may conclude that they were relatively harmless. The issue of psychological and physiological damage is quite another matter however. It can take years for reports of adverse reactions to filter through to authorities in such numbers that demand attention. On a clinical level, it appears that many physicians are more attached to the promise of SSRI safety and effectiveness than they are to an open minded receptiveness to their patients reports of deterioration of their condition. This appears to be a psychological need of the physician. It is an anomaly that I can only understand in relation to the marketing successes of pharmaceutical companies and the construction of depression as a medical illness.

My view is that depression and anxiety are not illnesses requiring medical attention. Our culture used to have a term which covered most of these experiences- it was called *life.* Some experiences in life can be entirely problematic – prominent psychiatrist Professor Thomas Szasz wisely referred to them as 'problems in living'. Fortunately, most of the problems in living which are currently being treated with SSRIs and other antidepressants tend to be resolvable with:- genuine care, concern and support from professionals or friends; problem solving strategies (perhaps involving legal, economic, social and interpersonal solutions); and with brains that are not being further compromised with introduced neurotoxins in the form of drugs, either illicit or medically prescribed. Those requiring more intensive psychological care are likely to be suffering from the sequalae of psychological trauma. Tragically so much of the apparent damage being caused to people with the mass prescribing of such substances is unnecessary- viable alternatives exist, and are now financially accessible via Medicare rebates. Unfortunately, it seems that allowing GPs to play the role of gatekeepers to psychological services has only ensured that through the required medical contact, the amount of scripts for antidepressants has radically escalated.

Anti-depressants and the problematic 50%

Professor Allen Roses (2008), Drug Discovery Institute of Duke University and former Senior Vice President for Genetics Research at GlaxoSmithKline, states that more than 50% of drugs don't work in more than 50% of people. According to Andrew Somogyi (2008), Professor of Clinical and Experimental Pharmacology at the University of Adelaide, this estimate has stood up to the test of time. Why would we assume that psychiatric drugs could be any different? One of the reasons perhaps is that most GPs have experience with the non-problematic proportion of people who do appear to benefit from these medications- such outcomes are bound to make almost any health care professional an enthusiast. It is surely rewarding to see such people improving as the result of one's intervention, and many of these patients are genuinely grateful for the help which has been provided. However, the fact that around 60% of people prescribed anti-depressants do not take them for more than 2-3 weeks as a result of adverse side effects (Healy 2004) suggests that Professor Roses' estimate also applies to psychiatric drugs as much as to those used in general medicine. Moreover, of the 40% that do remain on the drugs, it is possible that a significant proportion do so while experiencing adverse side effects and a deteriorating condition. In regards to these patients, a selective medical bias can develop whereby these people are seen as suffering from a deterioration of their original condition (eg. depression), and not as suffering from adverse side effects. It is perhaps difficult to believe that a drug so helpful to one patient could be so harmful to another, but this is Professor Roses' main point- an enormous variation in response exists to all drugs.

This possibility is borne out each day in my clinical work as a psychologist where a significant amount of the clients I am working with present with an adverse side effect profile, typically in response to SSRI anti-depressants. Around 10% of the Australian population is currently on SSRIs, meaning that if Professor Roses is correct in his estimate, a

possible 500,000 people may at any one time be doing badly on these drugs in varying degrees. Some of those who do not benefit from SSRIs present with few adverse side effects other than perhaps a failure to 'get better'. That is, they defy the statistical norm which sees the vast majority of depressive episodes resolving within around 3 months (Jureidini, in Beddoe 2007). As such people can remain somewhat depressed for many years, or even for decades whilst on anti-depressants, it is reasonable to conclude that the drug is not working for them. Other people can present at the more extreme end of the SSRI adverse effect profile, with symptoms as described earlier.

Pharmacogenomics & psychiatric drugs.

Why is there such an apparent variation in response to SSRIs? If humans share 99.9% of genetic make-up, it falls to the remaining 0.1% of genetic difference to account for differing responses to all medications (Mitchell 2008). There is no reason to assume that this would be any different for anti-depressants. Any of the 10 million genetic mutations, referred to as single nucleotide polymorphisms (SNPs), can create different responses to the same medications, from the life-saving to the life destroying. It is estimated that around 7-10% of the Caucasian population lack liver enzyme P450 CYP2D which plays a key role in breaking down many kinds of medications, including SSRIs (Breggin 2001). These 'poor metabalisers' have around one ninth of the normal ability to degrade and eliminate drugs from their body, resulting in severe reactions to even routine doses of drugs like the SSRIs. In addition to this genetic vulnerability, some drugs, including SSRIs can inhibit the activity of one or more of the P450 enzymes. As a result, the metabolism and elimination of the drug is being inhibited by the drug itself, again resulting in toxicity to both the SSRI and other medications. Breggin (2001) states that all SSRIs can inhibit the functioning of one or more liver enzymes.

Some people honestly report that SSRIs, or other psychiatric drugs such as benzodiazepines, lithium, anti-psychotics, are helpful for them. Other people honestly report that the drugs nearly killed them, either psychologically or physically, or both. Neither groups of people are lying. The answer to this anomaly lies in the study of pharmacogenomics (aka phamacogenetics). This is the science of genetic predispositions to varying abilities to break down (metabolise) and expel various chemicals. When applied to psychiatric drugs, pharmacogenetics explains the role of a specific group of liver enzymes (the CYP450s liver, the amounts of which we inherit from both parents) in the expulsion of drug chemicals. We all differ in our loading of these specific liver enzymes, whose only role is the metabolise and expel drugs which effect the functioning of the brain (psychoactive drugs). This includes all psychiatric drugs such as SSRIs, as well as nicotine, caffeine, cannabis, alcohol, amphetamines, psychedelics, opiates, etc. The evidence of this is seen in some people who appear to be hardly affected by a particular drug, while another person appears to have no tolerance of it at all.

Within the small grouping of CYP450 liver enzymes, we can be either:- **poor metabolisers** (with virtually none of the required enzymes); **intermediate metabolisers** (a semi loading of the enzymes); **adequate metabolisers** (a full loading of the enzymes); or **ultra-rapid**

metabolisers (more than the full loading). In regards to any particular drug, the poor or intermediate metobolisers can be expected to experience adverse side effects, while the adequate and ultra-rapid metabolisers can be expected to not suffer these. A person can have the full genetic 'loading' of one of the CYP450 enzymes (making them an adequate metaboliser of substances that are processed by that particular enzyme), a partial loading of another CYP450 enzyme (making them an intermediate metaboliser of different psychoactive substances), and a zero loading of another CYP450 enzyme (making them a poor metaboliser of other substances). This variance explains why the one person may be able to tolerate high amounts of alcohol (or a benzodiazepine), but have very little tolerance for cannabis (or an SSRI), or why a person can tolerate one psychiatric drug but not another.

My concern is for the patients who are displaying a deterioration of their condition since being put on an SSRI. Unless the physician is open to the prospect of adverse reactions as relatively common experiences, the course of treatment is often to increase the dosage levels, and/or to introduce additional drugs such as minor tranquilisers, mood stabilizers and even neuroleptics as the condition worsens. Although the pharmaceutical companies promote the notion that SSRIs take 2-3 weeks to be effective, the concentration of serotonin reaches a maximum level within 24-48 hours of commencing an SSRI (Beddoe 2007). It is during the times of dramatic changes in serotonin levels (as per introduction, increase or decrease of an SSRI) that patients can experience the most intense adverse reactions. These reactions can include an increase in both depressive symptoms and akathisia. Healy (2004) states that this increase in agitated depression manifests in the observed *seven fold* increase of suicidal ideation and the doubling of completed suicides for people on SSRIs.

Are these catastrophic reactions due to the natural history of the condition, or to the medication? Healy (2004) attempted clarify this by conducting a 'well group study', whereby a sample of 20 healthy people with no psychiatric histories were placed on one of two anti-depressants (one being an SSRI) for two weeks. Healy (2004 p.180) reports "two-thirds of the group felt significantly worse on one of the two drugs- not simply by virtue of inconvenient side effects...but in terms of being depressed or disturbed…". Two participants in the study became actively suicidal for the first time in their lives after only a couple of days on the drugs. Many well group studies conducted by the SSRI companies have found similar results, however these are rarely published. Only twelve out of fifty three studies relating to Prozac, and fourteen out of thirty five well group studies have been reported on. One can only conclude that the unreported studies are as unfavourable to the antidepressants as was Healy's study.

Professor Healy (2004), also a practising psychiatrist and former enthusiast of SSRIs, makes the point that anti-depressants have only been found useful for people who experience episodes of major depression. Psychiatrist and Head of Psychological Medicine at Adelaide Women's and Children's hospital, Jon Jureidini (in Beddoe 2007) states that "there is now general agreement that antidepressants are no more effective than placebo for treating mild depression. … As few as 3% of those receiving antidepressants from GP's suffer from severe depression.". As such, the vast majority of scripts for anti-depressants (that is, 97%) are prepared for a condition (mild to moderate depression) for which there is no proven efficacy.

There are viable alternatives to medication for most depressed patients. While there are debates within psychology as to which therapies have the most demonstrated efficacy in treating depression (see King 1999), most forms of conventional psychological approaches will assist with most episodes of depression, generally depending on the practitioner's years of experience and subsequent quality. It has also been clearly demonstrated by Mynors-Wallis**,** Gath**,** Day**,** Baker (2000) that GP's are able to assist depressed patients, achieving the same results as anti-depressant medication, utilising a simple Structured Problem Solving approach- there is, obviously, no risk of adverse side effects. In addition, Mynors-Wallis etal (2000) found no additional benefit to adding anti-depressant medication to the Structured Problem Solving. Where GP's learn this model, referrals to psychologists for more complicated, non-drug alternatives are usually not required.

Conclusion

Psychiatric drugs, in particular antidepressants, are a significant causal factor in escalating suicide rates in the Western world. With GPs becoming the 'gate-keepers' for access to psychological care, a radical increase in prescription of antidepressants drugs has been observed in Australia since the inception of the Better Access program. This radical increase in prescription of antidepressants has coincided with a radical increase in suicide rates- these observations are causally related. The sincere attempts to treat depression and anxiety in our country have resulted in increased treatment with psychiatric drugs and a consequent increase in suicide. In order to decrease suicide in Australia, we need to implement policies which result in a decrease in the prescription of antidepressant drugs. Psycho-social care is the main alternative to pharmaceutical treatment, and needs to be bolstered and supported in order that the public have more access to effective and safe treatment. The next section will discuss changes in Australia's psychology workforce needed to ensure greater access.

The Psychology workforce.

Most mental health practitioners in Australia are registered psychologists. In order to become a registered psychologist, one needs to undergo a minimum of 4 years academic study, 2 years internship and a commitment to ongoing professional development. Most of Australia's registered psychologists also have extensive post-registration training in psychotherapy, as well as higher degrees such as masters degrees and PhDs. The extent of training is comparable with most psychologists around the world.

When the Better Access program was initiated, the Australian Psychological Society (APS) managed to convince the Howards government of distinctions between types of psychologists. As clinical psychologists were in charge of the APS, they created a narrative which proposed that clinical psychologists are higher trained, higher skilled and achieve better results with their clients than non-clinical psychologists. There is simply zero research evidence to support this claim- in fact, the only relevant research evidence (conducted by Melbourne University to evaluate the Better Access program) found the exact opposite to the claims of the APS. It found there to be no differences in the severity of cases worked with; no differences in the types of treatments offered; and no differences in the outcomes of

treatments. In addition, close to 50% of psychologists 'grandfathered' into the status of being clinical psychologists had no masters or doctoral degree level training at all.

The only genuine difference between clinical psychologists and all other registered psychologists is the amount of payment they receive by Medicare for the provision of services. Clinical psychologists are paid by Medicare nearly 50% more than registered psychologists for providing the same service, to the same clients, for the same outcomes.

This state of affairs has ensured that in order to make a living which is higher than an equivalent of work for the dole income, registered psychologists need to charge a gap fee. The Melbourne University research also found that despite being paid a substantially higher rate, most clinical psychologists were still charging gap fees as well. The need which registered psychologists and mental health social workers have to charge gap fees in order to make a living become a barrier to service consumers accessing the required services. The quandary is that without charging a gap fee, the business model for most registered psychologists would be unviable- and in order to have psychologists available to consumers, psychologists need to be financially viable. The financial difficulties thus create a disincentive to provide services, and low income areas (where arguably, more services are needed) often go without an adequate amount of service providers as the economics of the area does not support the payment of gap fees.

The only way around this problem is for Medicare payments to be increased for registered psychologists so that they remain economically viable as service providers. The false dichotomy between clinical and non-clinical psychologists needs to be dismantled, as it is based on self-serving rhetoric of the APS leadership, not based on either radically different training, skill levels or client outcomes. The Psychology Board of Australia has simply complied with the APS false narrative, such that it is popularly viewed by psychologists as simply being the political branch of the APS. Radical reform of the PBA as a government body needs to be instituted, eliminating the artificial notion of 'endorsements' of practice areas, as most psychologists work across a range of practice areas.

Paying all psychologists and mental health social workers the same adequate hourly rate would remedy the financial disincentives which act as a barrier to easier access to psychological care in lower socio-economic, rural and regional areas. My suggestion is that all mental health providers be paid by Medicare $120 per 1 hour consultation. This would decrease the need for most of Australia's mental health workforce (registered psychologists) to charge a gap fee, and put all service providers on an even footing for business viability.

Recommendations:

- remove GPs from the gate-keeper/referrer role in the Better Access program, allowing people consumers to directly self-refer for assessment by a psychologist. This would save substantial amounts of money, and reduce the chance of consumers being routinely placed on antidepressant drugs.

- require that prior to prescribing any psychiatric drug, people have undergone a pharmacogenomic test so as assess if their body is capable of adequately metabolising the drug. The PBS needs to fund such tests. This expenditure will save many lives that are unnecessarily lost through the typical 'Russian roulette' of psychiatric drug prescribing. Such saving of lives will also result in massive financial savings to the economy and the government.
- the Federal Health Minister needs to cease seeking policy formation advice from prominent psychiatrists who have or have had financial ties to pharmaceutical companies. These people are not in a position to provide unbiased advice, due to being compromised by vested interests.
- Review the increasing trend toward mental health "hubs". These hubs while attractive to Government, require a lot of funding to establish and maintain, generally have high turnover due to low financial renumeration for providers due to their reliance on bulk billed Medicare rebates for practitioners and often do not facilitate access to mental health services to those with disabilities, transport issues, or reside a distance away from the facility. Adequately funding the Medicare system to allow clients to choose a mental health clinician in their local area is the most cost effective and easily implemented strategy.
- physicians need to receive more training in short term and effective non-pharmaceutical alternative to prescribing patients psychiatric drugs. Such short term interventions have been demonstrated effective and easy to learn. Physicians also need more encouragement to refer patients suffering from depression and/or anxiety on to psychological care, rather than prescribing as a first treatment option.
- all mental health professionals need to be paid the same flat rate by Medicare for services provided, including psychiatrists (whose current rate of pay is not justifiable by any criteria).
- all psychologists should be paid the same rate of pay by Medicare- a rate which makes their business model financially viable without having to charge exorbitant gap-fees. I suggest $120 per hour, but a case may be made for this to be higher.
- clients of psychologists and mental health social workers should be able to access up to 40 sessions of psychological help per year.

yours sincerely,

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