Submission to:

Senate Select Committee on Mental Health

Title: "*From Freud to Fraud – Prophets to Profits*"

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24th September 2005

Senate Select Committee on Mental Health
Parliament House
Canberra

Dear Committee Members,

Re: My submission to the Senate Select Committee on Mental Health

"From Freud to Fraud – Prophets to Profits"

(WARNING: Cynicism ahead! But, also a lot of truth. But first a disclaimer; I am NOT a shrink – or psychologist – or a therapist of any kind, shape, color and persuasion. (I think this is actually a distinct advantage when it comes to telling you some truths about the system – truths that no one else might tell you). Actually, my wife thinks I'm a nut. She may be right, and after reading what I have presented below, you may be inclined to agree. However, I don't agree! I have thought about the topic before you for a great deal of time, and discussed it extensively with some pretty smart dudes. Have a read - I'm sure you will profit from it….trust me!)

Preamble
If Australia's mental health system was a patient, it would be classified a "basket case". If this were not the case, why hold a senate enquiry? Why would you have received several hundred submissions? Why would you have heard so many tales of fractured minds, fractured families and a fractured society fixated on the need for immediate cures for psychic pains - psychic pains that actually arise from deep-seated existential crises (NOT for "biological" or genetic reasons – a commonly used obfuscation). It doesn't require a rocket scientist to know that the system fails at so many levels – and even worse, that no one has a simple answer on how to fix the "Gordian Knot" that is the mental health system. Gosh, no one can even agree on what mental health is! Don't believe me? Ask the various dignitaries and oracles that will appear before you. (see "Suggested Question 1", *Appendix 1*)

By and large, the mental health system has been under the province of the psychiatric profession for over a hundred years. Personally, I think they have had their shot at getting it right, and failed. Why they have failed is a complex story indeed. The philosophical basis of psychiatric practice is - according to many experts - fundamentally flawed (please see my comments below, and other submissions before you). Psychiatric practice is based largely on both vested (financial) interest and a *reason de etre* that is actually a societal quick-fix ("*get em' back to work*" as quickly and cheaply as possible). Actually, what I believe we are only now starting to see is the damage that this approach has caused…BUT more about this later.

Am I reserving my cynicism just for the be-suited psychiatrist sitting in an office surrounded by expensive antiques? No….the mental health system fails in many other domains, including within the ranks of psychologists – the other major group that lays claim to some sort of special insight into the human condition. But first, let's turn our attention to the psychiatrists and their "interesting"

submission….please read on! I personaly think this is a seriously flawed document that actually is symptomatic of the problems that occur when you leave something as important as mental health under the province of one group with enormous vested interest in maintaining the (perilous) status quo.

"Spin" Doctoring
The document submitted by the college of psychiatrist (on close reading) is full of – let's face it – obfuscation and empty rhetoric. For example, they claim (page 2, line 10) that psychiatrists;

"..bring a comprehensive and integrated biopsychosocial and cultural approach to the diagnosis, assessment, treatment and prevention of psychiatric disorder and mental health problems…."

This is simply *not true*. The vast majority of psychiatrists sit in an office and dispense pills and highly questionable advice to an assembly line of tortured souls that immediately return to their dysfunctional lives, only this time, sufficiently psychologically dulled to keep "soldiering on". It is precisely because psychiatrists DON'T involve themselves in the bigger picture ("…*biopsychosocial and cultural*…." blah, blah, blah) that the system has failed so many people, and particularly those in disadvantaged groups (see the multiple submissions by others). Private psychiatrists very rarely follow-up patients or relatives and never see people from certain socio-economic groups (Aboriginals, unemployed, prisoners, homeless etc, etc). Psychiatrists derive enormous rewards from society - I think it is time that each of them actually start doing what they profess and contribute to the ideal of a "…*comprehensive and integrated biopsychosocial and cultural approach*" that they profess to hold dear to their hearts (please see "Recommendation 1"*, Appendix 2*).

In actual fact, the entire highly verbose document presented by the college can be boiled down to 2 recommendations;

- Give them another billion dollars (please see page 3, line 9)
- Give them more "mental health" nurses (there are multiple references to this within the document)

In this manner, their already privileged positions can be further buttressed by (a) more money, and (b) more nurses conditioned to kowtow to their wishes in what is already an aristocratic power structure.

Actually, if the psychiatrists are so anxious about the under-funding of the mental health system, they might consider taking a pay cut. An average 50-minute consultation with a psychiatrist is charged at about $250. If they saw (at a conservative estimate) 8 patients a day, this would be an annual salary of 48 weeks x 5 days x 8 patients x $250 = $480,000. Yep, half a million dollars of (largely) taxpayers' money. Some, of course, will make much less, while some will make far more. (I suggest you check with the tax department). Actually, it wouldn't be so bad if all this money *was* helping things. Instead, we see ever-increasing rates of depression and anxiety, so much so, that we now talk about an "epidemic" of mental illness befalling Western societies! Go figure. (See "Question 2", *Appendix 1* and "Recommendation 2", *Appendix 2*)

Given this enormous pecuniary interest, is it any wonder that in the entire 26-page document that the luminaries at the college produced, the word "psychologist" is used only ONCE (page 15, line 34). Why is this? (please see "Question 3", *Appendix 1*) The simple fact of the matter is that Psychiatrists run a closed shop and that they fear the introduction of Medicare rebates for psychologists. This enormous unresolved battle has been around for years. What is the college's argument *against* psychologists? It is rather cleverly concealed in the oft repeated phrase "*..quality,*

safety and legal requirements….minimum number of specialists….committed to developing effective partnerships with the range of mental health professions…" (please see Page 4, line 3).

These are – speaking very frankly - weasel words. What they are really trying to say (or more accurately, NOT say) can be more accurately translated as:

"We don't want too many psychiatrists and we most certainly don't want any psychologists siphoning our income stream!"

This is after all, human nature. One of the roles of governments (I humbly submit) is to role to reign in the selfishness that lies at the heart of so many of our actions.

This 'closed shop' attitude is wide-spread amongst medical specialists and was most seen famously recently amongst the college of surgeons, and the need for the ACCC to intervene in the college's attempt to thwart the government's attempt to increase the number of surgical trainees (see "Recommendation 3"*, Appendix 2*). This is shameful behaviour. How do they sleep at night? *ANSWER;* With the help of lots of pills!!

Even MORE Spin Doctoring!
The above is by no means the only guff to be found in the submission. Below, I list some of the more bewildering excerpts form their document with my comments & suggested questions:

Guff 1
Pg 3, line 21; *"...service matrix…"*
Comment: Huh? What PRECISELY is this matrix? (apart from the movie starring Keanu Reeves!) Describe it please, in all its glory…

Guff 2
Pg 3, line 24; *"...stepped care…"*
Comment: Huh? What PRECISELY is "stepped care"? Once again, describe it please.

Guff 3
Pg 3, line 27; *"...encouragement of integrated staffing models".*
Comment: Huh? What PRECISELY is "integrated staffing models"? Draw a picture of it please…

Guff 4
Pg 3, line 30; *"Co-ordination of care must extend beyond mental health care to all other services needed by patients".*
Comment: Yeah right, like that's going to happen! A few years ago psychiatrists allowed the mentally ill to be turfed out of asylums into the streets! This is hypocrisy.

Guff 5
Pg 4, line 7; *"...models of collaborative service provision…"*
Comment: The word "model" must be their favorite word in whole wide world (sorry, world "model")

Guff 6
Pg 4, line 11; *"...it is imperative to scope and benchmark..."*
Comment: …'till the cows come home. Who will do this?

Guff 7

Pg 4, line 21; *"…requires a responsive and intergrated mental health workforce that delivers quality and sensitive care to consumers BLAH BLAH BLAH….Quality improvement and critical reflection on practice are core values of the profession"*
Comment: I would get a second opinion! Seriously though, why do you think the college employs a lawyer full time? Their in-house "quality control" is aimed at protecting "their own". If you don't believe me, ask the medical ombudsman in each state!

Guff 8
Pg 5, line 34; *"…seamless system of diagnosis, treatment and community service…"*
Comment: Do they care to comment on the current "seams" in the system or did these "seams" slip through their super-dooper model of *"…quality improvement and critical reflection on practice etc, etc."*?

Guff 9
Pg 6, line 25; "…*innovative models such as specifically trained mental health nurse(s)"*
Comment; Oh dear – another (unspecified) "model". And nurses are NOT the answer (or a particularly innovative model)…the American HMO system has used these for decades and experience shows that they are just used as cheap, stop-gap measures to give the ***appearance*** of mental health care. The psychiatrists simply want more people (other than them) to order around and do the "dirty work". And they DON'T want psychologists to "take up the slack"!

Guff 10
Pg 7, line 14; "*The model should…"*
Comment: Sad, isn't it?

Guff 11
Pg 7, line 24; "…*transfer of research findings to policy…"*
Comment: This is one of the weakest aspects of psychiatric practice. They get most of their new information from drug rep's and talks from drug company-sponsored talks by clinical "experts". Actually, drugs haven't really improved in the last 30 years or so, yet the marketing is always over-hyping these stellar "breakthroughs" in drug design. Such spin simply allows the drug companies to con Governments into forking over more money for drugs. Look at the US – the director of the FDA quite yesterday over such an issue! As the old adage goes; "there's gold in them thar pills!".

Guff 12
Pg 8, line 18; "*The RANZCP does not believe there is significant iatrogenesis"*
Comment: The RANZCP is lying through its (expensively capped) teeth! How many incidents of side-effects have their been? How many psychiatrists have been struck off? How many drugs have been recalled? How many families have been traumatized by poor treatment and management? Guestimates please?

As it turns out – and as mentioned above – the Director of the US FDA resigned yesterday, as reported in the New York Times (see text box at right).

Note the reference to the iatrogenic effects of Zoloft (a widely prescribed anti-depressant)? This is just the tip of the iceberg (please see "Question 4", *Appendix 1*) In particular, see an article

The New York Times
September 23, 2005
By Maria Newman

Lester M. Crawford resigned as the commissioner of the Food and Drug Administration this afternoon, telling his staff that at 67, he is ready to retire.

Dr. Crawford has been in the post only since July, yet his tenure was marked by several controversies, including delays on the approval of over-the-counter sales of the morning-after pill and questions about whether the F.D.A. had acted quickly enough to inform consumers about dangers involving popular medicines like the pain pill Vioxx and ***antidepressants like Zoloft.***

published in *Nature* – the world's foremost scientific journals (*Appendix 3*)

Guff 13
Pg 10, line 1; "…*transparency on funding…and an integrated pathway to inform…and private practice"*
Comment: Where is it currently "opaque"? What is the "integrated pathway"? (perhaps a map would help?)

Guff 14
Pg 10, line 26; "…*supportive of new modes of service delivery…"*
Comment; What do they really want here? The "…*reviewing of Medicare item numbers to allow specialist advice to be provided by clinicians…"* (line 32) Translation; They want to bill you for a phone call or e-mail!

Guff 15
Pg 13, line 12; "…*overcome these structural barriers…items numbers…"*
Comment; Translation; Give us the loot.

Guff 16
Pg 13, line 25; "…*must be linked to clinical outcome measurements…*
Comments: As should their fee structures actually (see "Recommendation 2", *Appendix 2*).

Guff 17
Pg 13, line 28; "…*better integration between clinical and non-clinical services*".
Comment: Another glib recommendation without a concrete suggestion as to how it can be achieved. Such statements are designed to give the IMPRESSION of making constructive suggestions – without doing so!

Guff 18
Pg 13, line 33; *"...flexible employment conditions…"*
Comment: Such as? They already call the shots…and have all the flexibility in the world….

Guff 19
Pg 13, line 35; "…*competitive award conditions…"*
Comment: Translation; Give us more loot.

Guff 20
Pg 14, line 6; "…*recurrent funding of…service models*"
Comment: "Models" again – **and**, give us more loot.

Guff 21
Pg 14, line 25: "..*MBS provides little financial incentives…"*
Comment; You must be kidding (please see "Question 5", *Appendix 1*)

Guff 22
Pg 14, line 30; "…*publicly funded outpatient services need to be readily available to all people with mental illness as part of the overall system of care*"
Comment; Why, what is happening now?

Guff 23
Pg 16, line 9; "…*require additional resources and support"*
Comment; Translation; give us more loot.

Guff 24
Pg 16, line 10; "*Funding models….are required".*
Comment; Translation; give us more loot.

Guff 25
Pg 16, line 28; "*Differential specialist reimbursement…one contributing factor".*
Comment; Translation; give us more loot.

Guff 26
Pg 17, line 14; "*Work practices within the fee-for-service environment make it difficult for GPs or private psychiatrists to give priority to non-reimbursed activities…"*
Comment; Translation; give us even ***more*** loot!

Guff 27
Pg 18, line 4; "…*varying models of consultations*…"
Comment; there's that word again (please see "Recommendation 4", Appendix 2)

Guff 28
Pg 18, line 28; "*Pathways between services"*
Comment; Concrete or gravel?

Guff 29
Pg 20, line 6; "…*examining* ***models*** *of collaborative service provision*"
Comment; please see "Recommendation 4" (Appendix 2).

Guff 30
Pg 20, line 14; "…*scope and benchmark the mental health system…"*
Comment; But who will do this? The shrinks have had 100 years to do this – and haven't. (please see "Recommendation 5", *Appendix 2*).

Guff 31
Pg 21, line 2; "…*acknowledge that the psychiatrist (is) the specialist who integrates biopsychosocial care within an appropriate cultural framework*"
Comment; This really is ludicrous. Is the college really deluded enough to believe they it is some sort of "Mother Teresa"?? If this was what was required, give more money to the Salvation Army. They would do a far better job. Society is highly fragmented and exhibits maladaptions at all levels (cultural, domestic, industrial, environmental etc, etc). The psychiatrists have not helped so far and there is no guarantee they will in the future…even with their extra billion dollars. And they have the gall to ask for "acknowledgement" of this role! Perhaps a nice hand-written letter?

Guff 32
Pg 21, line 15; "…*the RANZCP hopes to build research partnerships…consulting the community in improving…"*
Comment; What have they been doing so far?? Watching their stock options? Get on with it!

Guff 33
Pg 23, line 15; "*Communication and liaison with the patient's family…is paramount"*
Comment; It sure is – and rarely happens due to laziness on the part of the practitioner. (please see "Recommendation 6", *Appendix 2*)

Guff 34

Pg 24, line 32; "…*health model to an integrated model*.."
*Comment***;** Oh dear; please see "Recommendation 4" (Appendix 2).

Guff 35
Pg 25, line 5; "*The model should allow flexibility…respond quickly…non-stygmatizing…"*
Comment; I presume this means that the current system ("model") is currently rigid, sluggish and stigmatizing? If so, why? Not enough "funding models" perhaps?!

Guff 36
Pg 26, line 30; "…*look forward to the opportunity to meet members of the committee and provide further information to assist them make informed decisions…"*
Comment; Oh, to be a fly on the wall!

Mental Disease is NOT like Heart Disease!
The college's document asserts that;

"…*treating mental illness is analogous to ….conditions such as heart disease…"*
(please see page 2, line 22)

This statement is so dangerously wrong that it is almost criminally complicit in the harming of patients. Imagine if you will, that you went to a physiotherapist complaining of a sore back. How would you react if the physio' told you to just keep popping aspirin for the rest of your life and that everything would be just fine. Soon enough, everyone in the population would be crippled. This is precisely the model of health care presented to you by psychiatrists; take these pills forever, and you'll be OK. Instead, millions (literally) are being emotionally and psychologically "crippled". Why? Its cheaper to dispense pills that bona fide psychotherapy – something that most psychiatrist are NOT equipped to apply.

In this regard, please don't be fooled by the college's lip service about "lip service". While psychiatrists will claim that they realize that pills+talk is better than just talk alone – most have absolutely no idea what to actually SAY to patients in a psychotherapeutic sense. The younger psychiatrists will tell you this if you ask them (in secret). They are most cynical about the extreme psychopharmacology that pervades their profession (prozac is now found in detectable levels in Britain's drinking water!). They (the younger shrinks) desperately want to know what to "say" to their patients. Psychologists will tell you (at every opportunity) that THEY know what to say in order to cure without pills…I'm not so sure (see below).

Who DOES know what to say to someone in psychic pain?
In my view, (and here I reveal my own personal prejudice) psychoanalysts know precisely what to say. By "psychoanalyst" I mean those descendants of Freud that practice a "depth" psychology that explains quite elegantly why we get into so much trouble as a species of "intelligent animals". However, my invoking the name of Freud is a risky thing indeed! People immediately recoil, pull out the garlic and shout "begone satan!". To be sure, a lot of what Freud wrote was utter bunk. BUT there have been 3 generations of equally brilliant thinkers that have revised, rewritten and expanded upon Freud's important beginnings. The International Psychoanalytical Association (of which I am NOT a member) has 35,000 members and Australia itself has a very active psychoanalytical community. When psychiatrists go crazy, they are sent to psychoanalysts, who have often done a further 5-6 years training AFTER specializing as psychiatrists. They do NOT prescribe drugs – they use their art to heal with words. Words chosen poetically (and yes, scientifically!). Words that go directly to the heart of the human condition and that authentically address psychic wounds. But, has the Australian Psychoanalytical Association made a submission to your committee? Don't think so. Curious isn't it? In the next section, I'll tell you why….

Psychiatrists Hate Psychoanalysts Even More than They Hate Psychologists…
When psychiatrists meet analysts, they feel like naked frauds. Analysts can read them like a book – and psychiatrists know it. Analysts are not fooled by expensive suits or offices full of antiques. Nor are they fooled by lots of impressive degrees on the wall – and shrinks know it. Psychiatrists also know that analysts think that medications are grossly overprescribed and that psychiatrists are social apparatchiks putting profits ahead of people. Psychiatrists absolve themselves of their sins by telling us all that they are simply doing their job of reducing the pain being suffered by their patients. However, analysts do not dispense medications because they believe them to be (in the long term) highly counterproductive to personal and societal growth. The massive inferiority complex that psychiatrists possess (largely at unconscious levels) expresses itself as a potent antipathy towards analysts and they would – if they could – put psychoanalysts out of business completely. They have tried in the past – by fiddling with item numbers – and they will continue to try and get rid of these burs under their psychiatric skin. Don't believe me? Ask them (please see "Question 6", *Appendix 2*).

But Wait, Drugs Don't Work (as Claimed) Either!
If it wasn't bad enough that psychiatrists have contributed significantly to the parlous state of Australia's mental health (while no doubt helping the careers of quite a few fund managers!) we now learn – after protracted legal battles in the USA to get to the original research data – that antidepressants are no better than placebo (see *Appendix 4*) . Quelle horrere! Now, in their defense, shrinks will quickly point out that the "placebo" effect is very real – which it ***is***…but this argument leaves them kind of stuck. They are forced to conclude that people are responding (as Freud argued 150 years ago) not to the drugs themselves, but to the hope and authority located by the patient in the form of the shrink (who becomes in the patient's mind, a minor deity). This explains the paramount need for degrees on the wall, antique furniture and expensive suits…the vast majority of the "therapeutic" effect that psychiatrists claim to produce, is located in their impressive props and a very sophisticated form of shamanism.

Which brings us conveniently to the psychologists – a group that almost certainly also derives the majority of their curative actions from the "placebo effect".

Firstly, what do the Psychologists Want?
Well, money. Via Medicare. And why not? Surely, they can't do any more harm than psychiatrists – and they are cheaper by virtue of having less expensive lifestyles! Now that is all a bit cynical and mean. The reality is that "quality control" of graduates is poorer in psychology than it is in the medical specialties, and that **IS** a legitimate concern expressed (in code within their document) by the psychiatrists. BUT, there is no reason why this can't be tightened up…and anyway, psychologists are already entrusted with the responsibility of patients in an analogous manner to shrinks, so why not reward them from the public purse? In fact, psychologists should be able to (as in the USA) prescribe minor psychotropics such as anxiolytics and antidepressants. It is not rocket science to detect mental disorders and prescribe the correct medicines – despite what you will be told.

But Do Psychologists Really Help – in the LONG TERM?
The placebo effect and shamanism works up to a point – and then, more often than not – the patient relapses, and (basically) has to see the psychologist (or psychiatrist) over and over again – and often changes practitioner after such failures hoping to find the "best" one for them. In other words, in the absence of medication, most "talk" therapies fail to produce long term changes in the psychic structure such that a patient is empowered to take charge of their own life. Often, the reverse occurs – dependency on the drugs and/or practitioner. Of course, the psychologists may be able to point to a paper or two suggesting that cognitive-behavioral therapy might reduce panic attacks – but, these

papers have to be read VERY carefully for the fine print. Long-term studies in patients are rare and they are very selective in the initial choice of experimental subjects. Ask them (please see "Suggested Question 7", *Appendix 1*).

We are not "Stimulus-Response" Amoeba-Like Creatures.
Psychologists – in the main – treat us as though we were simple, single celled organisms wherein incredibly complex experiential states of mind are reducible to simple Pavlovian-like models. A psychologist doesn't see a person in all their magnificent complexity – they see a Pavlovian "dog" responding emotionally ("salivating") at the sound of some environmental "bell". This is a highly flawed view of the human condition. Why do they take this view? Well, firstly, it's easy. Secondly, they don't have to think about their OWN problems. Yes, that's right (and this is a dirty little secret) most people that gravitate towards working as a mental health therapist do so as a "defense" against their own (largely hidden) psychopathology. By diagnosing others – they avoid being diagnosed themselves. Hence, there is more than a grain of truth in the oft-heard aside; "they (psychologists/psychiatrists) are all nuts!".

Thus, the psychologist, avoiding the horror of the complexity of all our largely unconscious fears and conflicts says; "nope, it's all reducible to some very basic (stimulus-response) rules – Oh, and by the way – Freud was nuts and therefore there is no need for us to use (psychoanalytical) words such as";

- ego
- id
- super-ego
- repression
- libido
- projection
- defence
- splitting
- transference
- neurosis
- narcissism
- identification
- obsessive
- anal retentive
- oral expressive
- passive-aggressive
- fixation
- arrested development
- phallic
- castration anxiety
- erogenous zone
- drive
- sublimation
- ambivalence
- fantasy
- delusion
- dissociation
- Oedipal Complex
- Fetish
- Perversion
- Fixation
- Free association
- Idealization
- Imago
- Individuation
- "slips"
- dream analysis
- hysteria
- psychosomatic
- regression
- separation anxiety
- wish-fulfillment

Can you imagine a world without these words? Impossible, in the arena of mental health. Unless you are a psychologist. Now, when challenged, they will pay lip-service to Freud and say that yes, Freud got a little right, but most of it was wrong, unscientific, and downright dangerous! This is all untrue. Here is the truth; everything that the contemporary psychologist does has its origins in psychoanalytical thought and IS CONTAINED (AS A TEENY-WEENY SUBSET) WITHIN PSYCHOANALYTIC PRACTICE. In fact, about the only mantra that the psychologist has currently is CBT, CBT, CBT, CBT….for which there is some evidence for minor short term improvement, but for which there is NO EVIDENCE that it works in the long term (say, 5 years).

An interesting example of this is to be found in the covering letter of the submission by "Australian Psychological Society" and written Professor Lyn Littlefield OAM FAPS (dated May 19, 2005). The last line of (substantive) paragraph 3 states that the Society can;

"…assist in the burden of mental health in Australia."

What did they MEAN to say? This;

"…assist in (easing?) the burden of mental ***illness*** *in Australia".*

Typo?? (as will be claimed). I think not. This is "parapraxis" (unconscious slip) at its best! How many people have read and checked this letter without spotting the unconscious agenda here? As Freud sad:

"He that has eyes to see and ears to hear may convince himself that no mortal can keep a secret. If his lips are silent, he chatters with his fingertips; ***betrayal oozes out of him at every pore****."*

Having said all that, there are some Psychologists and Psychiatrists that adhere to psychoanalytical thought and practice. These are, however, in the minority, BUT increasing in number. My prediction is that their numbers will increase. They will *have* to if we are to really understand the crazy (inner AND outer) world we live in, and how to survive it.

What the Heck are "Counsellors", and do they Work!

No one knows what a counselor really is, and the laws do not govern the use of such a term (or the words "psychoanalyst" and "psychotherapist"). Let's look (as an example) at marriage guidance counseling – an arena that seeks to reduce suffering in a highly traumatic process. Bottom line; it doesn't work (*Appendix 5*). Which leads me to recommend that a National standard be established for such practitioners, and that legal restrictions be placed on the use of the terms "counselor", "therapist" etc, etc. (please see "Recommendation 7", *Appendix 2*).

Which leads me to my summary….

In Summary

- the RANZCP submission is almost useless, which suggests either it is
    - meant to obfuscatory ***OR***
    - evidence of a detachment of this organization from reality with attendant delusions of omnipotence and omniscience. (Hence, the grossly exaggerated use of the word "model" – **reality** is to be avoided and buried in words).

Either of these alternatives is a worry.

- the psychologists want to be "let in from the (financial) cold" and I think this will be a better use of taxpayers money than to continue to maintain psychiatrists in the "manner to which they are accustomed".

Which leads me to my final recommendations….

Final Recommendations

- do not hand over a billion dollars to the psychiatrist until they can explain EXACTLY how it will be used (perhaps a "scoping, benchmarking and modeling" document would help showing how they will "leverage their synergies" blah, blah, blah").
- My experience with HMOs in the United States is that the introduction of "mental health" nurses are a regressive manouvre, especially if they are placed "beneath" psychiatrists. Don't do it.
- Give the psychologists a piece of the Medicare action. They deserve it. They can do no more harm than the psychiatrists and it will significantly reduce iatrogenesis. It will also induce COMPETITION and remove the psychiatric hegemony and their blatantly self-serving monopoly.
- Listen to the psychoanalysts. PLEASE. Drag them before you and question them under OATH about all my claims! Get them to tell you the truth. I'm sure every one will be grown ups and be able to handle it – even the psychiatrists! (please see "Recommendation 8" *Appendix 2*)
- If you ***can*** manage to haul a psychoanalyst before you (kicking and screaming), ask them this; "Should anyone be placed in the care of the mentally ill if they have not undergone a thorough, personal psychoanalysis for a protracted period of time (5 days a week for several years)?"
- Establish an independent "Mental Health Commission" that monitors the nations mental health and which will make recommendations based on a thorough digestion of research findings here and abroad. Ensure that it has the broadest representation possible – even invite the drug companies along…but seriously stack it in favor of hard-nosed, no-nonsense truth seekers immune to spin, free lunches and expensive suits.

And finally, we would all do well to heed the words of Melanie Klein (brilliant psychoanalyst who died 45 years ago) when she said said;

"We must look to the future by seeing that child analysis is part of all primary education"

She is (was) absolutely right, so don't be fooled by people that seem to suggest that this is a new idea. (the RANZCP hardly mentions this much-need initiative). The potential savings derived from early intervention will save billions of dollars (literally) but more importantly, untold suffering.

Regards,

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Suggested Questions

1. What constitutes "mental health" and what approach does your association use to achieve it? How much of our poor mental health is due to maladaptive social structures and unblanced life styles?

2. What has caused the current "epidemic" of depression and anxiety in modern society and why hasn't the psychiatric profession (a) been able to predict or (b) reduce its incidence?

3. Why is the word "psychologist" only used ONCE (page 15, line 34) in the college's entire 26 page submission? Has there ever been a joint psychiatric-psychology conference in Australia?

4. What were the problems with Zoloft that led to the resignation of the director of the FDA? Wasn't the Nobel Prize awarded in the 1950s to the developer of the lobotomy? Why is insulin-shock therapy no longer used? Is ECT a nice thing?

5. What is the average wage of a psychiatrist in fulltime private practice?

6. What is the college's opinion on allowing full-time, psychoanalysis to be fully rebateable under Medicare for whomever wishes it? How many joint psychiatric-psychoanalytic conferences have been held?

7. What is the longest time period over which (supposedly) successful psychological interventions have been tracked in a randomly selected group of patients, and was treatment better than placebo? What were relapse rates and why did patients relapse?

Recommendations

1. That psychiatrists (and psychologists – if they are eventually allowed access to rebateable Medicare item numbers) be required to spend 20% of their time amongst;

- Homeless
- Unemployed
- Mental asylums
- Prisoners
- Aboriginals
- Alcoholics
- Old age homes
- Etc, etc.

This should be coordinated by Centerlink in liaison with the Department of Health (or my proposed "Mental Health Commission").

2. That the renumeration of psychiatrists (and psychologists) be pegged to (independently calculated) indices of mental health within the Australian community.

3. That the number of psychiatrists (and psychologists) in practice and training be determined by the Department of Health (or the proposed "Mental Health Commission") after consultation with ALL stake holders, including patients. Actually, this requirement should extend to ALL the medical specialties.

4. That the RACNZP college be given a thesaurus so that they can find alternate words to "model"!

5. Establish an independent "Mental Health Commission" that monitors the nation's mental health and that makes recommendations to Government based on a thorough digestion of research findings here and abroad. Ensure that its committee of management has the broadest representation possible – even invite the drug companies! – BUT stack it in favor of hard-nosed, truth seeking and honorable people.

6. That in ALL cases of severe illness (depression, panic disorder, psychosis, schizophrenia) the psychiatrist shall contact the first-of-kin (or primary care-giver) on day 1 of treatment and on a weekly basis thereafter until the patient stabilizes.

7. That the use of the terms "psychotherapist", "psychoanalyst", "counselor" etc, etc be controlled by legislation and require of practitioners that they meet the ethical and professional standards expected of them.

8. That the Senate Committee call before it the current president of the Australian Psychoanalytical Society and ask him/her their opinion on the state of Australia's mental health and what should be done about it?

British panel bans use of antidepressant to treat children

Nature **423**, 792 (19 June 2003)

Alison Abbott

UK regulators have ruled that a top-selling antidepressant should not be prescribed to children or adolescents who are suffering from depression.

The drug, paroxetine, is an ineffective treatment for major depression in this age group and could possibly increase suicidal tendencies, the Committee on Safety of Medicines (CSM) said on 10 June.

Paroxetine, a member of the same class of drug as Prozac, is widely used to treat depression and other nervous disorders. It is not licensed for use in children but can be prescribed by doctors on an individual basis — about 8,000 patients aged under 18 have been given the drug in Britain in the past year.

The CSM's ruling followed a review of fresh clinical data on 1,200 children treated with paroxetine for depression, social anxiety and obsessive−compulsive disorder. The information was provided by UK-based drug firm GlaxoSmithKline (GSK), which markets the drug under the name of Seroxat in Britain and as Paxil in the United States.

The data show that the children with depression did not benefit from taking the drug, the CSM said. It added that there was a two to three times higher incidence of "potentially suicidal behaviour" among those treated with the drug compared with those receiving a placebo, although total numbers were too small to be statistically significant.

The CSM did not rule on using paroxetine to treat social anxiety or obsessive−compulsive disorder, for which there was evidence of efficacy.

On 13 June, Senator Charles Schumer (Democrat, New York) called on the US Food and Drug Administration (FDA), to investigate the effects of paroxetine on children and teenagers. The FDA was expected to announce an investigation this week.

Over the past few years, GSK has been under increasing pressure from patients and their supporters, who say that paroxetine increases suicidal tendencies in all age groups. The company says that there is no evidence for this.

David Nutt, a psychopharmacologist at the University of Bristol, UK, says that the CSM ruling has little bearing on the debate about paroxetine's possible side effects in depressed adults. The CSM was concerned that the drug was ineffective in depressed children, so there was no reason to take any risk, he says.

Antidepressant efficacy may be overblown – experts.

SOURCE: British Medical Journal July 16, 2005.

NEW YORK (Reuters Health) – Antidepressants, for the most part, do not provide meaningful benefit, two investigators in the UK argue in a report in the **British Medical Journal** this week, having reviewed published medical evidence on antidepressant efficacy.

Most people with depression are often initially prescribed an antidepressant by their doctor. Prescriptions for these medications have risen dramatically in the last decade.

In an interview with Reuters Health, Dr. Joanna Moncrieff, an author of the report, said, "I do not think there is such a thing as a drug that will specifically relieve depression. I think so-called antidepressants are just drugs that do other things, such as sedating or stimulating people."

In fact, she continued, "I am sceptical as to whether there is a biochemical syndrome of depression despite the portrayal by the drug companies and some psychiatric literature."
Moncrieff, a lecturer at the University College London and co-chair of the Critical Psychiatry Network, describes depression as a condition that "should be dealt with without drugs, because it's something people need to learn to deal with themselves." Dr. Irving Kirsch of the University of Plymouth is a co-author of the report.

"The bottom line is that we really don't have any good evidence that these drugs work," she says. "I think we have to be highly sceptical. We have been treating all comers with antidepressants for years now, and we have seen an increase rather than a decrease in depression at the community level."

In an analysis published in 2002, Kirsch reviewed 47 studies involving the six most widely prescribed antidepressants. He concluded that 80% of the medication response in the patients treated with the antidepressants was duplicated in the patients on placebo. Moncrieff came to a similar conclusion in a review she published in 2001.

"People who seek help for depression actually have all sorts of different problems, and I don't think that they all share similar brain chemical imbalances," she says. "If we just focus on the chemical serotonin, nobody has been able to show that an abnormality in serotonin has been demonstrated in people with depression."

Kirsch and coworkers analysed the data sent to the U.S. Food and Drug Administration by the manufacturers of the six most widely prescribed antidepressants (fluoxetine [Prozac], paroxetine [Paxil], sertraline [Zoloft], venlafaxine [Effexor], nefazodone [Serzone] and citalopram [Celexa]). Concerted legal action under the freedom of information act was required before being given access to the data. Their research showed that although the response to antidepressants was substantial, the response to inert placebo was almost as great. The mean difference was about two points on the Hamilton Rating Scale for Depression (HAM-D). Although statistically significant, this difference is not clinically significant. More than half of the clinical trials sponsored by the pharmaceutical companies failed to find significant drug/placebo difference, and there were no advantages to higher doses of antidepressants. The small difference between antidepressant and placebo has been referred to as a "dirty little secret" by clinical trial researchers, a secret that was believed by FDA officials to be "of no practical value to either the patient or prescriber".

The New York Times

19, 2005

Married With Problems? Therapy May Not Help

By SUSAN GILBERT

Each year, hundreds of thousands of couples go into counseling in an effort to save their troubled relationships.

But does marital therapy work? Not nearly as well as it should, researchers say. Two years after ending counseling, studies find, 25 percent of couples are worse off than they were when they started, and after four years, up to 38 percent are divorced.

Many of the counseling strategies used today, like teaching people to listen and communicate better and to behave in more positive ways, can help couples for up to a year, say social scientists who have analyzed the effectiveness of different treatments. But they are insufficient to get couples through the squalls of conflict that inevitably recur in the long term.

At the same time, experts say, many therapists lack the skills to work with couples who are in serious trouble.

Unable to help angry couples get to the root of their conflict and forge a resolution, these therapists do one of two things: they either let the partners take turns talking week after week, with no end to the therapy in sight, or they give up on the couple and, in effect, steer them to divorce.

"Couples therapy can do more harm than good when the therapist doesn't know how to help a couple," said Dr. Susan M. Johnson, professor of psychology at the University of Ottawa and director of the Ottawa Couple and Family Institute.

One couple, in Boonton, N.J., saw two marriage counselors over 13 years.

"One therapist hurt our marriage and actually a caused our separation," said the husband, Jim, who did not want his last name used out of concerns for his privacy.

"She told my wife, 'You don't have to put up with that,' "

[Truncated at this point – You get the message!]