

Legislative Council

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MENTAL HEALTH BILL

(Extracted from Hansard)

The Hon. A. BRESSINGTON (21:50): I warn members in advance this is quite lengthy—I have culled it—and if I seek leave to conclude, you all know why. I rise to speak to this most important bill, the Mental Health Bill 2008. This bill states that this is for an act to make provision for the treatment, care and rehabilitation of persons with serious mental illness with the goal of bringing about their recovery as far as is possible; to confer powers to make orders for community treatment, or detention and treatment, of such persons where required; to provide protections of the freedom and legal rights of mentally ill persons; to repeal the Mental Health Act 1993; and other purposes.

I have researched the aims and objectives of this bill and compared it with science, and I must say I have some serious reservations about what is being proposed; what has been amended from the 1993 bill; and also the medical premises that have been used to put into legislation how mentally ill individuals could be treated under this law. The most disturbing part for me is that we will now include children under the age of 16 in the Mental Health Act. Time and again, we are told in this place that we must look to the evidence, yet when evidence is produced and is contrary to the intention of the state, the evidence seems to be ignored. The evidence shows that early intervention produces the best results. The evidence shows that the least invasive form of treatment will often produce better outcomes for those with a mental illness. The evidence shows that a community visitors' program is also effective and is best delivered by the non-government sector.

I notice that these matters are not dealt with in the bill and I am concerned that there is little differentiation between a person who is at serious risk, as opposed to a person who is perhaps a little eccentric and who can be placed on a community order at the request of a family member, with no compelling directive to ensure that adequate legal representation is provided to the person whose mental capability is being questioned. It is fair to say that a society can be judged by how it treats its most vulnerable—and that is the second time I have mentioned that tonight.

After we debate this bill, we should be able to feel as though the best interest of the individuals has been served by the deliberations of this parliament. If shortfalls are identified, then this bill should be the tool with which we are able to address these shortfalls so that fewer people fall through the cracks. We should be taking steps to ensure that those who are at serious risk to themselves and others receive appropriate intervention, support and treatment, and if detention is necessary for the safety and wellbeing of those individuals, that a safe and secure environment is provided for them. Those who do not require detention should still be able to rely on the services

being funded appropriately and adequately so as to allow them to live within the community, and they should be encouraged to be as independent as possible, but also have access to intervention and support when things go pear shaped for them.

We cannot promise that now. In fact, community confidence in government run operations such as this is at an all time low. One only has to take a trip to Semaphore and sit outside with a cuppa to see just how many times they are approached for money and cigarettes—and the locals know that the people doing this are part of the mental health system and that they are floundering. These are people who have been put out into the community to live independently and who, for the most part, have been left to their own devices. I cannot help but wonder, if the non-government sector were financed sufficiently and the many services that already exist were able to extend their services for practical support, counselling and the biosocial aspect of mental health needs, how much different our current landscape would look.

At this point I would like to include the recommendations of the Office of the Public Advocate in the record. The paper was released on 1 May 2006 in relation to developing a community visitors' program, the same as programs implemented in other states and specifically in relation to the program in Victoria that has seen many successes in ensuring that Victoria's mentally ill are receiving an appropriate level of care and that their rights are respected.

In November 1995, Judy Clisby, a student of the School of Social Work and Policy, University of South Australia, as part of the parliamentary internship scheme under the supervision of the Hon. Robert Lawson MLC produced a research report 'Community Visitors in South Australia: A strategy for ensuring high standards of care and protecting the human rights of people with mental illness'. The research strongly recommended as follows:

- Recommendation 1: that a community visitors program be set up in South Australia to monitor standards of care and protection of rights in public and private sector institutions offering psychiatric in-patient services. Features of the community visitors program must incorporate functions of monitoring, investigation of complaints, advocacy and support, independence from funding bodies and service providers, a statutory basis, annual reports to both houses of parliament, regular meetings with key officials in health and with the Minister for Health; adequate resources with secure funding that does not detract from existing funding for services, and appropriate criteria for the recruitment, training and support of volunteers;
- Recommendation 2: that a working party be established to consult extensively with consumers, consumer groups and service providers to develop a model suited to unique South Australian conditions, to ensure that consumer focus is the primary consideration governing the program, to investigate the target population services of the program, linkages between the community visitors program, community advocacy agencies, commonwealth funded schemes for nursing homes and hostels, and the supported residential facility scheme; and
- Recommendation 3: that the working party report in sufficient time for its recommendations to be incorporated into the review of the Mental Health Act 1993, the Guardianship and Administration Act 1993, and the Supported Residential Facilities Act 1992.

In this same report the location of the service was canvassed between the Office of the Public Advocate, Health Advice and Complaints, and the Ombudsman, and concern was raised about the lack of advocacy provisions for monitoring standards of care and protection of rights for government, non-government and private services, except under the provisions of the Office of the Public Advocate.

The Clisby report supported the Office of the Public Advocate as the most appropriate location for a community visitors scheme in South Australia, and the Public Advocate at the time saw it as augmenting the functions of the office under section 21 of the Guardianship and Administration Act 1993 and providing an external system of monitoring standards of care and right to protection in both the public and private sectors. The most compelling factor in choice of location was the independence of the auspicing agency. A significant proportion of respondents recommended the Attorney-General's Department with its dual advantage of independence and access to legal advice. Those are the main points of the study; I will not read out the rest because it is late.

The area of mental health is one that is of wide concern not only to those who need to be provided with effective services but also to those who treat the mentally ill, those who care for them and those in the community who, for whatever reason, are impacted by decisions made in the delivery of those services. It concerns medical practitioners, people who care for those with mental illness issues (both professional and family carers), as well as members of the wider community who are concerned themselves, because of misperceptions surrounding those whose mental health is not all we would hope it would be.

The interesting thing about mental illness is that there is no true measure to detect it. It depends greatly on the interpretation of behaviours as being abnormal, and this is where I see a problem with diagnosis, because there is more to mental illness than the demonstration of eccentric or even bizarre behaviours. There is no medical examination, there is no genetic test to show a predisposition or risk of incurring a mental illness. Some very well-known psychiatrists have jumped ship on the practices of modern psychiatry because they say that psychiatrists are nothing more than the distributors of legal drugs to the unsuspecting.

Thomas Szasz is Emeritus Professor of Psychiatry at the State University of New York Health Science Centre, and is internationally acclaimed as one of the most important writers in present-day psychiatry. In 2002 he stated:

There is no blood or other biological test to ascertain the presence or absence of a mental illness, as there is for most bodily diseases. If such a test were developed, then the condition would cease to be a mental illness and would be classified, instead, as a symptom of a bodily disease.

The aim of that statement by Professor Szasz was to point out that there are a number of contributing factors to why an individual may experience a psychotic break, or even why a person may suddenly appear to be less psychologically functional. The causes can range from allergies to certain preservatives found in our food to brain tumours and hormone imbalances. In fact, recent science has revealed that the very medications we use to treat low-level mental disorders such as depression and sleep disorders can themselves contribute to the illness and hurl a person into a full-blown suicidal ideational episode.

An article from *Medical News Today* reveals that a test is now available to determine whether or not a person's genetic make-up would be a contraindication to the use of a certain antidepressant medication. NeuroMark (a Boulder, Colorado company) has announced the immediate availability of a genetic test to identify people at risk of suicidal ideation (thoughts of committing suicide) when prescribed an antidepressant drug. The test, called the Mark-C test, is expected to help restore public confidence in antidepressant medication and help to reduce a recently announced spike in suicide rates amongst US youth. Kim Bechthold, NeuroMark's CEO, said:

This is an exciting example of the power of genetics to address a critical need and make important drugs safer for patients worldwide.

In September 2007, the Centre for Disease Control (CDC) announced that, in 2004, there was an 8 per cent rise in suicide rates among 10 to 19 year olds—the year the FDA issued public health warnings linking antidepressant drugs with suicidal ideation and behaviour. The largest percentage increase in rates from 2003 to 2004 was among females aged 10 to 14 at 75.9 per cent, followed by females aged 15 to 19 at 32.3 per cent, and males aged 15 to 19 years at 9 per cent, according to the CDC. In a statement the company said:

We feel a sense of responsibility, given the current climate, to provide the test to physicians immediately so that they may identify patients who would benefit from closer monitoring or even a change in therapy. It is our hope that this early test will encourage more people to consider an antidepressant drug treatment who would benefit from it.

It is interesting that, during the trial of that test, some 37 per cent of people showed an adverse reaction to this drug, which is one of the most widely prescribed antidepressants in the western world. About 37 per cent of people who were tested for the genetic contraindication for this drug developed symptoms such as suicidal ideation and attempts at suicide and, when they were taken off the drug, those particular side-effects abated, and it was put down to the fact that it causes brain inflammation and it also has serious physical side-effects for them.

We have become a nation looking for quick fixes, and those quick fixes are usually in the form of medications. Knowing that this test now exists I think should be a compelling argument for this country—particularly, this state—to enter into research into this test. It would make a physician's job far easier when they are prescribing these drugs for their patients to know that they are genetically compatible with them and that the risk of their patients 'going off' and trying to commit suicide would be greatly reduced, and that means that the people who are compatible with antidepressants will get the help they need and, for the people who are not, we can look for other sorts of treatment for them, whether that be another kind of antidepressant or another kind of therapy altogether.

It could be argued that a person should be administered medication only when all other therapies have failed and the person's condition either does not improve or deteriorates to the point where they are at risk of serious harm to themselves and others. While I am no expert on mental health, I have seen some situations that raise concerns as to how mental health treatment in the first instance has become almost entirely medication based and how a person's life experiences and emotional state are pondered little, if at all, by some in the field of psychiatry. Indeed, for state

governments, the prescribing of medications could be seen as a cost shifting exercise, because those medications are almost always made available on the federally funded pharmaceutical benefits scheme.

It is a sad state of affairs indeed when people who are prescribed heavy duty medications become addicted to them and are then left to their own devices. I have seen this happen many times, and I have seen the human tragedy of a system that resorts to medication as a first, second and last port of call. It is true that getting to the core emotions of an individual is a time-consuming and labour-intensive exercise and, again, the issue of a duty of care to those in the mental health system does come into question.

We have seen a shift away from institutionalised care and a move towards encouraging independent living within the community. As the best care scenario, we would all choose the latter where and when possible. Unfortunately, with the noble ideal of independent living, there is an expected increase in responsibility for government to ensure that those who are placed in the community have an acceptable quality of life, which would also eliminate the risk of exploitation, violence and discrimination against them.

This would mean that those who have been netted into the mental health system and live independently still require a level of monitoring and support to assist them to be the very best they can be. Sadly, I see no moves in the bill before us to identify that there are a variety of persons who need a variety of support mechanisms. This, of course, applies not only to those who will be detained but also to those who roam the streets and are unable to make decisions in their own best interests, for whatever reason.

Our body is a complex piece of work, and it is regulated by our psychological wellbeing and our emotional status at any given moment. Of course, all of this is determined by the chemical stability of our central nervous system. The brain and its functions are the least understood, and the connection between our brain and our emotional wellbeing is influenced by many factors. Stress and trauma reduce our resilience to cope, and this in itself creates a situation where our body will produce a number of hormones in an effort to counter the emotional, physical and psychological effects of that stress and trauma.

Of course, early intervention and support at the onset of stress and trauma would be desirable, and such interventions should include counselling and various kinds of practical assistance and mechanisms that would see a problem solved or at least a solution realised, but that does not happen in most cases. In fact, the age at which our children are being introduced to quick fixes is as disturbing as the number of adults on medications. Antidepressants and anti-anxiety medications are prescribed like lollies, and for our young people this can create a lifetime of problems. I seek leave to have inserted in *Hansard* a one-page statistical table without my reading it.

Leave granted.

Attachment A

Table 1. Number of patients who had at least one prescription filled for a PBS/RPBS listed antidepressant drug in the 2007-08 year, by age and State/Territory.

State ²									
NSW	VIC	QLD	SA	WA	TAS	NT	ACT	Australia	
0 to 1 years	12	16	12	*	8	*		*	48
2 years	22	13	14	6	8	6	*	*	69
3 years	38	11	18	7	10	*	*	*	84
4 years	33	18	37	5	9	11	*	*	113
5 years	73	46	69	19	18	14	*	*	239
6 years	102	68	117	25	21	14	*	*	347
7 to 10 years	901	512	1,007	192	188	122	21	40	2,983
11 to 15 years	3,130	1,882	2,818	563	775	324	53	142	9,687
16 to 18 years	5,206	4,100	4,047	1,255	1,582	620	46	280	17,136
19 years and over	447,927	360,853	308,515	128,707	143,778	43,892	5,891	19,178	1,458,741
Age unknown ¹	161	95	86	39	50	9	*	8	448
TOTALS	457,605	367,614	316,740	130,818	146,447	45,012	6,011	19,648	1,489,895

¹ 'Age unknown' is where the Departments administrative systems do not contain enough information to accurately determine a patient's age.

² Patient State/Territory is the first State/Territory of the patient in the year. If a patient moves within a year then the data reflects their initial State/Territory.

* indicates that a table cell was 3 or less and has been suppressed for confidentiality reasons. Suppressed cell values have not been included in totals.

Table 2 contains information by generic drug name, As patients may have received more than one of the indicated drugs within the year, the individual drug totals will not add to the total number of patients.

Table 2. Number of patients who had at least one prescription filled for a PBS/RPBS listed antidepressant drug in the 2007-08 year, by generic drug name, age and State/Territory.

Drug name	Patient age	State									
		NSW	VIC	QLD	SA	WA	TAS	NT	ACT		Australia
0 to 1 years	*	*	*	*	*	*	*	*	*	*	
2 years	*	*	*	*	*	5	*	*	*	5	
3 years	5	*	9	*	*	*	*	*	*	14	
4 years	5	*	18	*	*	10	*	*	*	33	
5 years	10	6	28	11	5	9	*	*	*	69	
6 years	19	*	48	10	*	13	*	*	*	90	
7 to 10 years	138	47	321	62	19	65	*	6	*	658	
11 to 15 years	294	126	503	123	74	64	*	10	*	1,194	
16 to 18 years	248	185	222	109	107	49	*	7	*	927	
19 years +	59,999	40,145	38,775	20,874	19,688	7,360	854	1,698	*	189,393	
Age unknown	26	13	11	5	6	1				62	
AMITRIPTYLINE HYDROCHLORIDE Total		60,744	40,522	39,935	21,194	19,899	7,576	854	*	1,721	192,445
0 to 1 years	*	*	*	*	*	*	*	*	*	*	
2 years	*	*	*	*	*	*	*	*	*	*	
3 years	*	*	*	*	*	*	*	*	*	*	
4 years	*	*	*	*	*	*	*	*	*	*	
5 years	5	*	*	*	*	*	*	*	*	5	

The Hon. A. BRESSINGTON: The table outlines how many of our young, state to state, are on antidepressants of one kind or another, and it is a staggering figure indeed. Antidepressants were never meant to be used long term, yet I know many people who have been prescribed these medications for decades where the original cause was never identified. We may have a grasp on the minimum mechanical functions of the major organs, but there is still a lot to be discovered about the intricate crossover of systems that keep our body and mind healthy. What fascinates me about the entire topic of mental health is that the emotional experience of an individual is skipped over as if of no consequence to our emotional state and how that impacts on us physically and mentally.

We all remember some years ago when the medical profession was disputing the addictive properties of Valium and Serapax and, after many thousands of women had been prescribed 'mother's little helpers', as they were called, it was discovered that they were, in fact, highly addictive and were being widely abused. These particular medications remain a problem for many, and the effect those medications have had on the body's regulatory systems of hormones, etc., has been devastating.

At the drug rehab centre where I used to work, 90 per cent of our clients last year were middle-aged housewives who had been battling with an addiction to Valium and Serapax for decades. Those women had been on those medications for most of their adult life, and they are only now realising the effect that has had on their ability to function day to day. These people have a great struggle ahead of them when coming off these medications. None of them could remember why they were actually put on them in the first place—they were not sleeping, they were new mums, and all they needed was some sort of social support network to get them through some difficult periods in their life that were new to them.

Many of our generation remember the saying, 'Have a Bex, a cuppa and a lie down.' For so many years, as a society we greatly underestimated the side-effects of

medications. At the same time, our mental health services rely heavily on the use of drugs as treatment, when in actual fact the compliance rate of drugs to treat, say, schizophrenia and bipolar is sometimes as low as 15 per cent. Despite the low compliance with mediaeval treatments, we seem to ignore the ever-increasing research showing that bio/psycho/social approaches, such as cognitive behavioural therapy, and others that target a person's adverse life experiences, often produce better long-term results than any medication.

I make it clear that I am not advocating total abstinence for those who have been diagnosed with a true mental illness. I am advocating that the one-size-fits-all approach we currently have in the name of treatment needs serious revision.

Renée Garfinkel, who wrote an article called *Marketing Mental Illness: The way to sell drugs is to sell psychiatric illness*, made the comment that 'disorders to be included in psychiatry's diagnostic and statistical manual of mental disorders (DSM), published by the American Psychiatric Association, are chosen by a majority vote of APA members and is on the same scientific level as you would choose a restaurant'. She also states:

When the American Psychiatric Association published the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1952, the book contained only 112 entries. That figure has more than tripled over the past 50 years. The disorders listed in today's DSM and the mental disorders section of the World Health Organisation's International Classification of Diseases include: reading disorder, disruptive behaviour disorder, disorder of written expression, mathematics disorder, caffeine intoxication and nicotine withdrawal disorder.

These are all now classified mental illnesses. These publications comprise a grab-bag of billing terms for the mental health industry. This also accounts for the growth in the number of disorders contained in the DSM. Some believe it has been motivated by purely economic principles.

The first increase took place in 1968, coincident with US government insurance becoming available to the mental health industry. That year, the number of disorders in the DSM jumped from 112 to 163. By 1980, the DSM-III edition added another 61 disorders, for a total of 224. With the publication of the DSM-III-R in 1987, mental disorders increased to 253. In 1994, the total had risen again, this time to 374. But the money trail goes deeper.

A study published in April 2006 by public health researchers from the University of Massachusetts and Tufts University in Boston disclosed that every psychiatrist expert involved in the development of the mood disorders listed in the DSM-IV had financial ties with drug companies before or after the book was published. This report was the first to officially document the wide-ranging and incestuous monetary relationship between the pharmaceutical companies, psychiatrists and other mental health industry personnel responsible for the manual.

Depicted as diagnostic tools, the DSM and the International Classification of Diseases (ICD) mental disorders sections are used not only to diagnose mental illness and prescribe treatment but also to resolve child custody battles, discrimination cases based on alleged psychiatric disability, to support court testimony, to modify education and much more. All this, and yet there is no science to this diagnosis

system, and insurance companies estimate that the cost of treatment for disorders that cannot be physically proven is two times greater than for general medical conditions.

In 1995, after more than \$6 billion of taxpayer funds had been poured into psychiatric research, psychiatrist Rex Cowdrey, Director of the NIMH, admitted:

We do not know the causes of mental illness. We don't have methods of curing these illnesses yet.

Psychiatrist Colin Ross points out:

The way things get into the DSM is not based on blood test or brain scan or physical findings. It is based on descriptions of behaviour, and that's what the whole psychiatric system is.

I have long been sceptical of some of the mythology used to diagnose mental illness, especially with individuals who have a known history of substance abuse. I do not believe that enough attention has been paid to the signs and symptoms of addiction. I also know that the mental health system and the drug and alcohol system do not talk to each other and do not work cooperatively together, and this bill will not improve that situation. In fact, in conjunction with federal initiatives, this bill will see most drug addicted people referred, by their treatment providers, to mental health services for assessment. I guarantee that those drug and alcohol services will not see those clients again.

I have heard the statistics about drug users and the high level of comorbidity. The question is: if those in the mental health industry were trained adequately in the effects of drugs on an individual, they would also be able to better distinguish between a person who is truly mentally ill and a person who is caught in the grip of addiction, and there would be a clear and definite difference in how they were treated.

Anyone who knows addiction knows addicts exhibit some quite bizarre behaviours while using mind altering drugs. That is actually why they are called 'mind altering drugs'. I have personally seen many people of various age groups, the youngest being 14 at the time and the oldest 57, who were misdiagnosed with schizophrenia and bipolar, or manic depression, as it used to be known. When I say misdiagnosed, the impact that this misdiagnosis has had on the individuals and their families should be realised.

Being caught in the mental health system is not a flash in the pan experience, and for some the long-term physical effects of misdiagnosis is as devastating as the decline in their quality of life. I am not sure how psychiatry became the profession that was considered to be the supreme power, but I will state for the record that I have seen more harm done to some by the policies that are driven by psychiatry.

The reliance of this profession on medication is profound. Probably the one that stands out most is a 37 year old man, who was a methamphetamine addict, who was literally trapped in a psychotic state for five long years. His psychosis would ease when he did not use meth multiple times during the day, but he would slip into psychosis when he would be able to afford to use more regularly.

He was married, with four young children, and his wife did not know that he was using drugs. This man, husband and father of four had been able to hide his drug use, and his wife put his odd behaviour down to stress, overwork and his consumption of alcohol, which, by her own admission, was less than one stubby per day. She

believed that the combination of all of these things was responsible for his odd and erratic behaviour and his mood swings.

He gradually became worse over time and, eventually, his psychosis became so obvious that over the period of four years he spent time in and out of Glenside, where he was put on medication, detained for a short period of time, and released into the care of his wife. He would cease his medication because it would make him feel too dopey, and within days his merry-go-round would begin again because he would start using his illicit drug.

His behaviour became more frequently erratic, and his admissions to Glenside became more frequent for longer periods, but nothing had changed—nothing—in how he was handled. Even though absolutely no progress was being made, in fact, if we were to be honest, his behaviour had deteriorated with more frequent psychotic episodes lasting longer; but the treatment never varied.

Eventually, this man became more and more violent until he ended up on the wrong side of the law after five years. When he went to gaol his family approached DrugBeat and me, and the program manager and I went to visit him in Yatala. He admitted that he had been using methamphetamine and smoking dope and that he had been a recreational drug user since the age of 12. Now he was looking at a lengthy stint in gaol. Isn't it just a little peculiar to members here, as it is to me, that a question was never asked, that a drug test was never taken, and that he was prescribed heavy duty anti-psych medication in hospital and also as an outpatient, without ever being tested for the presence of drugs known to induce psychosis?

I guess it is the lack of imagination that staggers me in this case. We managed to negotiate home detention for this man under court order to attend the program for 15 months. He has now been drug-free, alcohol-free and psychosis-free for three years. I have left out a lot of the detail of his five-year reign of terror on his wife and children. However, just as an example, on one occasion he was sure his wife was having an affair and that her lover was living in their wardrobe. He removed and burnt all the clothes from the wardrobe because he believed that this lover of his wife was also wearing his clothes when he was not home. He removed the doors from the wardrobes and would not sleep with the light out.

His wife was not allowed to sleep in another room and he would sit and watch her all night to make sure she did not leave the room. If she needed to go to the bathroom he would follow her. He became so obsessed with this lover that he erected a glass shed in his backyard so that he could see everything and everyone who went through the house. He controlled the electricity from the shed and he would run secret missions during this time at home to plant what he believed were microphones all through the house and randomly turn the electricity on and off during meal times and while the kids were watching TV, and their life was absolute mayhem.

He also believed that his wife had put a tracking device in his telephone so that she would know when he was coming home and she could hide her lover in the wardrobe. He threatened his wife with an axe and had her pinned down in the backyard in front of his children. This went on for almost all the five years and the only relief was when he would be admitted to the hospital for a couple of days.

That entire family was traumatised by his drug-induced psychosis, and his family could not get the help they needed. He would stop taking his medication because it made him dopey and he was even more aggressive on the medication once

he started to come down from it. The wife made many inquiries of the treating psychiatrist and she stated to me that she felt as though he thought she was just making all this up in order to get her husband admitted.

This man was coming closer and closer to hurting someone and the family was held to ransom. When things got really bad and Families SA stepped in, guess what was required? He was required to go to anger management classes and the mother was required to go to parenting classes because her children were acting out in day care and at school. That was the total sum of assistance and, if things did not improve, the department was going to take out an order on their four children. No-one questioned why his behaviour was so bizarre; no-one offered to have him drug tested and put into a program.

This family, as well as the extended family, were isolated and devastated. When he was released on a court order to attend, he was placed on medication, which he did not take for the entire time. He made good progress over the 15 months and went regularly to visit his psychiatrist, who put his progress down to his medication—and just remember, he was not taking his medication at all. Not once did the treating psychiatrist ask me, the program manager or this person what therapy was being used, nor did he ask the client how it was working for him. At the end of 15 months of detention and after showing numerous clear drug tests, he was taken off home detention and resumed his normal working hours.

He went back to the psychiatrist for his final visit and asked how long he would need to be on the medication that had been prescribed for him, and he was told, 'We will see about reducing it in about 12 months but it is my recommendation that you stay on that medication for quite some time yet.' When he informed the psychiatrist that he had not been taking the medication at all and that what had helped him to get his life together was the various programs that he had undertaken, was the psychiatrist curious as to what had assisted his client? No; he was not. Did he inquire as to what the client thought had been useful for him in particular in that 15 month period? No, he did not. What he did say was, 'I could have had you thrown back in gaol for not taking that medication,' that being included in the court order, 'and I have a good mind to report you.'

This is not an isolated case study of people who have been diagnosed with a mental illness while under the influence of illicit drugs and who have had their recovery complicated by taking antipsychotic drugs that were not necessary after they had stopped taking their drug or drugs of choice. I often wonder whether in fact that is why the non-compliance rate is so high. I do not want to sound cynical, but surely these practices need revision and evaluation.

I discussed these matters with the minister in the hope that some guidelines could be put in place but was told by her that the medical profession would laugh at us for trying to direct medical experts in the area of treatment.

My argument is that we could significantly reduce the number of people in the mental health system with some commonsense expectations that a diagnosis is carried out on individuals who are not under the influence of substances that by their very nature can affect their psychology and behaviour. This measure, along with the implementation of the test mentioned earlier, could see better outcomes for individuals who struggle to keep their head above water because the system drags them down rather than assisting them to rise above it.

This man, his wife, his mother, his father, his two sisters, his brothers-in-law and his children lived every day in fear of what might happen for five long years, and it took his getting arrested for anyone to find the core issue behind his repeated psychotic episodes. And, as I said, it is not an isolated case. Both the program manager and I tried on numerous occasions to meet with the psychiatrist to discuss the process of recovery that this man had undertaken and perhaps set up a link with him and his practice. However, no interest was shown. So, eventually, we just accepted that we have a system in place that is content sometimes to do more harm than good. It seems that we have two treatment options for people with substance abuse issues and what appears to be mental illness: gaol if they commit an offence or medication.

I would also like to draw the attention of members to at least three cases where members of the public have been put at risk. The first is the case of the two men who were attacked by their neighbour and stabbed numerous times. Their neighbour knocked on their door and then proceeded to viciously attack them with a knife, telling them, 'The pain will be gone soon. Soon you will be dead.' The perpetrator was a person with a history of substance abuse who was also involved in the mental health system.

Another was the case of the young man who attacked his elderly next door neighbour in the backyard with a hammer and killed him. He was also a known drug user. I had many conversations with this young man's mother, and she was beside herself. She could get no assistance for this young man, and he ended up killing his elderly next door neighbour. He was also involved in the mental health system.

Even more recently, there was the case in Davoren Park, where a man stabbed his two year old son to death, attacked his 15 day old baby and then stabbed himself to death. This man, according to his neighbours, had a long history of substance abuse and was also involved in the mental health system. I implore members and the minister to recognise what is the common denominator here.

In 2002, Dr John Anderson of the neuroscience clinic at Westmead spoke of the correlation between the use of antidepressants, marijuana, suicidal tendencies and psychosis. His studies revealed that a person using marijuana who was also being prescribed antidepressants had a 75 per cent increased chance of tipping over the edge because of the chemical interaction between marijuana and prescription medications. He also stated that a person using marijuana should only be prescribed doses of medications at around 25 per cent of the usual dose. If that applies to antidepressants and marijuana, surely it is not a long bow to draw to understand that the chemical interaction between amphetamines and antipsychotic drugs needs close attention.

People with a genuine mental illness are rarely a threat to others. They may have odd behaviours and they may make some people feel a little uncomfortable, but the behaviours that are being exhibited by some labelled as mentally ill are giving mental illness a bad reputation. Frances Nelson QC went public with the fact that she had notified the mental health system on five occasions of the risk that the man at Davoren Park posed. She also stated that she knew of about 150 people who also concerned her as being a risk to themselves and others. The Attorney-General, the Hon. Michael Atkinson, stated on radio at approximately 9.15 am that what she said made sense and that legislation could be passed within two weeks to address her concerns.

I know that applied to the Parole Board, but these people are diagnosed with mental illness and, according to my information, also have a history of substance abuse. If the Hon. Frances Nelson QC can see they have correlation that they are a risk to themselves and others, and we are doing nothing about it, this bill in its entirety is not going to solve this problem.

Obviously what we are doing is not working and, if we are not prepared to up the ante and change our approach, then more tragedies like that I have already mentioned will continue to occur and I believe the number will increase to a point where the government cannot ignore the signs any longer.

The questions we need to ask are: what is the difference between true mental illness and drug induced psychosis? How can an accurate diagnosis be made if a person's mind is altered by either licit or illicit drugs at the time of assessment? How long will it take for our mental health and health systems to collapse under the pressure while we ignore what to many are just common sense action steps?

Over a 12-year period I learnt a great deal about addiction, mental illness and about the systems in place, and over the years I became more and more disgusted that millions of taxpayer dollars literally are used to churn over an industry of human misery. It is like a machine that chews them up and spits them out, and the people in that machine are like drones. They have come to rely fully on medication, whether or not it works. I have waited for three years for an opportunity to tell this truth in this place, and this speech has actually been that long in the making.

I have here a paper that I would like to table for members to look over, if there is any slight interest in how this bill would be used. It is called 'Infectious Agents in Schizophrenia and Bipolar Disorder', written by Dr Robert H. Yolken, MD and E. Fulle Torrey, MD. I read this study probably six or seven weeks ago and it was quite revealing. It states:

The idea that schizophrenia and bipolar disorder might be caused by infection is not new. This was a prominent hypothesis in the early years of the last century. For example, an article entitled 'Is insanity due to a microbe?' was published in Scientific American as early as 1896. Research to test this hypothesis by identifying causative viruses was already being conducted by the 1930s, when data were reported from experiments in which cerebrospinal fluid (CSF) from patients with schizophrenia was injected into rabbit brains.

New research in the field continues, aided increasingly by impressive technologic advances in microbiology and virology. As recently as the past decade, reports documented the presence of influenza virus, rubella virus, bovine disease virus, and other infectious agents in patients with schizophrenia and bipolar disorder, as well as the presence of other infectious agents in childhood paediatric autoimmune neuropsychiatric disorder associated with streptococcal infections (PANDAS) and obsessive-compulsive disorder.

In this article we briefly highlight the background of this research; discuss our own research on Toxoplasma gondii, herpes simplex virus (HSV)...

Background and rationale

Why should we look for infectious agents in schizophrenia and bipolar disorder? Such a hypothesis is consistent with the known genetic contributions

to these disorders. Indeed, a genetic predisposition is well established for most chronic infectious diseases, including tuberculosis, malaria, polio, AIDS and peptic ulcers caused by Helicobacter pylori. The hypothesis is consistent with the role of neurotransmitter abnormalities in schizophrenia and bipolar disorder, because specific infectious agents have been shown to alter dopamine, serotonin, glutamate, amino butyric acid and acetyl choline in animal models. The hypothesis is also consistent with neurodevelopmental models of schizophrenia and bipolar disorder.

This goes on to say that there are, in fact, a number of viruses that a person can have and can contract that would lead to signs and symptoms of schizophrenia that may not manifest until their early teens, and rarely are these viruses tested for.

People start to show these symptoms of schizophrenia or bipolar, are diagnosed on their behaviour rather than on the pathology, are then put on medication and those medications can actually aggravate the condition and make them far worse, physically and mentally, and make them quite psychiatric, and that could be a permanent condition, whereas a simple antibiotic, if these things are traced, could actually remove those signs and symptoms within weeks and they could be restored to full mental and physical health in no time at all, but we do not do these tests.

An additional important reason to look for infectious agents in schizophrenia and bipolar disorder is that CNS infection by specific pathogens frequently mimics the clinical symptoms of primary psychiatric diseases, for example, Carofen College reviewed 108 cases of psychiatric disorders resulting from suspected or confirmed CNS viral infections. In 62 cases a specific virus was implicated, including HIV, HSV1, HSV2, Epstein-Barr and CMV, and measles, mumps, coccidia and influenza viruses. Among bacteria, the fact that the spirochaete of syphilis can cause the symptoms of schizophrenia was well known to psychiatric commissions of an earlier era. More recently, infection with the spirochaetal organism borrelia—

The Hon. P. Holloway interjecting:

The Hon. A. BRESSINGTON: Just let me get through this word first—borrelia burgdorferi has also been associated with schizophrenia-like symptoms in some persons.

The Hon. P. Holloway interjecting:

The Hon. A. BRESSINGTON: Mr President, I do have quite a bit more to go. I know this is probably boring for most, but it is—

An honourable member interjecting:

The Hon. A. BRESSINGTON: Well, you know, I am seeking leave to conclude because I do want to read the rest of this onto the record because I think it is very important to the debate. If we are debating a mental health bill then we should actually be knowing what we are dealing with, or what we could be dealing with. I seek leave to conclude my remarks later.

Leave granted; debate adjourned

At 10:38 the council adjourned until 28 April 2009 at 14:15.

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MENTAL HEALTH BILL

(Extracted from Hansard)

The Hon. A. BRESSINGTON (20:00): I will resume my comments on the Mental Health Bill, having sought leave to conclude my remarks on the last Wednesday of sitting. Just to recap briefly, the main point so far is that there are many viral causes that can mimic or show the signs and symptoms of schizophrenia and bipolar disorder. Many of the people in our mental health system at the moment who have been diagnosed with schizophrenia may well have fallen victim to these viral infections. They have been on medication quite some time, and it is a concern that perhaps they are not receiving the medical attention and medical examinations that they need prior to a diagnosis for those mental illnesses dictating their medications and treatment.

Proving a causative role for infectious agents in schizophrenia and bipolar disorder would open the door to new treatments and disease prevention strategies. With the support of the Stanley Medical Research Institute, several double-blind treatment trials are being conducted that involve the use of adjunctive antibiotics and anti-viral medications in persons with schizophrenia and bipolar illness.

To date, these medications show some promise in patients with recent onset disease. The results are less remarkable in persons with long-standing illness. In the future, it might even be possible to develop a vaccine to protect children against possible infections that contribute to these two mental illnesses. Early intervention and early detection seem to be the key.

Even with what is known today in clinical settings, some patients who present initially with symptoms suggestive of schizophrenia or bipolar disorder could instead be in the initial stages of viral encephalitis. Some physicians would argue that patients with first admission psychosis should have a lumbar puncture and a CSF analysis adding other studies, as appropriate, if indicated by an increase in CSF protein or lymphocytes. A small sample of the CSF could be frozen and stored for future analysis.

With further advances in research at the interface between psychiatry and infectious disease, these samples may eventually provide the key to proving the connection between infection and mental disturbance and pave the way for pharmacological treatment specifically targeted to the causative infectious organism.

I have a paper that was written by Dr James Gottstein, who is a graduate of the Harvard Law School 1978 and Bachelor of Science at the University of Oregon. He is currently the president of the Law Project for Psychiatric Rights where he works on a pro bono basis. His paper is titled 'Involuntary Commitment and Forced Psychiatric Drugging in the Trial Courts: Rights Violations As a Matter Of Course'. I am not

going to read out the entire study (for which, I am sure, members are all very grateful), but I would like to quote a small piece of this study. This is his opening statement:

A commonly-held belief is that locking up and forcibly drugging people diagnosed with mental illness is in their best interests as well as society's as a whole. The truth is far different. Rather than protecting the public from harm, public safety is decreased. Rather than helping psychiatric respondents, many are greatly harmed. The evidence on this is clear. Constitutional, statutory, and judge-made law, if followed, would protect psychiatric respondents from being erroneously deprived of their freedom and right to decline psychiatric drugs.

However, lawyers representing psychiatric respondents, and judges hearing these cases uncritically reflect society's beliefs and do not engage in legitimate legal processes when conducting involuntary commitment and forced drugging proceedings. By abandoning their core principle of zealous advocacy, lawyers representing psychiatric respondents interpose little, if any, defence and are not discovering and presenting to judges the evidence of the harm to their clients. By abandoning their core principle of being faithful to the law, judges have become instruments of oppression, rather than protectors of the rights of the downtrodden.

I am not suggesting for one moment that a person who is exhibiting behaviour that may be diagnosed as a mental illness should be allowed to commit crimes against society or themselves or involving property and that there would be no consequences or intervention, because I am not a bleeding heart do-gooder. I hold the firm view that every person who co-exists as a member of society must take personal responsibility for their actions and for the effect that their actions have on members of the wider community. However, just as the client I spoke of earlier was able to recover and has repaid his debt to society many times over, so too does any person who has a mental health issue have the right to try.

There are numerous causes for aberrant behaviours. Those causes are well listed and well researched, and I mentioned them earlier in my speech on this bill. Not all mental health issues are caused by substance abuse, as we all know, but could we not at least start with the process of elimination? By that, I mean getting the proper history of a person and, if substance abuse is an issue, dealing with that. If there are viral infections, we should test for them and deal with them and see how the person progresses. When a person is presenting and re-presenting and no progress is being made, would it not make sense to first of all take these precautionary measures and identify what could be the core issue with respect to the person exhibiting mental health problems, such as schizophrenia, bipolar or psychosis?

There is already sufficient legislation in place in the Controlled Substances Act 1984 to allow for a person to be put into mandatory treatment if substance abuse is an issue and, if anyone in this place believes that this is a violation of human rights, please spare me the platitudes, because what we are talking about here is being able to involuntarily commit people into the mental health system. I know that there are opinions that enforced treatment for substance abuse perhaps does not work, but the research from overseas shows a very different result, and I think it all depends on the kind of treatment a person is receiving as to whether the argument should be based around whether it is to be enforced treatment. I think the whole issue of enforced

treatment for people with substance abuse issues comes down to the mental picture that we get in our head about the sorts of places people would attend to receive the treatment and perhaps even the counselling they need.

Human beings have committed the worst atrocities against their own kind while professing to be trying to deal with mental health issues. We have used the vulnerable as lab rats, in my opinion, and the human toll is at the extreme end. In 1888, Swiss asylum superintendent Gottlieb Burkhardt became the first known psycho-surgeon when he removed brain tissue from six patients. Although one died and others contracted epilepsy, paralysis and aphasia (a loss of ability to use or understand words), Burkhardt was pleased with his newly subdued charges and reported the results in glowing terms at the Berlin Medical Conference of 1890.

The year 1935 truly marked the true birth of psycho-surgery. Egas Moniz, a professor of neurology in Lisbon, Portugal, observed an experiment in which the frontal lobes of two chimpanzees were removed, leaving the animals docile and vacant. Moniz wasted no time in conducting the same operation on his own mental patients and pronounced the procedure a stunning success. However, a 12 year follow-up study revealed that Moniz's patients suffered relapses, seizures and death.

In 1935, after hearing of operations that rendered monkeys docile and malleable, Egas Moniz conducted his own psycho-surgery on troublesome patients. His fellow psychiatrists lauded his work, and he was even awarded the Nobel Prize in 1949, but his victims viewed matters in an entirely different light. In 1939, Moniz was shot five times and paralysed by one of his leucotomised patients. In 1955, another patient attacked him, this time fatally. Some may say that indicates that they have a mental illness. I would say that it probably indicates they were pretty displeased with the way in which they had been treated, and it also shows that removing brain tissue from a person does not necessarily mean that they will remain docile and malleable for the rest of their life.

On 14 September 1936, an American psychiatrist, Walter Freeman, hammered an icepick through the eye socket of a patient and into the frontal lobes of the brain. Slashing the instrument from side to side, Freeman destroyed wide sections of tissue. Following Moniz's lead, Freeman described his lobotomy as 'mercy killing of the psyche' and widely promoted it. At the height of his fame, Freeman toured cities in a campervan called the lobotomobile, publicly lobotomising patients for the press corps and curious onlookers. The psychiatric community successfully convinced state governments that psychosurgery would reduce mental health budgets.

The superintendent at Delaware State Hospital, for example, was so taken in by the propaganda that he hoped to reduce the number of mental patients by 60 per cent. The combined total of anticipated deaths and discharges would provide savings of \$351,000. By the time operation icepick ended in the 1960s, an estimated 113,000 people—40,000 of them Americans—had been lobotomised, with the death rate ranging from 10 to 20 per cent. At least 22,000 of those were fatalities.

In spite of the multitude of victims whose lives have been completely destroyed by psychosurgery, psychiatrists have never been forced to stop the butchery. Today, instead of icepicks, psychiatrists use a scalpel or electro implants to destroy healthy portions of the brain, crippling patients.

I give that historical account of psychosurgery, not to say that there may not have been some improvement in the way in which we do it—I know we do not use

icepicks—but, rather, to show that psychiatry on the whole has a dubious history. They have done these types of experiments on human beings with little success and little long-term outcome—not very good outcomes for the patients—yet this particular modality is held up to be the be all and end all authority on mental illness.

Previously, I mentioned the increase in mental illnesses listed in DSM-IV over a period of decades. It now refers to disorders such as written expression disorder and, as I will address later, ADD and ADHD for children. For none of these is there a medical or genetic test that could be conducted to show that these mental illnesses exist on their own, that there is not some other sort of antagonist which is contributing to the signs and symptoms we are seeing. Although we talk often about no funding, not enough resources, and needing bigger and better facilities to house people, it seems we are somehow reluctant to look into what might be the primary cause of people suffering from hallucinations, and whatever else.

This has been a historical practice of psychiatry, and they have got it wrong many times in the past. In 2009, one would hope that we would be prepared to look at that history, rather than believe that it does not need to be acknowledged. We have done all this before. We have tried all this before and it has failed. We have not made people well. Very few people who are caught up in the mental health system recover well and get on with their life—yet we persist. We persist to do it in the same way in which they were doing it even in 1888. One has to ask the question: why do we do this?

It was always the belief that those with a mental illness were subject to certain psychopathology; that is, those who murder and maim without fear of conscience and those who were not able, for whatever reason, to live within the reasonable expectations of a civilised society. However, the higher the expectations of governments and bureaucracies to moderate people's behaviour and freedom of speech through the requirement to be politically correct, the more confusion there is about who is mentally ill and who is simply being their true authentic self. We are all known for eccentric behaviours and oddities, but more and more this is now being listed in DSM-IV and branded as a sign or a signal that someone has a mental illness.

I have also seen average citizens in search of nothing more than justice become labelled as belligerent, vexatious, unreliable, or even unhinged, because they dare to stand up to what they have been able to prove in the courts time and again and seek recourse. In fact, I would go so far as to say that the actions of this place and the other place at times can take and have taken some people to the brink of insanity through nothing more than refusing to admit that due process was set aside because certain powers simply wanted to win in order to deliver a profit or sometimes simply to save face.

There seems to be little acceptance that our actions and decisions in this place here affect many who would otherwise have been content to live their lives and to raise their children with as little interference as possible, but it seems that, once you invite the government into your life, you will struggle to regain any kind of normalcy from that point on—and I have literally seen hundreds of examples of this. We have now been convinced that depression is a mental illness. I am very much aware that people with depression can be absolutely immobilised by this condition, and I am also acutely aware that short-term use of re-uptake inhibitors can have a positive effect on their feeling of wellbeing, but I challenge depression being classified as a mental illness. Again, this will be seen as highly politically incorrect.

I believe that, at some time, most people in their lives have been depressed and that their lives have fallen in a hole for a period. It is also my experience that those who get to the reason why have a far greater chance of recovering and living well than those who rely solely on medication to take away the feeling of uncomfortableness and despair. Of course, in a medication focused society this may be hard to comprehend, but that is where we are today; that is, where anyone who does not feel 100 per cent all the time suffers episodes of mental illness and they need to be medicated for that.

I have read stories of teenagers presenting at a doctor's surgery who are stressed because of the expectations placed on them today, and rather than being told to take care of themselves and to cut back on their responsibilities, they are prescribed antidepressants such as Prozac. Now, governments are partly responsible for this because we gradually expected our teenage children to work, study for year 12 exams, and then told them they were old enough to make their own decisions about whether or not they wanted to live by the rules of their parents—all this, expecting them to be adults before they have even completed their adolescence.

We create the environment and then wonder why these days so many kids suffer from depression. My theory is that they are expected to grow up way before their time and they miss the fun, the real fun of growing up and being able to establish a healthy level of autonomy, a sense of worthiness and an opportunity to connect emotionally with family and to live their lives with reasonable expectations and limits. Today it is all or nothing. I believe this has been a social experiment that has failed our children dismally and created a market for mental illness to be invented and medications to be promoted. The quick fix has been created. It was not an accident: it was merely poor social policy and now we live with the consequences.

Our families have been under attack and we are creating a society where the need for families is minimised to the point where it is no longer important to so many. Our kids can leave home, if they do not like the rules, and set up house before they have any preparation time for adulthood or responsibility. If we are to have a revamped mental health act that is about true mental health, then we need to look at a social policy that has fragmented our families, our values and our responsibility to our children. Most families are trying desperately to create meaningful relationships with their children but, sadly, the external environment does not support those parents.

We really did not figure out where our kids fit in the scheme of things, I do not believe, and we still struggle with that. We are not sure any more of what the role of parents is. Just as corporations are losing that generational knowledge, I believe that, as a society, we are losing that generational knowledge of family, the hierarchy of family and how that all fits into the scheme of helping our kids to grow into well balanced adults who have a reasonable understanding of personal responsibility.

Family breakdown is a main concern for many communities. Rather than look back on what we have done differently that has not worked, we just seem to push forward with policies that put everybody under a great deal of distress, trauma sometimes and strain, and it seems to be nobody's responsibility to look, wind back the clock and admit that somewhere along the line we have thrown the baby out with the bath water. I also have a paper called 'An Epidemic of Depression' from the *Psychiatric Times*, volume 25, No.13. I will not read the entire study, which I am sure members will be pleased about, but will table it so that members have access to it if they desire. I will quote a couple of paragraphs as follows:

Major depressive disorder (MDD) has become psychiatry's signature diagnosis. Depression is diagnosed in about 40 per cent of patients who see a psychiatrist. This percentage is double that of just 20 years ago and it is far higher than that of any other diagnosis. The World Health Organisation estimates that worldwide depression is the leading cause of disability for people in mid-life and for women all ages. Consumption of antidepressants has soared since 1990. Roughly 10 per cent of women and 4 per cent of men in the United States take antidepressant medication at any time. By 2000, antidepressants were the best selling prescription drugs of any type, yet epidemiological studies suggest that there are still vast numbers of untreated depressed individuals.

So, literally, we are all depressed! It continues:

To catch the problem early a presidential commission has recommended that every adolescent in the country should be screened for depression by the time he or she reaches the age of 18. Screening is proceeding in some schools. What accounts for this seeming epidemic of depression? Although depression has been part of the psychiatric canon since the earliest writing of the ancient Greeks, depression was a relatively insignificant diagnosis just 50 years ago.

*In our recent book, *The Loss of Sadness: How Psychiatry Transformed Normal Misery into Depressive Disorder* (Oxford University Press), we argue that the recent pandemic of seeming depressive disorder is the result of changes in the psychiatric diagnostic system presented in the DSM -III in 1980, and that persists to the present. In many respects DSM -III and subsequent versions has been one of psychiatry's greatest accomplishments. It was the first to use observable symptoms rather than unobservable and undemonstrated etiological processes to define the various types of mental disorders.*

Its clear definitions of discrete categories of disorder enhance diagnostic reliability, thus putting to rest anti-psychiatric arguments about the spuriousness of psychiatric diagnosis. These definitions allowed psychiatrists to communicate in a common theory - neutral language, irrespective of theoretical perspectives, that improve the cumulativeness of research, yet these undoubted achievements also entailed some important disadvantages. These drawbacks have become especially apparent in the definition of MDD and have had substantial social consequences.

A diagnosis of MDD is warranted, according to DSM, when a patient has at least five of nine specified symptoms for at least two weeks, and the five symptoms include either depressed mood or an inability to derive pleasure from life. The sole exception is that bereaved patients are not considered to have a disorder if they otherwise meet the criteria, as long as their symptoms are not unusually severe and last no longer than two months. The reason for the bereavement exclusion seems obvious: people who respond to the loss of an intimate with intense sadness, sleep and appetite difficulties, a loss of concentration on usual roles, and the like, do not have a mental disorder.

Rather, they are responding normally to a situation of intense loss. The distinction between sadness that is a normal result of painful losses and

depressive disorder is a fundamental one that has been explicitly recognised throughout the 2,500 year history of psychiatric medicine.

Yet, the bereavement exclusion rate raises the question of whether people with enough symptoms to meet the MDD criteria — after, for example, the unexpected loss of a valued job, the collapse of a marriage, the failure to achieve a highly-valued goal or the diagnosis of a life-threatening illness in oneself or a loved one — are similarly reacting normally to situations of intense loss. For thousands of years, until DSM-III, physicians understood that these kinds of situational contexts were an important consideration in determining whether someone was experiencing normal—although intensely distressing—sadness or a depressive disorder in which something has gone wrong with mood processes, and the sadness symptoms are no longer linked to the situation or likely to remit over time. Unlike many other diagnoses in DSM, which contain qualifiers that require symptoms to be 'excessive' or 'unreasonable', no such qualifiers exist for MDD. Aside from the bereavement exclusion, the diagnostic criteria do not take into account the context in which symptoms arise.

Ample scientific evidence, ranging from infant and primate studies to cross-cultural studies of emotion, suggested that intense sadness and response to a variety of situations is a normal biologically-designed human response. Recent epidemiological analysis suggests that the consequences of stresses can be either normal or abnormal and similar to those for bereavement. In its quest for reliability via symptom-based definitions that minimise concern with the context in which the symptoms appeared, DSM unintentionally abandoned the well-recognised, scientifically supported, indeed, commonsensical distinction between normal sadness and depressive disorder.

The blurring of the distinction between normal intense sadness and depressive disorder has arguably had some salutary effects. For example, it has reduced the stigma of depression and created a cultural climate that is more accepting of seeking treatment for mental illness. Many people with normal sadness might benefit from medication that ameliorates their symptoms. However, the usefulness of medication for normal sadness and especially the trade-off between symptom reduction and adverse effects has not been carefully studied, partly because the necessary distinctions do not exist within the current diagnostic system.

We have seen that psychiatry is actually capable of blurring lines that used to be quite clear. I am not suggesting that anyone who has been diagnosed with depression should not seek some sort of medical intervention, but I was also told that these serotonin reuptake inhibitors were never designed for long-term use. They were actually designed for a period of about six weeks to help rebalance the central nervous system and the endorphins such as serotonin and dopamine which help to balance our mood. At Drug Beat, for example, I have seen people who have been on antidepressants now for 15 years. When one antidepressant stops working they are simply prescribed another and another, and they reach the point where they have a serious addiction and their lives are falling apart. They cannot even remember why they were prescribed a medication in the first place.

The detox, I might tell members, and the recovery period from these kinds of medication is very severe, and it must be done very slowly. We have one particular

client in Drug Beat now who has been reducing her doses of anti-depressants for more than three years. The effects of that on her have been quite remarkable, both physically and emotionally, and she has gone through some pretty dodgy times wondering whether she could complete her program. She is there voluntarily, but her family makes the point that since she has been on these medications for so long it seems that nothing is able to give her pleasure of life any more.

She derives no pleasure from her children or her grandchildren. As she comes off these medications now (and she is at the tail end of this), she said that it is like she has just moved out of this huge black fog she has been living in for so long.

So, we need to be careful about this sort of stuff, and we need to be aware that the legislation that we put in place here has a remarkable effect on people's lives and also on the latitude that is allowed to be taken by professionals who prescribe these medications. I had a conversation with the Minister for Mental Health and Substance Abuse, and I was quite surprised, when trying to get a handle on how we regulate this, that if we were to try to do that we would be laughed at by the medical profession.

After three years, I am still not clear what our role is in regard to regulating that kind of thing, but you would think that, if we were to do research on this and find that these kinds of practices were doing people great harm, it would be the role of this parliament to step in and regulate to some degree. Frankly, I, for one, would not care a toss whether the medical or psychiatric professions wanted to laugh at me for taking a proactive role in reversing some of the damage we are doing.

We do a lot of good things, also. Members should not get me wrong: I am not saying that the whole of the mental health system is a failure. However, when it is not working for everyone, when it is not working on a case-by-case basis and when the one-size-fits-all approach does not work, I believe we have an obligation to look for other means and other ways to help those people who have approached the system or been caught up in the system for whatever reason, and I do see that as a responsibility of this place and the other place. To quote further from that document, it states:

Psychiatrists need not be moralists, judging whether patients should or should not take medication for life's normal disappointments and suffering. It is, however, each psychiatrist's responsibility to diagnose as fully and as accurately as possible and not to bias a patient's decision regarding treatment by a diagnosis that mistakenly labels as a disorder what is likely a normal response that will abate on its own as the patient copes with a difficult life change. Watchful waiting, as well as a range of empirically tested psychotherapeutic interventions that are demonstrated to be as effective as medication for treating non-severe conditions, might be substituted for prescriptions in such cases.

That is a medical paper that basically backs up my concerns with the way that this system is going. Another concern I have is that we will see ADD/ADHD in children included in DSM-IV, and we still do not even know that ADD/ADHD exists. We do not know that it is not food allergies, we do not know that it is not partial deafness or, again, viral infections. There is a number of allergies and conditions that can cause children to be overactive, hyperactive and have poor attention.

To make the point, I went to a meeting some months ago now at which about 600 people were in attendance, and it was about this very issue of ADD/ADHD in children. All people attending had had their children diagnosed or were in the process

of being diagnosed with ADD/ADHD. Some of them, I might add, had to do nothing more than walk into a doctor's surgery and ask for a prescription of Ritalin or Strattera for that diagnosis.

In the process, the people who were conducting this meeting had the DSM-IV criteria for ADD/ADHD and, for a child to be diagnosed with those particular disorders, they have to exhibit only six of a list of about 39 symptoms. The people conducting this meeting read out the symptoms, and we were all asked to stand and, when we counted six symptoms that we knew that we exhibited, to sit down.

It should be remembered that this is a room with 600 adults, and there were pockets of people sitting down all over the place. They read the list of symptoms for ADD/ADHD and, by the time they had finished reading through the whole 30 symptoms, there was not one adult in the room standing.

I do not believe that every adult in that room was ADD/ADHD. However, these are the sort of signs and symptoms and the tools that are being used to diagnose our children with ADD/ADHD. A lot of these children are being put on some pretty heavy duty medications that do result in kids being addicted to amphetamines. I have seen kids who have been diagnosed with ADD/ADHD who exhibit more signs of addiction than they do of ADD/ADHD.

I have also seen children who have been diagnosed with ADD/ADHD who have had a change in diet and who have had a regular sleep pattern and routine implemented in their home, and their behaviour changes dramatically and their concentration improves, and teachers comment on the change. My seven year old son is one of those kids. He was diagnosed with ADD/ADHD at the age of three, and the recommendation was that he go on medication. I did not do that. I went through the process of learning about ADD/ADHD.

We are very careful about his diet: he does not drink coke or eat chocolate. His understanding is that he is allergic to these foods, and he can make the choice, when he goes to a friend's place, to refuse to eat these foods. He says himself that, when he eats them, they make him feel unwell. This is a seven year old child who has been educated to understand that he has a reaction to certain foods and drinks and that he needs eight hours sleep a night. I am proud to say that, at the age of seven, he can take a level of personal responsibility to make sure that he is not disruptive at school.

So, there are a number of things we need to consider. One of the amendments I will move in relation to this issue is that children under the age of six should not be prescribed these medications. That is not based on my personal experience with my son. It is based on a handful of freedom of information documents from the TGA that show adverse effects on children who have been prescribed Ritalin and Strattera under the age of six.

It should be remembered that these drugs that we are giving these kids have never been approved for use for anyone under the age of 16, yet we are prescribing these drugs to children, some as young as 12 months old, and these children are being described as disturbed toddlers. I would like anyone in this place who has dealt with toddlers to explain to me how, at some stage, every toddler is not a little disturbed, because that is what being a toddler is about.

It was my original intention to read out a number of these documents, but I will read only a couple of them. As I said, these are freedom of information documents (public case details) from the Therapeutic Goods Administration. The first

one relates to a five year old boy who was prescribed Zoloft. He was admitted to hospital with severe muscle twitching and severe, continuous facial twitching. After a night of observation, the Zoloft was ceased.

Another one relates to a 12 year old who was prescribed Zoloft. He was diagnosed with a platelet disorder, resulting in an increasing bleeding time. The patient was hospitalised, and Zoloft was ceased. Another one relates to a five year old who was prescribed Strattera who, after two days on the medication, was having ideations of throwing himself in front of a car. He was hospitalised for a week. His medication was stopped, and his suicidal ideations—at the age of five—ceased within a week.

A four year old who had been prescribed Zoloft was admitted with agitation, nausea, palpitations and severe parasthesia. This four year old was suffering severe panic and feelings of impending death. He was on 50 milligrams of Zoloft, a dose that most adults probably could not tolerate. One of the other reasons he was admitted was depression—at the age of four. He was hospitalised, put under observation, medication was ceased, and within a week he was a normal four year old child again.

I need to stress this because I feel that medication as a first resort is a disturbing practice, but we have so many parents out there who do not know that there are alternatives. There are so many parents who do not understand diet, exercise and all that sort of thing. I am not saying that it is the government's responsibility to make sure that people know, but surely it is the government's responsibility to educate people, to put that information out there and distribute it as widely as possible, and to discourage the use of these medications on our children.

I saw a case of a 12 month old baby on Prozac, because the baby was not sleeping at night. Now, we could get a bit cranky with the parents for accepting that their 12 month old should be on Prozac, but I believe we could also get quite peeved at a medical practitioner who prescribed Prozac to a 12 month old baby when the baby was, in fact, simply teething. Parents need to understand, and be educated at parenting classes, that when they have children they will have sleepless nights.

Life changes when you have a child, and it changes when you have two children. We have lost that generational memory, or knowledge, of parenting and all the rest of it, and if families cannot provide that kind of knowledge we have to do something—other than have 12 month old children on medications that change their central nervous system biology for a very long time, if not forever. We do not know what effect these drugs will have on the developing brain of a 12 month old baby. In 10 or 20 years' time, when these kids grow up and perhaps exhibit signs and symptoms of schizophrenia or bipolar, or whatever it might be, because of what was done to them at 12 months old, what will the face of our mental health system look like? We need to have a vision for this, we need a long-term view; we need to take responsibility, because no-one else will and it will continue and be perpetuated.

I think I have covered the main points I wanted to make, and I think I also made most of these points in my previous contribution, so I will close on this. I beg all members in here to do their own research into the history of psychiatry. I am not by any means anti-psychiatry but I think that when we start holding up one modality in particular as the be-all-and-end-all for finding solutions to our mental health system we leave ourselves wide open to catastrophe in the future.

The historical practices of psychiatry, psychosurgery, and all those sorts of things are, to say the least, dubious. There are many other people out there and many other—I will say it—non-government organisations that treat people with mental illness without medication, and actually do what psychiatry was meant to do in the first place, which was to study the soul. I believe that 'psyche' is the Greek word for soul. This was never about manipulating brain chemicals, and whatever else: it was about getting to the depth of people's distress—what sends them into a spin in the first place, what changes their body chemistry and creates depression and trauma (and whatever else), and dealing with those traumas, rather than medicating (because it is a cheap option) and trying to get people to forget that they have a history and that they are a part and product of their emotions.

Let us start to get back on track and start treating people as people rather than receptors for any kind of medication that we would like to prescribe for them. For me, this is a bill that needs serious consideration and, if we can do things differently and do them better in the future, that is what we should be aiming at, rather than just revisiting a bill for the sake of it. So, I leave that contribution with members.