MENTAL HEALTH AMENDMENT BILL 2015

Second Reading

Resumed from 17 November.

DR A.D. BUTI (Armadale) [12.20 pm]: I rise to speak on the Mental Health Amendment Bill 2015. If one were to look at the history of when the Mental Health Bill was debated last year, one might think that this debate will go on for a couple of months, but we are very fortunate that this is a very simple bill that seeks to bring in some slight amendments, although they are not slight in the sense of their consequences and what we are trying to do with this bill with the definition of "psychiatrist" as a result of changes made by the registration board, or was it the health board?

Ms A.R. Mitchell: It was the medical board.

Dr A.D. BUTI: Yes, it was the Medical Board of Australia. If this amendment is not passed, it may result in a shortage of psychiatrists in Western Australia, which may affect the operations of the new Midland Public Hospital. The amendment to the definition of "psychiatrist" is a sensible amendment, and I foreshadow that we do not want to go into the consideration in detail stage for this bill. I am sure that the parliamentary secretary's advisers—is that them at the back of the chamber?—will be very happy about that. They may have wanted to spend an afternoon and evening at Parliament, rather than go back to their offices. However, if we do not tell their boss, maybe they can stay here all afternoon!

Mr D.A. Templeman: The parliamentary secretary can take them for lunch!

Dr A.D. BUTI: Okay, we will see whether we can do that.

Mr W.J. Johnston: We can get it done by one o'clock.

Dr A.D. BUTI: Actually, it will be done by one o'clock, and that is a perfect time for lunch!

Even though the opposition agrees with the bill and we will not seek to interrogate the proposed amendments, next year there will be an issue with the Mental Health Act 2014 regulations. I am sure that the parliamentary secretary has received, as I think most of us have received, an email from a number of widely respected organisations such as the Health Consumers' Council, Richmond Wellbeing, Helping Minds, Carers WA, the Mental Illness Fellowship of WA, Consumers of Mental Health WA, the Mental Health Law Centre and Mental Health Matters 2. Section 6(4) of the Mental Health Act 2014 states —

> A decision whether or not a person has a mental illness must be made in accordance with internationally accepted standards prescribed by the regulations for this subsection.

The proposed regulation seeks to include the *Diagnostic and Statistical Manual of Mental Disorders*—DSM—published by the American Psychiatric Association, to determine whether a person has a mental illness rather than to use only the *International Statistical Classification of Diseases and Related Health Problems*—ICD-10—published by the World Health Organization. That is a worry, as outlined in this email from the group of mental health organisations, which states —

> We request the regulation is amended to read:
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> For section 6(4) of the Act, a decision whether or not a person has a mental illness must be made in accordance with the diagnostic standards set out in the *International Statistical Classification of Diseases and related Health Problems* [ICD] published from time to time by the World Health Organisation [WHO].

That publication should be sufficient, which means that we do not need to include the DSM from the American Psychiatric Association. I think we always have to tread very carefully when we look to America for our standards for psychiatric treatment or psychiatric definitions. I do not think that America is necessarily the place where best practice is to be found internationally. I am sure that the parliamentary secretary will correct me if I am wrong, but by allowing, or bringing into play, the DSM, we will be the only jurisdiction in Australia that uses that publication rather than relying on the World Health Organization publication, the ICD.

To give a bit of flesh or context to the amendment sought by the mental health organisations, I want to extensively cite a paper by a former colleague in this place Dr Martin Whitely, the former member for Bassendean. Since leaving Parliament, he has received his PhD. He prepared a paper on the rationale for the amendment not to include the DSM, which is now DSM–5, sought by the group of mental health organisations. The report states —

> If the draft regulation is not amended this would allow individual mental health practitioners to choose whether they use the latest version of the ICD or the extremely controversial DSM5 (published in

> May 2013) when exercising their powers under the Act. By defining who is mentally ill these 'standards' will determine who can potentially be involuntary detained and treated against their will, most often with psychotropic drugs with potential serious adverse side effects. The standards must therefore be based on valid and reliable definitions of mental illness. We emphasise that removing the reference in the proposed regulation to DSM5 would not prevent psychiatrists or other medical doctors using DSM5 to diagnose mental illness. It would simply ensure that when the powers afforded to psychiatrists under the *Mental Health Act 2014* are used the definitions of mental illness applied are 'internationally accepted' as required by the act.

The parliamentary secretary's second reading speech refers to the coercive nature of the Mental Health Act whereby people can be involuntarily admitted to a facility as a result of a mental illness; therefore, it is very important to understand how we determine whether a person has a mental illness. Dr Whitely goes on to state —

> DSM5 has been globally criticised as arbitrarily broadening the boundaries of mental illness and classifying normal human behaviour and emotions as disease. Significant international organisations including the British Psychological Society and countless prominent international psychiatrists have been very critical of DSM5. In April 2013, three weeks before DSM5 was published, the Director of the US National Institute of Mental Health … Dr Thomas Insel, stated that DSM5 lacked 'validity' and that consequently the NIMH 'will be re-orienting its research away from DSM categories'. Put plainly DSM5 is not 'internationally accepted' or even universally accepted in the USA and therefore the proposed regulation is inconsistent with the *Mental Health Act 2014*.

I am led to believe that when this legislation was being debated in the other house last night, the minister was not overly receptive to the idea that this regulation needs to be amended. Of course, with the government's reshuffle at the end of the year, the parliamentary secretary may become the Minister for Mental Health. If, by the end of the year, she is not the Minister for Mental Health, I am sure that she will be a minister of the Crown. But let us get back to this very important issue before us. One of the most notable critics of the American "Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition" is Professor Allen Frances. That is interesting because he led the development of the prior edition, the DSM–IV, published in 1994. Soon after the DSM–5 was published in 2013, he wrote —

> The lesson should be clear that every change in the diagnostic system can lead to unpredictable overdiagnosis.

That is a real problem. Due to the government's inclusion of the DSM diagnostic definitions published from time to time by the American Psychiatric Association, these groups have expressed their concern that there will be an over-diagnosis of people with mental illness. The consequences that can flow from that include involuntary hospitalisation and, of course, involuntary medication. As we know, in the American health system there seems to be a propensity to over-diagnose and over-medicate people. I am concerned that we are not going with the internationally recognised International Classification of Diseases standard, and ask why the DSM needs to be included. If people are not convinced yet, this part of Dr Whitely's paper is important and, hopefully, will convince people. He writes —

> Professor Frances has identified many DSM5 changes that will likely add to '*the history of psychiatry (which) is littered with fad diagnoses that, in retrospect did far more harm than good.*'

I will go through the 10 changes. Remember that during the number of years that Dr Whitely spent in this chamber he was looking at over-medication of children, particularly for attention deficit hyperactivity disorder. A few years ago now, because of Dr Whitely's work, some changes had to be made at a primary school in my region. A queue of children were lining up at recess time to receive their medication for ADHD. That was sometimes in response to the kids being just a bit hyperactive, or boys were just being boys, generally. There were not many females in the line. I worry that by including this American standard, we will see over-diagnoses and the consequences from that. The following is Allen Frances' list of concerns —

> 1. Disruptive Mood Dysregulation Disorder: DSM 5 will turn temper tantrums into a mental disorder …

That would be a problem in this house, would it not, member for Mandurah? A few people in this chamber could be over-diagnosed if temper tantrums can be diagnosed as a mental disorder. Dr Frances continues —

> We have no idea whatever how this untested new diagnosis will play out in real life practice settings, but my fear is that it will exacerbate, not relieve, the already excessive and inappropriate use of medication in young children …
>
> 2, Normal grief will become Major Depressive Disorder, thus medicalizing and trivializing our expectable and necessary emotional reactions to the loss of a loved one and substituting pills

and superficial medical rituals for the deep consolations of family, friends, religion, and the resiliency that comes with time and the acceptance of the limitations of life.

The *Four Corners* documentary on Monday night, which I saw about one and a half minutes of, was about being a teenager today. The problem is that we have come to the view that we have to be happy all the time. Life is not like that; we are not always happy. We do not have to always be happy. It is better to be happy than not happy, but because someone is not happy does not mean that we have to have grave concern. A bit of resilience needs to be built up in people. There is nothing wrong with people failing, feeling sad or grieving given the context of their experience at that time. There will be problems if we create a diagnostic standard of normal grief being a major depressive disorder. Dr Frances continues —

3. The everyday forgetting characteristic of old age will now be misdiagnosed as Minor Neurocognitive Disorder, creating a huge false positive population of people who are not at special risk for dementia.

As I say, there is no upside to ageing. As people age, they often forget things. A study indicated that increased exercise by people ranging in age from 64 to 85 will decrease the rate of the onset of dementia. If the parliamentary secretary becomes the Minister for Sport and Recreation, it would be advisable to look at investing in programs that lead to increased activity among all sections of the population, particularly among the ageing sector. Dr Frances continues —

4. DSM 5 will likely trigger a fad of Adult Attention Deficit Disorder leading to widespread misuse of stimulant drugs for performance enhancement and recreation and contributing to the already large illegal secondary market in diverted prescription drugs.

Dr Whitely stated numerous times in this chamber, and wrote a book on the issue, that there has been over-diagnosis of ADHD in children. There is no doubt that is the case. I cannot see any reason that would not necessarily happen also in the adult population. We have to guard against that. Dr Frances states —

5. Excessive eating 12 times in 3 months is no longer just a manifestation of gluttony and the easy availability of really great tasting food. DSM 5 has instead turned it into a psychiatric illness called Binge Eating Disorder.

The DSM–5 manual now contains a psychiatric illness called binge eating disorder when people engage in excessive eating 12 times in three months —

6. First time substance abusers will be lumped in definitionally in with hard core addicts despite their very different treatment needs and prognosis and the stigma this will cause.

7. DSM 5 has created a slippery slope by introducing the concept of Behavioral Addictions that eventually can spread to make a mental disorder of everything we like to do a lot. Watch out for careless overdiagnosis of internet and sex addiction and the development of lucrative treatment programs to exploit these new markets.

8. DSM 5 obscures the already fuzzy boundary been Generalised Anxiety Disorder and the worries of everyday life. Small changes in definition can create millions of anxious new 'patients' and expand the already widespread practice of inappropriately prescribing addicting anti-anxiety medications.

9. DSM 5 has opened the gate even further to the already existing problem of misdiagnosis of PTSD in forensic settings.

10. DSM 5 includes a proposal for 'Somatic Symptom Disorder' (SSD). This new diagnosis will encourage *'a quick jump to the erroneous conclusion that someone's physical symptoms are 'all in the head'* and mislabelled as mental disorders '*the normal emotional reactions that people understandably have in response to a medical illness'*.

This list should ring alarm bells not just in light of the consequences for people but also due to the additional costs to the health budget every year. As we know, the health budget is one of the biggest imposts on the state's budget every year. If we create a diagnostic environment that allows the standards to be increased by referring, of all places, to America, rather than the internationally accepted standards, there is no doubt that the rate of diagnoses of people with a mental illness will increase. There is just no doubt about that. If we just went with the internationally accepted definition from the "International Statistical Classification of Diseases and Related Health Problems", which is the definition that most of the world accepts, we would have fewer people being diagnosed with mental illnesses. We are not saying that what is being proposed by the government will remove the international standards; we are saying that it will enlarge the diagnostic standards by including the definition from the "Diagnostic and Statistical Manual of Mental Disorders", published by the American Psychiatric

Association. That cannot mean anything but an increase in diagnoses and, I would say, over-diagnoses or misdiagnoses, and consequently people being held involuntarily in hospitals and other authorised places, and also an increase in over-medication. I cannot see an upside to the government including the American Psychiatric Association's diagnostic tool, the DSM—none whatsoever.

I return to Dr Whitely's paper, which continues —

> Professor Frances details his arguments in his 2013 book; *Saving Normal: an insider's revolt against out-of-control psychiatric diagnosis, DSM5, Big Pharma, and the medicalization of ordinary life* (Harper Collins, New York). His concerns can't be dismissed as the architect of the old edition protecting his work from revision. While criticizing the proposals in DSM5, Professor Frances has identified that the DSM4 process he led inadvertently helped 'trigger three false epidemics. One for Autistic Disorder... another for the childhood diagnosis of Bi-Polar Disorder and the third for the wild over-diagnosis of Attention Deficit Disorder.'

This is Professor Frances, who was the architect of DSM–IV. He has gone back and revisited that work, which he says resulted in the triggering of three false epidemics. The problem is that we now have DSM–5, which is just making the problem worse. Dr Whitely's paper continues —

> Professor Frances, believes that financial conflicts of interest are not necessarily as important as what he terms 'intellectual conflicts of interest' in driving the diagnostic inflation in DSM–5. He contends 'experts always overvalue their pet area and want to expand its purview, until the point that everyday problems come to be mislabelled as mental disorders.'

Dr Whitely then talks about financial ties to the pharmaceutical industry and the American Psychiatric Association being very heavily reliant on certain pharmaceutical funding; this is, of course, a problem.

The paper continues, further along —

> These conflicts of interest are of great concern but ultimately mental health outcomes are what matters. On this measure to the DSM fails miserably. Americans are amongst the largest per capita consumers of mental health interventions in the world and yet their mental health outcomes are appalling. Validating by regulation the American Psychiatric Association deeply flawed, Big Pharma friendly, diagnostic standards, leaves WA mental health consumers, particularly involuntary patients, vulnerable to similar outcomes.

That is what I think people need to understand, and I hope the Minister for Mental Health digests, over the summer recess before we return next year, the fact that including the DSM diagnostic standard will result in no improvement in the treatment of Western Australians with mental illnesses or disorders—none whatsoever. The ICD standards that are published from time to time by the World Health Organization are sufficient; we do not need to also include the DSM standards.

Dr Whitely's paper continues —

> Western Australia is the only Australian state which effectively outsources it definition of mental illness to foreign jurisdictions in its Mental Health Act. Other states attempt to define mental illness within their acts. We must therefore ensure that the standards are truly internationally accepted. Furthermore Australia is a member nation of the World Health Organisation but obviously not the American Psychiatric Association. Why should we follow the lead of the American Psychiatric Association when we have no opportunity to influence its' processes?

It is appalling—absolutely appalling. Time and time again we hear this government talk about best practice in Western Australia and how we are leading Australia in X, Y and Z, but with the Mental Health Amendment Bill 2015 it is trying to outsource to a US body, over which we have no influence, the standards used in mental health diagnosis.

The paper continues —

> While many of the criticisms of subjectivity of assessment of behaviours are common to both the DSM and ICD, the DSM generally contains looser, less rigorous diagnostic criteria. Studies comparing diagnosis and prescribing rates for a range of psychiatric disorders using DSM and the equivalent diagnostic criteria in ICD have established that for the majority of disorders rates were significantly higher when using DSM. The World Health Organisation's ICD is 'a product of collaboration... between very many individuals and agencies in numerous countries' and enjoys more international acceptance than the American Psychiatric Associations DSM.

It would be like Australia deciding to no longer be a member of the United Nations and to instead become a member of the Organization of American States. It is just ridiculous—absolutely ridiculous.

The final paragraph of Dr Whitely's excellent paper reads —

> For the purposes of the *Mental Health Act 2014* there is absolutely no need to have two alternate diagnostic frameworks. The ICD is sufficient and it covers the full spectrum of physical and mental illness. Having one genuinely 'international' diagnostic framework will deliver greater consistency in the application of mental health law and provide clearer guidance to clinicians applying the law and the Mental Health and State Administrative Tribunals who deliberate disputes in its application.

Of course, it is not completely relevant to the bill before us, but it is relevant to the operation of the act that this bill seeks to amend. The issue with regard to regulations will become a very important point for us to debate next year, but in respect of the bill before us, there are some sensible and necessary amendments, including a change to the definition of "psychiatrist", and a couple of other minor amendments, including the deletion of the word "authorised" in respect of hospitalisations.

As I said, the opposition supports the passage of this bill, but we urge the government to look very seriously at the regulations and, in particular, at the need to amend section 6(4) with regard to outsourcing to an American organisation, over which we have no influence, our mental illness diagnostic tools.

MS A.R. MITCHELL (Kingsley — Parliamentary Secretary) [12.48 pm] — in reply: I would like to take this opportunity to thank the member for his support of the Mental Health Amendment Bill 2015 and his appreciation of the need to improve the situation for the registration of psychiatrists in Western Australia as a result of a policy change with the Medical Board of Australia and the Australian Health Practitioner Regulation Agency. The matters he raised about the documentation and work by Dr Whitely on DSM–5 are under consideration in the formation of the regulations, which are with parliamentary counsel. I am sure they will be given the consideration they deserve. I thank the opposition for its support because it is important that we make sure that we have as many recognised and qualified psychiatrists as possible ready to work in our system in Western Australia. Thank you.

Question put and passed.

Bill read a second time.

Leave granted to proceed forthwith to third reading.

Third Reading

Bill read a third time, on motion by **Ms A.R. Mitchell (Parliamentary Secretary)**, and passed.