To: Australian Government Productivity Commission, Mental Health Inquiry
From: Christine Newton, lived experience, retired Registered Nurse
Date: 5th April 2019

ISSUES

- Examine the effectiveness of current programs and initiatives across all jurisdictions to improve mental health, suicide prevention and participation, including by governments, employers and professional groups.
- Assess whether the current investment in mental health is delivering value for money and the best outcomes for individuals, their families, society and the economy.

1.0 EXECUTIVE SUMMARY

Prolonged exposure to antidepressants had a devastating impact on my life. It took a healthy, productive 45yo seeking help for mild depressive symptoms at menopause, down a path where I now live with bipolar disorder, a serious and chronic mental health illness.

I chose to publicly share my health experience with the Productivity Commission to highlight to the Australian Government the urgent need to review a practice where antidepressants are still being used outside the Royal Australian and New Zealand College of Psychiatry (RANZCP) guidelines, causing substantial injury, damaging productivity and even loss of life amongst people diagnosed with bipolar disorder.

I presented in a high-risk group. The RANZCP and Therapeutic Goods Administration (TGA) placed treatment guidelines and alerts in place to protect consumers like me who were at risk of antidepressant therapy (TGA, 2018). The College also provided alternate options that, when eventually used, benefited me (Malhi et al, 2015). These were all dismissed. I went on to suffer adverse drug reactions to multiple antidepressants for ten years. The prolonged exposure to neurotoxins took me from being healthy, happy and productive to living on the Disability Support Pension with suicidal planning.

This practice is continuing, there are no safety nets in place for a consumer who enters the rooms of private consultants; nobody was intervening when the treatment compromised my wellbeing and endangered my life. There are more checks to the protection of consumers of the building industry than are provided to this country's most precious resource. I was vulnerable, I had neither the knowledge nor capacity to help myself. Other health care workers and government stood by whilst consultants practiced outside their college's guidelines and caused a permanent disability. This continued over a prolonged period under the care of multiple care providers, so it is fair to assume that the problem is systemic. A problem that my government needs to urgently address.
I can't stand by knowing that what happened to me wasn't an isolated case. Using my own 32 years working in the health industry, and 12 years of lived experience has helped me write 9 areas of reform. They are designed to:-

- Identify and protect bipolar consumers at risk of adverse drug reactions from antidepressant therapy;
- Identify psychiatrists who are practicing outside their scope of practice; and
- Provide access to current technology and Specialist Bipolar Clinics for Australians living with treatment-resistant bipolar disorder.

2.0 MY HISTORY

2.1 PRE-MENTAL HEALTH ILLNESS

At 45yo I was happily married. I provided 32 years' experience to my workplace, most of this as a Clinical Nurse in a busy emergency department. My career was a large part of my identity. My husband and I owner-built our own home on the weekends and had a healthy social life. My life was full, balanced and happy. ***I was safe.***

2.2 MENTAL HEALTH EXPERIENCE

In 2006 I was prescribed antidepressants for mild perimenopausal depression. I deteriorated with suicidal ideations and placed in the care of a psychiatrist. Dr A prescribed the antidepressant Lexapro (escitalopram) and increased it to 60mg, triple it's recommended dose. I depression continued to worsen with psychosis. In 2008 I was diagnosed Bipolar Affective Disorder type 1 with 'mixed states'. Lexapro was reduced to 40mg, double the recommended dose. The addition of a mood stabilizer neither buffered nor masked an adverse drug reaction from the antidepressants.

The *'RANZCP Clinical Practice Guidelines for the Treatment of Bipolar Disorder'* advised psychiatrists that when treating patients with mania or mixed state that they must first *"exclude organic causes (including) prescription medication-induced"* and *"cease any antidepressant"* (Mitchell et al, 2004).

- My organic cause of menopause was not treated for 6 years;
- From 2006-2016 I was trialed on nine antidepressants; these caused a medication-induced bipolar disorder and sustained my instability; and
- Antidepressants were not ceased despite not being clinically indicated for mixed state presentation.

My brain was all over the place. Mostly *mixed states*; distractibility, expansiveness, depression, irritability, tears, agitation, auditory hallucinations. I spoke rapidly, was excitable, made errors, couldn't multitask, had poor insight, delusions of grandeur, extreme anxiety, and I had cognitive and motor retardation. I became the person that threw charts and slammed doors. I lost my sixth sense, common sense and filter. I told people what I thought but was usually wrong. I was also paranoid that I was being talked about at work. I believed I had to go to work to prove that I was okay. Instead I destroyed my career. I went from a stable senior employee to changing jobs eight times in five years. Managers and human resources could see I was a risk, I went through an indignant process of having HR bully me out of my position.

Another time I was hypomanic in an interview. I didn't understand why they didn't inform the next person that all further interviews had been cancelled as I was awesome. However, the feedback differed. I was told that despite being the most successful applicant, they could not provide me the position because of my *"behaviour".* A further application for a similar position and I was told *"people like you should not apply for jobs where you can't be supervised"*, I wasn't shortlisted. When I was hypomanic, I would become an author, I put 82 pages together after my husband's death. I spent all my money and could completely justify it at the time. Distractibility and cognitive decline caused me to turn the wrong way down a one-way street, run red lights and eventually lose my driver's licence. My life as I knew it was gone.

Long term friends dwindled, my career and identity were taken from me. I was not functioning at any level, bills not paid, the house was a mess, having a shower seemed impossible. My nursing registration lapsed, everything that was important was now gone. I gained 45kg in the first 5 years, then decided to have a gastric lap band whilst hypomanic. As a direct result of all the above, I now exist with social isolation, multiple medical comorbidities, a polypharmacy of treatment, and dependant on Disability Support Pension. I'd quickly became a burden. Whilst struggling with symptoms of bipolar disorder I couldn't stop one recurrent thought; I should take my own life. **I was no longer stable, reliable or safe.**

3.0 TREATMENT EMERGENT AFFECTIVE SWITCH

I now understand that I suffered an adverse drug reaction to antidepressants which caused: -

- antidepressant-induced bipolar disorder;
- treatment emergent affective switch (TEAS); and
- treatment-emergent suicidal ideations.

Antidepressants were prescribed under the supervision of consultant psychiatrists. I repeatedly told them that the treatment didn't work. I had no idea they were sustaining the bipolar symptoms. Psychiatrists are trained to recognise this; the RANZCP provided treatment guidelines to prevent these reactions, they weren't followed. Instead my first episode of remission was withheld for ten years.

In 2015, the RANZCP reviewed their practice guidelines and added a *'Recommendation Box'* for the '*Administration of Antidepressants in Bipolar Disorder'* (Malhi et al, 2015). I met the criteria of a bipolar patients at risk of *Treatment Emergent Affective Switch* (TEAS), an adverse drug reaction that causes instability through mood switches (see table 1). Despite my failure to respond to antidepressants my psychiatrists chose not to follow their college's Recommendation Box. There was no opportunity for my brain to recover from a neurotoxic drug reaction when I was prescribed back to back antidepressants. Some antidepressants seemed better than others, and the intensity of the symptoms varied depending on the dosage or combination of antidepressants prescribed. However, remission was withheld until every last one was ceased. I am aware that there is a clinical indication for antidepressants for some people with bipolar

depression. I am aware that some people with bipolar benefit from the use of antidepressants. I was never one of these, my rapid deterioration was evidence of this.

TREATMENT EMERGENT AFFECTIVE SWITCH (TEAS)

8.6.	Upon commencing antidepressants, patients with bipolar disorder should be closely monitored for symptoms of mania, and if these emerge antidepressant therapy should be discontinued.
8.7	Antidepressant therapy should be avoided in bipolar disorder patients with a history of rapid cycling and/or a high level of mood instability
8.8	Antidepressant therapy should be avoided during 'mixed states' (mania with depressive features or depression with manic features)
8.9	The prescription of antidepressants should take into account any past history of a treatment emergent affective switch (TEAS).

(Table 1. excerpt from Malhi et al, 2015 Recommendation Box 8. p82)

Dr B, a psychiatrist, wrote to my GP, in 2015: –

> *"When I first saw her* (Dec '14) *... I felt she has a mixed mood state"; "I believe that Christine remains in mixed mood state with more depressive features"; "there is also the option of trailing or re-trialing an antidepressant"* (Attachment 1).

In 2015, he prescribed my seventh, eighth and then ninth antidepressant. He discussed the use of Electroconvulsive Therapy (ECT) and Trans Magnetic Stimulation (TMS), all of this without removing the cause.

In 2016, I found research which supported combining two mood stabilisers - I asked Dr B if we could trial this. I improved so I weaned myself off the last antidepressant, every day was better than the previous. In January 2017, I woke up and walked straight past that couch that I had spent the last decade sitting in. I walked outside with purpose, watered the garden, pulled some weeds, and enjoyed it. I forgot such simple experiences existed and could be so easy. I will have bipolar disorder for the rest of my life. I've had no further episodes of hallucinations or suicidal thoughts, everything is calmer.

Ten years, adverse reaction resolved with the appropriate treatment and ceasing the cause.

4.0 CORRESPONDENCE FROM PSYCHIATRISTS

Without access to my clinical records held by the private psychiatrists, the only history I could obtain was correspondence sent from them to the GPs. The following statements are part of this: -

Dr A	Sept 2009	*"limited benefit from prescription medication and her mood instability persists"* (Attachment 2);
Dr C	Apr 2014	*"adverse drug reaction SSRI / SNRI's"* (Attachment 5);
Dr D	Aug 2015	*"I wonder if she had a delayed reaction to it (bupropion)"* (Attachment 3);
Dr B	Dec 2016	*"a history of notable sensitivity to side effects and adverse reactions to many of the serotonergic antidepressants"* (Attachment 4).

Prior to reading these statements I had, in good faith, assumed that Drs A and B were not aware that my mood instability was caused by an adverse drug reaction. However, the quotes obtained demonstrate that all the psychiatrists who assessed and treated me were aware that this was happening, and they had informed my GPs. They breached my right to be kept safe by failing to: -

- inform me that I had an adverse drug reaction;
- discuss the ongoing risk of taking these medications, which included suicide;
- cease the classes of medication that were causing the adverse reaction;
- cease the classes of medication that had no therapeutic benefit; and
- follow their college's practice guidelines that, when instigated, let me achieve remission.

I have attached a letter that Dr B wrote to my GP in December 2016 *(Attachment 4)*. He stated: -

- I had *"a complex history", "a history of … adverse reactions to many of the serotonergic antidepressants" and "Valdoxan".*
- He observed my response to recently combining two mood stabilisers at my suggestion. *"Epilim has helped her, particularly in combination with gabapentin"* I was *"the best I've ever seen Christine".* I had stopped Valdoxan. I did not have a "complex history". I had a neurotoxic drug reaction to antidepressants whilst Drs A and B deviated from RANZCP guidelines and withheld evidence-based options.
- Witnessing a positive outcome, and understanding my adverse reactions, Dr B then plan my future treatment. *"buspirone is a specific 5HT1A receptor partial agonist and her previous reaction to serotonergic drugs would mean an even higher degree of caution on my part (in truth, I think she would tolerate it perfectly well)."* There was nothing "*perfectly well*" about the past ten years. Dr B discussed the use of buspirone for anxiety, but failed to discuss the risks in prescribing buspirone, or any serotonergic drug with me.

5.0 ANTIDEPRESSANT USE IN BIPOLAR DISORDER

The International Society Bipolar Disorder (ISBD) task force reviewed the use of antidepressants in bipolar disorder. They concluded: -

- *"There is striking incongruity between the wide use of and the weak evidence base for the efficacy and safety of antidepressant drugs in bipolar disorder. Few well-designed, long-term trials of prophylactic benefits have been conducted, and there is insufficient evidence for treatment benefits with antidepressants combined with mood stabilizers. A major concern is the risk for mood switch to hypomania, mania, and mixed states. Integrating the evidence and the experience of the task force members, a consensus was reached on 12 statements on the use of antidepressants in bipolar disorder"* (Pacchiarotti et al, 2013). These were integrated into the RANZCP treatment guidelines.

- The World Federation of Societies of Biological Psychiatry (WFSBP) reviewed treatment of mixed episodes and concluded *"the use of antidepressants for the acute and continuation treatment of mixed episodes or for the prevention of mixed episodes cannot be recommended and may be potentially hazardous"* (Grunze et al, 2017).

- The European mania in bipolar longitudinal evaluation of medication study in France (EMBLEM) (Azorin et al, 2009) found: -
    - *Despite not being clinically indicated, antidepressants were used in 53% of patients with mixed state, and 28% of patients with pure mania.*
    - Antidepressants were frequently prescribed, and the above usage pattern had not changed at the 24 months follow up.

- The EMBLEM study discussed reasons antidepressants were still prescribed in patients with mixed state when not clinically indicated. They suggested: -
    - *"co-occurrence of depressive symptoms with manic states,*
    - *the continuation of a prescription for a depression,*
    - *misgivings concerning a brutal discontinuation of antidepressants,*
    - *anxiety concerning a depressive switch,*
    - *the patient's insistence on maintaining his/her treatment and*
    - *also, certain psychopathological hypotheses which consider that mania constitutes a depressive."* (Rosa et al, 2010)

My treatment with antidepressants was not clinically indicated. Combination therapy with a mood stabilizer or antipsychotic at best had a poor effect in masking the adverse reaction. Dr B planned the use of yet another serotonergic drug despite documenting an adverse drug reaction to them. GPs were not intervening and seeking a second opinion. My pharmacist explained that most patients with Lithium prescriptions are also receiving antidepressants.

I'm aware that change is occurring, but nobody is monitoring the psychiatrists who are not keeping current in their practice. Nobody knows what they are doing in their private rooms. After I achieved remission, I asked Dr B if he could assure me that he wouldn't use antidepressants again in my care. He advised me that he may feel they are needed in

the future. I have no doubt that Drs A and B would continue using antidepressants and cite controversy to justify their deviation from RANZCP guidelines despite there being *"weak evidence base for the efficacy and safety"* and that they *"cannot be recommended and may be potentially hazardous"* for my presentation.

Only one thing should have mattered when these doctors chose my ongoing treatment, and that was the patient sitting in front of them who was acutely unwell with a serious adverse drug reaction. They documented this, then persisted with a neurotoxic assault that destroyed my life.

Fifteen years since RANZCP said stop antidepressants for patients with my presentation, and changes are still not reaching consumers. I passed through the hands of multiple consultants and GPs, nobody protected me. I am not alone, experiences like mine are regularly shared through social media. The EMBLEM study discussed reasons why antidepressants were prescribed when they were not clinically indicated, there observations are valid in Australia.

> *These issues must be considered systemic and therefore require government intervention.*

6.0 ANTIDEPRESSANTS AND SUICIDE IN BIPOLAR DISORDER

I never wanted to die, my brain saw the world differently, benign things became opportunities. Heights were about the fall instead of the view. I spent 20 minutes standing on Kessell's Road overpass contemplating suicide onto the bus lane below. When the ruminating wouldn't stop, I'd shared my darkest secret with a stranger on Lifeline. Dr A said I showed resilience, I nodded but my brain told me I was weak, not resilient. I never understood that it was the medications that caused me to think this way. Antidepressants were continued. Dr D stated *"When she is depressed* (including mixed states and rapid cycling) *she has constant thoughts of suicide and images to so with death and dying. She has always been able to resist any suicidal thoughts."* (Attachment 3)

In 2015, a combination of agomelatine and bupropion caused ultra-ultra-cycling within days. In the depressed phase I planned my overdose in detail, I was an emergency nurse and knew exactly what was required and the outcome. Ruminating the detailed plan was endless. The depression was paralysing, I couldn't get up to act on my plan. This time I could see the cause and effect. I immediately stopped the bupropion and informed Dr B.

- The Victorian Coroner investigated 35 suicides by people with bipolar disorder. He found that 60% had not reached benchmark standards in treatment, 46% were taking antidepressants at their time of death. It was impossible for him to conclude a relationship between antidepressants and suicide. (Keks, 2009).
- Antidepressants with mood disorders was not associated with a reduction of suicide rate, and it was not possible to exclude that they can induce, worsen, or precipitate suicidal behaviour, especially in those affected by mood disorders with depressive or mixed features. (Raja et al., 2009)
- *"During treatment with antidepressants (even when coupled with mood stabilizers), patients with bipolar disorder have significantly higher rates of non-lethal suicidal behaviour compared to those on mood stabilizers without antidepressants, and thus require careful monitoring."* (Yerevanian, 2007).
- ISBD task force found that suicide in bipolar disorder accounted for 3.4–14% of all suicide deaths, and that 23–26% of people with bipolar disorder attempt suicide. (Schaffe, 2015).

I believed what I was told, that I needed antidepressants to treat the depressive features of mixed state bipolar disorder. However, the psychiatrists knew I had an adverse drug reaction, they were trained to prevent this occurring. They chose various mood stabilisers and antipsychotics to attempt to mask the reaction instead of ceasing the cause. They prescribed off label doses of antidepressants and combining them with others. I shouldn't have been required to prove resilience to treatment-emergent suicidal ideations.

It's in inconceivable that I, and others like me, are still being put through a torturous neurotoxic drug reaction when it was preventable. I cried when it stopped, tears of relief that it was all over, and tears of disbelief that a decade of fighting suicidal ideations was preventable. I never met the statistics criteria of suicide or the attempted suicide. I do not judge anyone who did. I understand why one day you cannot find the resilience to keep putting yourself through

this pain when your brain is giving you concurrent hopelessness, no self-worth, and you're a burden conversation.

There is no accountability in a system where clients are still held responsible for treatment-emergent suicidal ideations, attempts or death. My submission must therefore reach out to those who did not survive, but are instead buried with a social stigma of suicide. In an era of suicide prevention this warrants urgent attention.

my mental, physical, and psych-social stability were all damaged, my pre-bipolar self was barely recognisable, the damage was now systemic.

All bipolar journeys differ, but it is evident that we have clusters of physical, psycho-social comorbidities which compromise our recovery. Simple things like stress. I'd previously worked in a busy emergency department; adrenaline helped me multitask and find solutions when there were no further resources. Now any adrenaline, even in a positive social environment, is my enemy. My functioning can unravel in a nanosecond. More stressful triggers can convert into mood instability that can last for months. Other hormones have had the same impact on my health; thyroid, oestrogen, and melatonin. RANZCP states that underlying causes of bipolar disorder and mood instability need to be identified and treated (Malhi et al, 2015). The list is extensive and can be outside the scope of practice of psychiatrist.

Consider nutrition. When exposed to psychotropic medications I developed a craving for fatty carbohydrates. At the same time bipolar instability meant a loss of capacity to prepare healthy food or exercise. I became obese and developed elements of malnutrition. At different times I had deficiencies in B12, folate, vitamin D, zinc, tyrosine, and iodine. Each of these added to my mood instability. I needed these screened before treatment-resistant bipolar could be considered. I used an Integrative GP who has been the only person to undertake a comprehensive assessment of the nutritional, hormonal and genetic causes of my mental health instability. My current psychiatrist and GP know I see her, they value her assessment and treatment as it is outside their scope of practice. Nutritional deficiencies are treatable and related mental health symptoms reversable. Drs A and B failed to identify these causes of mood changes, they prescribed psychotropics which led to more weight gain and the spiral continued. (Mood and Food Centre; NPS, 2014)

The above example demonstrates how something as simple as nutrition can place clients at risk of the misdiagnoses of treatment-resistant bipolar disorder before screening and treating all medical and psycho-social causes. Im the decade in which I failed to respond investigations at best were limited to an annual drug serum levels, FBC, ELFTs, TSH and possibly B12. This is not a comprehensive assessment for a client who is about to have significant pharmaceutical changes or brain stimulation. The use of psychotropic medications without addressing these is negligent.

My failed treatment caused a cascade of health issues as my body was taken out of equilibrium. I now have multiple chronic health illnesses and take a polypharmacy of medications. I do my utmost to keep my GP, psychiatrist and rheumatologist informed about what the others is doing with my treatment. Too frequently I see them glaze over with tunnel vision on their own specialty rather than the whole patient. This is why a treatment-resistant client needs a multidisciplinary review, including input from other specialist. My thyroid disorder frequently impacts on my mood; my autoimmune treatment has impacted with drug interactions. My HRT was taken off the market, it sent my bipolar in a tail spin till a suitable substitute was found.

My illness was now systemic, but I am still treated as if my primary problem is bipolar. It was menopause and an adverse drug reaction. It should never have been permitted to become this complex.

Bipolar also caused external stresses on my employability, relationships and finances. I was no longer physically, psychologically or socially the person who first presented to a psychiatrist. My illness had become systemic, my management more complex, but treatment remained focused around psychotropic drugs with limited consideration of the changing physical and psycho-social causes.

The difficulty with 'Treatment-Resistant Bipolar Disorder' diagnosis is the risk that it takes the client down an algorithm that treats bipolar disorder resistant to treatment. The next step is a psychiatric intervention. Dr B discussed with me the use of ECT and TMS for this. I would have had a more comprehensive assessment if the terminology was *'failure to respond to psychotropic medication'* as a step before *'treatment-resistant'*. This would have opened a large flow chart of medical, hormonal, pharmaceutical, substance, psychological and social causes to be considered prior the diagnosis of 'treatment-resistant'.

I am aware of the work that *Black Dog Institute* is providing through the *Bipolar Clinic* in Sydney. A one-off appointment with a professor in psychiatry who specialises in bipolar disorder is a significant support system. The appointment is primarily based around assessment, diagnosis and a treatment plan with psychotropic medication. The benefits to both the client and treating psychiatrist in providing direction for ongoing management of true treatment-resistant mood disorders is significant. It is not funded for a multidisciplinary assessment.

Better Access provided access to a psychologist. However, I found that psychotherapy had little benefit whilst the cause of my mental health instability was sustained by an adverse drug reaction.

> *Treatment-resistant is far more than a formula on how many medications have failed.*
> *A failure-to-respond to treatment must first be considered as a symptom of something missed.*
> *A multidisciplinary team is optimal as bipolar becomes systemic and impacts every part of our lives.*

8.0 PHARMACOGENOMIC TESTING

Pharmacogenomics is relatively new and will play an important role in tailoring pharmaceutical treatment and provide better client outcomes. Many mental health medications are metabolized through the liver. This test can indicate if a person has an increased risk of adverse reactions because a medication is metabolised too slow; or they are inefficient because the rate of metabolism is too rapid. The risk can now be assessment in the laboratory instead of on the client.

This could have changed the course of my illness through informed decisions. If this test was available at the beginning of my illness, a mild depression may have remained just that. It could have prevented trials with nine antidepressants, off label prescriptions and combinations of antidepressants. It could have prevented Antidepressant-Induced Bipolar Disorder; Treatment-Emergent Affective Switches; and Treatment-Emergent Suicidal Ideations. My pre-menopause life would have taken a natural course instead of the path of pharmaceutical mismanagement. (Rahikainen, 2019)

9.0 PRODUCTIVITY

I am on the Disability Support Pension and will use this service for 14 years by time I reach retirement age. In the same period, I will no longer contribute to superannuation or taxes. At my worst I was reviewed by a psychiatrist fortnightly, clinical psychologist on alternate weeks, and had frequent GP appointments. Complications has now left me with four chronic illnesses, and a polypharmacy of drugs. I was beyond losing my productivity. These health outcomes caused a significant financial burden on Centerlink, Medicare and me.

The social impact was far more reaching. I rapidly lost my career, identity, self-worth, credibility, friends, finances, health and stability. Everything I valued was either damaged or taken from me in a very short period. One day I couldn't make it into the shop to buy milk as depression paralyzed me from walking any further. I found an alcove in a baby change room where I crawled into a ball. A lady who lived on the streets found me in her place. I had reached a worse state than her on that day.

10.0 PROFESSIONAL ACCOUNTABILITY

I was educated, employed, happily married and active. I didn't change, I was medically damaged to the point of being made permanently disabled. I asked for help with a common menopause symptom of mild depression.

- Conservatively I attended over 150 appointments for assessment and treatment by private consultants whose job included recognising and managing adverse drug reactions.
- I trusted that they met AHPRA's registration standard and practiced within their scope of practice.

It's fifteen years since the RANZCP 2004 treatment guidelines informed their psychiatrists to cease antidepressants in clients at risk of mood switches (Mitchell et al, 2004). Four years since the College updated this and provided a strong statement in a *'Recommendation Box'* cautioning their use in high risks patients (Malhi et al, 2015). TGA had alerts in place.

None of this protected me. There is no reason to justify nine failed trials with antidepressants whilst it was documented that they caused harm without therapeutic benefit.

I passed through the hands of multiple psychiatrists, GPs and psychologist. I kept stating that the drugs weren't working. Stigma devalued my voice. Not one health professional in ten years stepped up to stop the injury. I asked my GP for a second opinion, he told me I should go back and talk to my current psychiatrist about this. My rights were dismissed, there were no safety-nets in place to protect me.
Despite significant improvement when they were finally ceased Dr B stated that he could not exclude the use of antidepressants again. He was not going to change his practice. On a previous occasion I had sat in his office in tears whilst detailing my treatment-emergent suicide plan. I can't describe the level of distress I went through and the concurrent loss of everything I valued because he chose to deviate from his college's guidelines.

To add to my trauma, I needed to adjust to learning that this could have been prevented. The people I trusted to see me through my mental health journey had instead been the ones who injured me. The only way I can adjust to this is by ensuring my story is both heard and used to facilitate changes that stops other vulnerable people being injured when seeking health care. I need to know that nobody else is put through what I experienced.

> *I am not an isolated case. Neurotoxic injury includes permanent disability, loss of productivity, and death. It breaks people and families. We need our government to pick up this batten and fix a system which doesn't monitor the service provided by private consultants.*

11.0 REFORMS

Bipolar disorder is a severe and common psychiatric disorder. In 2016 there were: -
- 568,046 Australians aged over 15 who had been diagnosed with bipolar disorder;
- 352,581 with current symptoms, half of whom require income support. (Harper, 2016).

This is a large population of Australians who struggle daily. Case studies show the marked improvement that people with bipolar make when treatment strategies are changed to exclude antidepressants (El-Mallakh, 2005). This simple change is life altering. The following are reforms I have drawn from quality management systems that I have worked with in health care, multidisciplinary systems I have worked with in acute and community care, and my lived experience with a mental health illness.

11.1 Identify and protect bipolar consumers at risk of adverse drug reactions from antidepressant therapy.

11.1.1 AUDITS

It is time to support the RANZCP and TGA by auditing the prescription of antidepressants in clients with ICD codes for mixed features, mania and rapid cycling. Audits are an accepted part of maintaining standards of care in specialties to prevent negative outcomes, e.g. surgery. The same should apply for mental health consumers.

11.1.2 SAFETY-NETS

There needs to be safety-nets for clients who fail to respond in private practices. There were no clinical audits, case management or second opinions to alert anybody of my medication-sustained injury. A mandatory review should be provided at agreed time intervals if a patient does not reach mental health targets (eg Young Mania Rating Scale and the Hamilton Depression Scale). Random clinical audits of at-risk ICD codes may also assist in ensuring that practice is current.

11.1.3 SUICIDE PREVENTION

My suicidal thoughts were treatment-emergent and stopped when evidence-based treatment was started, and antidepressants ceased. This adverse drug reaction was *'preventable*'. In an era where there is a significant funding for suicide prevention, I am not aware of strategies looking directly at this preventable cause in a high-risk population where 23-26% (approx. 142,000) people who live with bipolar will attempt suicide. To live with suicidal thought, no matter how resilient you are, is inhumane. It is not the consumers job to find resilience to antidepressant-induced suicidal ideations.

This cannot wait until 2020 before the government intervenes.

11.2 Identify psychiatrists who are practicing outside their scope of practice.

11.2.1 CONTINUAL PROFESSIONAL DEVELOPMENT

The RANZCP produces a monthly journal for members, ANZJP. Through this they notify significant guideline changes such as the revised *RANZCP Clinical Practice Guidelines for Mood Disorders* (Malhi, 2015). This is a significant document and it should be able to be assumed by any consumer that their treating physician is dedicated to best practice and therefore attentive to such updates. I believe it would be simple and appropriate for the College to track adherence to reading the guidelines by a response from Psychiatrists indicating they have and linked to Continual Professional Development (CPD).

11.2.2 SCOPE OF PRACTICE

I attempted to find a psychiatrist who specialised in bipolar disorder. I was told that there wasn't a 'bipolar specialist'. Bipolar was common, the bread and butter of every practice. I was referred to a private consultant without knowing anything about their skills. Medicare and I paid a significant amount of money believing they were current in the treatment of bipolar disorder.

As part of the 'Registration Standard' psychiatrists are required to practice within their scope of practice. Their annual registration renewal requires that health care professionals only provide *"services that they are trained, qualified and competent to perform"* (AHPRA,2016). Drs A and B both promoted on their websites that they treat patients with bipolar disorder. As a consumer it was fair to assumed this meant that they were current in this sub-specialty, and that their marketing was not misleading. There is no method for myself or my GP to establish if they attended CPDs specific to bipolar disorder in the past two years, or if twenty years had lapsed.

It would seem reasonable for consumers to know that a psychiatrist had an endorsement from the RANZCP before they were permitted to promote on their websites that this was a field that they were currently trained, qualified and competent to perform. CPDs could attract an endorsement which was valid for 2 years. Not having an endorsement does not stop the psychiatrist treating bipolar disorder but should be designed to encourage them to remain current, ensure a better consumer/consultant match, and reduce the risk of medical negligence by consultants practicing outside their scope of practice.

Consumer have the right to know if their clinicians are current in the service they are deliver.
The current system prevents both the client and referring GP from accessing this information.

11.2.3 Provide access to current technology and specialist clinics for Australians living with treatment-resistant bipolar disorder.

11.2.4 PHARMACOGENOMICS

Pharmacogenomics can now help where clinicians and pharmaceuticals have previously failed. This is a one-time test which currently does not attract a Medicare rebate of $147 for a mental health medication panel. If the exercise of the productivity commission was financial only, then to have this test available through Medicare will repay itself just by stopping ineffective or dangerous prescriptions of antidepressants. The true value is in preventative medicine would have been to prevention of the onset of bipolar disorder, and for others, to save lives.

$147 is a small outlay towards giving someone their life back.

SPECIALIST BIPOLAR CLINIC for TREATMENT-RESISTANT BIPOLAR DISORDER

A Specialist Bipolar Clinic must be able to provide more than a second opinion. It needs to provide a service with multidisciplinary practitioners who can comprehensively assess the reasons that a client has failed to respond to psychotropic treatment. The clinic will provide a one-off multidisciplinary assessment and treatment plan. The goal is to remove the layers of the onion and identify underlying medical, hormonal, pharmaceutical, substance, psychiatric,

psychological and social pathology that may be obstructing remission. Only then should a client be truly identified as treatment-resistant. It may reduce the overuse of psychotrophic medications, or other interventions such as ECT or TMS when not clinically indicated.

It should not be a top down model as all members of the team are specialist in their own field. A weekly case conference to discuss each case will generate a plan tailored to each client's needs. As a Queenslander, I would love to see a pilot program for bipolar clinic like this in my state. We have some great multidisciplinary practitioners suited to leading up such a program.

Specialist Bipolar Clinic (example): -

- A referral from treating psychiatrist.
- A mental health RN will obtain a history from the patient, care providers, hospitals and/or carers; complete initial assessments; initiate pathology (eg recommendations from Mood and Food Center, hormones, inflammatory markers, pharmacogenomics); make appointments with clinic practitioners depending on the identified needs.
- One-off assessments are completed depending on needs. eg psychiatrist, clinical psychologist, dietitian, social worker, and /or occupational therapist. If there are comorbidities another specialist may be consulted, eg gynaecologist, pharmacist, geriatrician, physician, Integrative GP.
- Case conference to develop client tailored treatment plan.
- A copy of the report is provided to the psychiatrist, GP and client.
- The client will receive a detailed package which will provide: -
    - crisis plan;
    - summary from each discipline providing beneficial pathways e.g. the type of psychotherapy recommended, pharmaceutical plan, employment support.
    - list the resources that can access in the community, hospital, private practice and/or online.
- The client's progress can be reassessed to measure outcomes.

Failure-to-respond to treatment is an opportunity to reassess the client as a whole.
It supports a process of a multidisciplinary assessment to screen out clients
who are not treatment resistant, and treat those who are.
It will give them the right to achieve optimal productivity by addressing the cause of persisting instability.

Thank you for listening

A simple perimenopausal depression was grossly mismanaged, I found myself in a vulnerable situation with a serious mental health illness. The only people I trusted were my psychiatrists. Nobody knew they were the cause; and those that did failed to stand up and protect me.

Outdated treatment had dire consequences. Neurotoxic outcomes were documented, along with my failure to respond to antidepressants therapy. There were no systems in place to protect me from medical negligence. There is no accountability when suicidal ideations, attempts and deaths are considered a weakness of the client. In an era of suicide prevention bipolar disorder isn't a target group. My treatment-emergent suicidal ideations were not complex. The only intervention required was to follow the College's guidelines and heed TGA alerts.

In any other specialty severe drug reactions, near death or deaths are considered a *sentinel event* and would demand investigation with a coordinated implementation of solutions. Sustaining an injury without clinical indication or therapeutic benefit should demand government intervention.

In 2019, the bipolar community is still full of "*me too's*" on social media. Members in closed groups feel safe to openly discuss their mood switches, mixed states, mania, rapid cycling, instability and suicidal ideations whilst their psychiatrists are trialling or re-trialling another antidepressant. Threads of antidepressant induced switches seem the norm. They are oblivious of guidelines that psychiatrist should be following to prevent this. They hang onto hope that their psychiatrist is trying everything possible when multiple antidepressants have failed even when combined with other medications to mask the reaction. They share the chaos in their daily lives, relationships and workplaces. '*Me too*' is strangely comforting, it lets us know we are not alone when everything has failed.

I understand why the voice of this group is not loud, any stress takes a toll on our illness and lives. It's not easy to stand up for your rights when the consequence is mental health instability. We are faced with both our illness taking our voice from us, and then stigma stealing the credibility of our voice when we attempt to speak up. Please don't let this be a reason to not hear us. The focus must be about clinical outcomes and moving the treatment standard to a minimum of current practice guidelines. Bipolar treatment should not be stuck in the 1990s, however evidence-based changes seem to be moving faster than implementation with devastating consequences. We should be far more progressive than this in Australia.

I recently had the privilege of attending the International Society of Bipolar Disorder annual conference which was held in Sydney this year. I attended as a consumer with lived experience. It was well represented by young fresh psychiatrists, and researchers who were exploring treatment beyond the antipsychotic, mood stabiliser, antidepressant trilogy. The use of antidepressants was barely mentioned, it seemed a given that it was detrimental in the treatment of at-risk bipolar patients. This was not a new concept for such a forum. There were several psychiatrists whom I spoke with who chose never to use antidepressants in the management of any of their bipolar patients; my treating psychiatrist does the same. I was reassured and hopeful for the future.

What was concerning were the psychiatrists who were absent, that had nothing else to learn when an event this significant was on their doorstep. The ones who will keep doing the same thing for the next twenty years unless the government intervenes and protects people from this injury. We need reforms in place to change as the current system cannot monitor or manage where change in practice has not been implemented. Failure to intervene is impacting on the quality of life, mental health, physical health, social inclusion, education, employment, and financial status. It attributes to treatment-emergent-suicides.

> The foundation of our health care service is that our doctors remain
> current in their practice and cause no harm.
> It's now time to review why some psychiatrist are still choosing to prescribing antidepressants in cases where there is *"weak evidence base for the efficacy and safety"* (Pacchiarotti, 2003).

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ATTACHMENTS

1. Correspondence Dr B to GP, Dec 2015.
2. Correspondence Dr A to GP, Sept 2009.
3. Correspondence Dr D to Dr B, Aug 2015.
4. Correspondence Dr B to GP, Dec 2016.
5. Correspondence Dr B to GP, April 2014 (pending)