

Thank you for the opportunity to provide a submission to the Productivity Commission's draft response. I advised the PC through submission (454) that the public remained at risk of an injury or death, as a direct result of psychotropic treatment. I provided reforms to mitigate the risks. I wanted to see a draft report that would protect current and future generations. Instead, it failed to close the gaps in access to safe treatment despite the number of submissions from consumers, carers, advocacy groups, professional bodies and health care workers to the PC regarding similar injuries. I am unable to walk away believing that the Productivity Commission's draft report contains gaps that will continue to injure the next generation. I need to know my loss becomes a catalyst to protect others.

DRAFT REPORT FEEDBACK

- **Stigma.** The PC uses the term “**suicidal behaviour**” to identify warning signs of suicide. ‘Behaviour’ is not an appropriate term to describe something as important as suicidal risks. Society frequently confuses a ‘behaviour’ as something that can be controlled. Eg good behaviour, bad behaviour. A more acceptable descriptor currently used is **Signs of Suicide (SOS)**

COUNTING MENTAL HEALTH

I've frequently been told that there is not a test for mental health illness. This fallacy supports a failure to guide treatment by using national rating scales. Uniform quantitative data is the foundation of a healthcare system. These should be as mandatory as someone with hypertension having their blood pressure checked and documented. *If we are not counted; we don't count.*

- **National Rating Scales.** National, illness-specific, rating scales will assist in monitoring:-
 - o early signs of improvement or deterioration;
 - o identifying response to treatment changes;
 - o identify medication reactions that mimic mental health symptoms;
 - o support treatment changes;
 - o provide a uniform tracking scale that can be shared between health care workers;
 - o graph illness pattern over long periods;
 - o flag consumers who do not reach targets for early review;
 - o provide transparency and accountability of care provider/s;
 - o provides digital data for national health monitoring.

They are available digitally or even on Apps that can be downloaded to clinicians to monitor.

- **Targets.** Setting safe parameters for rating scales will encourage :-
 - o Reassessment of the cause.
 - o Change in treatment.
 - o Identify early patterns of medication induced symptoms.
 - o Identify need to use refer to other care providers.
 - o Identify need for referral to MH Clinic.
 - o Justify use of other tests such as pharmacogenetics.
 - o A tool for clinical audits.
 - o Protect consumers by early intervention when treatment failed.
 - o A tool for AHPRA to assess treatment.
 - o Government use of de-identified data to support upgrade in resources.

MAINTAIN CLINICAL EXPERTISE

Right Door. There is a need for specialist health care workers to be both trained and identifiable so GPs and consumers can get the right treatment. Currently, the only way to establish a care-providers *scope of practice* is through self-marketing on websites; word of mouth; trial and error; and internet ratings. None of these are reliable.

- Encouraging psychiatrist and MH allied health services to be generalist in all areas of mental health treatments is supporting their deskilling and increasing the difficulty for consumers to access experts for complex needs. Bipolar disorder is considered the ‘bread and butter’ of all psychiatrist. It is a complex illness; has a high level of disability which can be easily mismanaged; and has poor outcomes. The right door should not have been about accessing any psychiatrist, but access to the right psychiatrist.
 - o Support RANZCP in establishing BPAD, and depression as sub-specialty areas for training.
 - o Support this in all other allied health services.

It’s not accepted that an orthopaedic hand surgeon can perform orthopaedic spinal surgery. The PC cannot support a system that continues to provide a lower standard to access specialty experts in MH areas at high risk.

CPDs. Medication side effects and adverse drug reactions (ADRs) need to be better identified and managed by care providers. The PC recommended a CPD for medication side effects. I don’t believe this is enough. The following CPDs should also be recommended to ensure medication safety and current evidence-based practices.

- o **Deprescribing** medications (see below).
- o Revised *RANZCP Clinical Practice Guidelines* are significant documents. These should be made mandatory CPDs for psychiatrist to ensure current practice is maintained.

As part of the ‘*Registration Standard*’ annual registration renewal requires that health care professionals only provide “*services that they are trained, qualified and competent to perform*”. There is no method for myself or my GP to establish if the consultant I am referred to has attended CPDs specific to my illness 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 prevent them from practicing. Such a system would let the consumer know where the consultants interest lay.

SAFE TREATMENT

- **Deprescribing medications** is identified as an essential part of minimising risks of pharmaceutical treatment. It is a national crisis that requires a national strategic approach with attention to psychotropic medications. Some individual bodies are attempting to identify this need, but this will result in an ad-hoc outcome. It won’t reach all consumers requiring the service, nor be implemented by care providers who don’t believe this applies to them.

<http://www.nswtag.org.au/wp-content/uploads/2018/06/1.3-Deprescribing-Guide-for-Selective-Serotonin-Reuptake-Inhibitors-SSRIs-and-Serotonin-Noradrenaline-Reuptake-Inhibitors-SNRIs.pdf>

In my experience I found poor understanding by consultants on how to cease antidepressants despite documenting life threatening ADRs. It was through my own research that I learnt that a second mood stabilizer with antidepressant properties was required before removing the antidepressant; thus,

preventing rebound depression. This should not have been the consumers job to find solutions. The Government pays consultants to recognise ADRs, and deprescribe them when treatment compromises the consumers wellbeing. Instead further psychotropics were added to try and treat the drug reactions.

Canada is taking a lead in national deprescribing strategies. Below are links on how their Government has implemented this to support care providers and protect consumers.

<https://deprescribing.org/>

<https://www.ismp-canada.org/download/safetyBulletins/2018/ISMPCSB2018-03-Deprescribing.pdf>

<http://medstopper.com/>

- **Pharmacogenomic Testing.** My test results were like looking into a mirror. What I had explained to my healthcare providers was real. The information included in this document, together with relevant clinical information, would have guided my treatment, and minimised risks of injury that I sustained. The experimenting could have happened in a test tube instead of the years of unguided treatment in my body that lead to permanent injury. Key points:-
 - o minimise risk by using pharmacogenomic guided treatment decisions,
 - o one-off cost (\$197) by PBS for non-responding and treatment-resistant consumers,
 - o test results provide preventative measures, and
 - o they provide a guide to future treatment decisions, including yet undiagnosed illnesses.

In the *'Impact of Pharmacogenomics on Clinical Outcomes for Patients Taking Medications with Gene-Drug Interactions in a Randomized Controlled Trial'* (Thase, 2019) they conclude ***“when patients who switched medications were assessed, all outcomes were significantly improved in the guided-care arm compared to treatment as usual”***; and ***“pharmacogenomic testing significantly improved outcomes among patients with MMD and at least 1 prior medication failure.”***

This should be an essential test for consumers who fail to respond or have adverse drug reactions. There is limited pathology test to guide psychiatrist in treatment decisions and help protect consumers when so many ADRs can mimic MH symptoms.

ACCESS TO EXPERTS IN TREATMENT-RESISTANT MENTAL HEALTH ILLNESS

Treatment-resistant. Nobody starts at 'treatment-resistant'. The PC is putting preventative strategies in place for injuries that have their roots in childhood. I support this. However, they are failing to address the other side of the coin. The issues that cause MH illnesses to evolve into a complex systemic presentation with significant medical, psychological and social deterioration. (Sub 454 p6)

Mental health treatment frequently focuses around psychotropic medications with psychological support. Silo's in the health care system are poorly equipped to remove the layers of the onion and address the *root causes of treatment resistant consumers*. A team of professionals are required.

MH Clinics. Failure to train and provide access to experts in specialty mental health fields has left gaps for safe treatment for complex presentations. This is known to delayed appropriate treatment, increase recurrence, chronicity, and suffering. It worsens occupational, family, social and economic outcomes. There are associated increase healthcare costs and suicide attempts.

Nobody should be considered treatment-resistant without assessment by multidisciplinary team with specialty knowledge in the consumers presentation, eg Bipolar Clinic. Mental Health Clinics should provide a one-off opportunity to identify missed causes, optimise future treatment and provide consumer

resources. This is where the value of using a national, illness specific, rating scale with targets to protect consumers can be seen. Failure to reach targets would generate a requirement to step away from silo management.

Exclude underlying causes should never be a sentence in the RANZCP treatment guidelines. It needs to be a chapter. This is the foundation of a MH clinic.

Mental Health Clinic. Clinics should be available in major centers with support extended to rural sites via skype. They provide comprehensive assessment of medical, psychological, psychiatric, nutritional, pharmaceutical, genetic and social causes that prevent remission. The purpose is to provide multidisciplinary assessment, diagnosis and planning; but not implementation. Below is an example on how a Mental Health Clinic could function: -

- MH Case Manager allocated: -
 - obtain history from patient, care providers, hospitals, carers;
 - complete subjective and clinical assessment ratings;
 - initiate relevant pathology (eg recommendations from Mood and Food Center, hormones, inflammatory markers, pharmacogenomics);
 - make appointments with practitioners depending on identified needs.
- One-off assessments completed by relevant health care professionals. eg psychiatrist, clinical psychologist, dietitian, social worker, and /or occupational therapist. If there are comorbidities then provisions could be made for further external consultations eg pharmacist, geriatrician, Integrative GP.
- Case conferencing is used to develop a consumer tailored treatment plan.
- A copy of the plan is provided to the psychiatrist, GP and other relevant health care workers.
- The consumer will receive a package including: -
 - crisis plan;
 - summary from each discipline providing beneficial pathways e.g. the type of psychotherapy recommended, pharmaceutical plan, employment support.
 - List of relevant resources that can be accessed in the community, hospital, private practice and/or online.
- The consumer's progress can be reassessed to measure outcomes at intervals.
- A list of illness specific treatment options, for example, bipolar disorder could receive added information about:-
 - Facial recognition or social media activity Apps;
 - Bipolar support groups;
 - Interpersonal and Social Rhythm Therapy (IPSRT);
 - Blue-blocking glasses for mania;
 - Antioxidant and anti-inflammatory treatment;
 - Maybe, faecal transplants in the future;
 - Strategies for work, relationships, triggers,
 - Strategies to manage hypomania, bipolar depression ...

Failure to respond is just a starting point, a time to open a flow sheet of assessments and reassessment, it should never be the end of a treatment algorithm.

- **Multidisciplinary service providers.** To fill the gaps the PC should consider expanding service providers beyond commonly recognised GPs, psychiatrist, and allied health workers.

It was an Integrative GP who provided the most comprehensive assessment of my MH, identified abnormal pathology, corrected this, and improved my mental health in doing so. This reduced my dependence on psychotropic medications. Both my regular GP and psychiatrist valued her input and support her treatment as this was outside their scope of practice. I believe that the Commission should include specialties such as Integrative GPs, pharmacist, and co-morbidity providers who have an interest in mental health illness.

MITIGATE RISKS

I find the hardest thing in speaking out about my injury is the mental health stigma. The voice of those who have sustained an injury through psychotropic medications must always have the same value as any other individual, but we don't. In all specialties severe drug reactions, near death or deaths would demand investigation with a coordinated implementation of solutions. Mental health consumers have the same health rights as every other Australian.

At the Hearing I discussed a healthcare crisis in Bipolar Affective Disorder as an example of the risks from psychotropic medications. I make no apology for singling out this illness. It has poor outcomes, accounting for one quarter of national suicides. In 2015 RANZCP added a Recommendation Box for the use of antidepressants in bipolar disorder (Mahli,2015). Treatment guidelines were updated in line with a consensus report from the International Society of Bipolar Disorder (Pacchiarotti,2013) to protect at-risk consumers from antidepressants. This was not new, similar warnings and protective guidelines have been in place in Australia for 16 years (Mitchell,2004). Despite this, my GP, pharmacist, social media, and other submissions to the PC indicate that the use of antidepressants in at-risk consumers remains common.

- **AHPRA** investigated my injury and stated that in complaints from Mental Health consumers, with no witnesses, the outcome would usually come down to the consultant's word over mine. My right to complain was taken from me. Such a process failed to provide a training opportunity; ensure accountability; leaves other consumers at risk; and did not report a serious drug injury to TGA. The exercise seemed futile. For this reason, I believe that a MH consumer advocate within AHPRA could ensure the process remains transparent. I would have also benefited from access to my medical records prior the investigation.

AHPRA's feedback stated - *"Board notes that while there is some conflicting evidence on the use of antidepressants for bipolar disorder, it is common and would generally not be considered a substantial deviation from accepted practice"*.

What bothered me most was that the Board described my treatment as 'common' practice. 'Common' does not mean safe or evidence based. It does not mean it followed RANZCP Recommendation Box. The common off-label prescription of antidepressants sustained medication-induced mental health symptoms in a previously healthy person for ten years. This should not have any place in our health system, let alone a 'common' one. If this is common, then AHPRA should have RED flags alerting the Government that too many Australians have been compromised or remain at risk, and this needs urgent intervention.

My injury proves that a sixteen-year implementation period for change has not altered the practice of some psychiatrist. The training phase is over. The Government needs to intervene, ensuring practitioners are held accountable when AHPRA failed me. The Government's own shortcomings that permitted my injury when they failed to identify and mitigate risks. Please consider the following strategies for this healthcare crisis.

- **Medication-induced suicides** must be identified as a national priority. To achieve this medication-induced suicides need to be first identified, and not clumped in with other causes. It requires a separate suicide prevention strategy; **and given the same level of urgency that is provided to all other healthcare-related deaths.**

Neurotoxicity of medications is hard to quantitatively measure. However, the 'lack of evidence' can no longer be the justification to do nothing. This inaction only supports a health system which buries its mistakes. Strategies that may assist include:-

- Changing terminology. Change 'suicide' to 'medication-induced suicide' when indicated.
- Make it a priority with the Coroner to better identify medication-induced suicides.
- Coroners should meet with people with lived-experience of medication-induced near deaths to better understand this ADR.
- Further education of GPs and specialist. Especially when consumers state "the medications are making me worse, or not helping."
- Risk Cause Analysis. I encourage the PC to support RCA for bipolar patients who are currently treated off-label with antidepressants and subsequently attempt or complete suicide. This is the only way that the Government can start collecting data and change outcomes.
- Prioritise genetic research that will identify at risk groups of suicide, see below.
- Support pharmacogenomic testing.
- Support illness specific rating scales and treatment targets to early identify medication-induced changes.
- Provide informed consent of risks to all consumers.
- Provide black box warnings by TGA.

"OPRM1 is a Polymorphism A118G is associated with emergence of suicidal ideation at antidepressant onset in a large naturalistic cohort of depressed outpatients". My pharmacogenetics show I have this polymorphism. It would be interesting to see the role of this emerging science in preventative medicine. <https://www.nature.com/articles/s41598-019-39622-3#Tab5>. There needs to be provisions to expedite rapidly changing science and technology to protect consumers.

Treatment-emergent suicidal ideations are not complex. The only intervention required was to follow the RANZCP guidelines and heed TGA alerts, stop the cause of the ADR.

Only once have I been asked by a psychiatrist if I had current suicidal ideations. I brought it up a few times, there was no follow up. I learnt to live with this in silence. When it became overwhelming, I spoke to a stranger on Lifeline. The extent of this health crisis is underestimate. Suicidal dialogue needs to be opened periodically by care workers.

The PC needs to identify new ways to provide monitoring safe care from treatment-emergent injuries. Maybe a card that comes with new prescriptions that the user can document their own mood trends on, including SI. They can give it to their doctor when reviewed or need to review early if they meet certain criteria, including SI.

- **Adverse Drug Reaction Monitoring.** ADRs can go unidentified as they can mimic mental health illnesses. The risks of psychotropic medications are extensive. Other submissions have discussed these in detail. Missed diagnosis, or failure to manage a drug reaction can lead to:-

- prolonged exposure to the causative medication;

- unnecessary prescription of medications to treat or mask the drug reaction;
- unnecessary interventions such as ECT and TMS;
- unnecessary hospitalisations;
- trigger the onset of other illnesses;
- functional and social impacts;
- and death.

If an ADR caused nephrotoxicity, or hepatotoxicity then it would be identified, and the causative agent would be reduced or ceased. This routine monitoring and intervention prevent injuries and saves lives. Clinical pathways to identify and prevent neurotoxicity is not as clear cut.

To date the PC has failed to adequately address a system that is adding to morbidity and mortality of some MH consumers from their medications. This cannot improve if Government agencies such as the Coroner, TGA and AHPRA fail to gather meaningful data to change outcomes. Rating scales, targets, RCA are a starting point to improve outcomes and accountability. However, if there is an ongoing failure to collect meaningful data on ADRs, then we will continue not to count.

- Root Cause Analysis. The PC should recommend RCA for bipolar patients. I again select this group due to evidence of cause and effect. Those with BPAD on antidepressants who attempt suicide as ‘near misses’; completed suicides as ‘Sentinel Events’.

This is the only way that the Government can start collecting data and change outcomes. Up to 14% of people living with BPAD will complete suicide in their lifetime; a further 26% will attempt suicide; and nearly all will need to find resilience to suicidal ideations. Over 352,000 Australians with active bipolar disorder need to know if these outcomes could be prevented by better management.

- Evidence. I am led to believe that catastrophic outcomes occurring within our health system cannot be addressed because of the lack of evidence available in mental health. I would challenge that the issue is not the lack of evidence, but rather the failure of the Government to collect this and protect consumers. The Coroner, TGA and AHPRA have been unable to collect meaningful statistics of injury or deaths to identify the extent of prescribing when it is not clinically indicated or when it leads to detrimental outcomes.

In my submission I detailed how antidepressants had a risk of causing mood instability in bipolar disorder with a history of mania, mixed features, rapid cycling or a history of a drug reaction known as ‘Treatment Emergent Affect Switch’ (TEAS). TEAS is where a substance or medication causes a mood switch, usually to hypomania, mania, rapid cycling and mixed features. However, when the switch is missed, consumers are led to believe the ADRs and associated disabilities are chronic symptoms of their illness. Antidepressants can also induce bipolar disorder and cause treatment-emergent suicidal ideations. These could have been prevented by following treatment guidelines.

Table 1.

Current warnings and guidelines to protect consumers	Sub 454
TGA Product Information and Consumer Medicines Information documents warning of risks associated with the prescription of all antidepressants to consumers with bipolar disorder. (TGA, 2018)	p1
2004, RANZCP Clinical Practice Guidelines for the Treatment of Bipolar Disorder provided warning of the risks associated with antidepressants, and guidelines to protect consumers. (Mitchell, 2004).	p3
2005, Case studies show the marked improvement that people with bipolar make when treatment strategies are changed to exclude antidepressants (El-Mallakh, 2005).	p8

2007, "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).	p5										
2009, The Victorian Coroner investigated 35 suicides by people with bipolar disorder and found that 60% had not reached benchmark standards in treatment, and 46% were taking antidepressants at their time of death. It was impossible to conclude a relationship between antidepressants and suicide. (Keks,2009)	p5										
2009, Antidepressants with mood disorders were 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, 2009)	p5										
2009, The European mania in bipolar longitudinal evaluation of medication study in France (EMBLEM) 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.	p4.										
2010, EMBLEM discussed reasons antidepressants were prescribed in patients with mixed state when not clinically indicated. They suggested, and this is important in Australia: - - "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 - certain psychopathological hypotheses which consider that mania constitutes a depressive."	p4.										
2013, International Society of Bipolar Disorder (ISBD) task force reviewed the use of antidepressants in bipolar. They made these two points in their conclusion. " There is a striking incongruity between the wide use of and the weak evidence base for the efficacy and safety of antidepressant drugs in bipolar disorder. There is insufficient evidence for treatment benefits with antidepressants combined with mood stabilizers. " (Pacchiarotti, 2013)	p4.										
2015, RANZCP updated the clinical guidelines to reflect the outcome of ISBD. This included their highest warning, a identify high risk consumers; " Recommendation Box 8. Use of Antidepressants in Bipolar Disorder " which identified bipolar consumers who were at high risk of developing TEAS. (Malhi, 2015). <table border="1" data-bbox="159 1377 949 1624"> <thead> <tr> <th colspan="2">TREATMENT EMERGENT AFFECTIVE SWITCH (TEAS)</th> </tr> </thead> <tbody> <tr> <td>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.</td> <td>CBR</td> </tr> <tr> <td>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.</td> <td>CBR</td> </tr> <tr> <td>8.8. Antidepressant therapy should be avoided during 'mixed states' (mania with depressive features or depression with manic features).</td> <td>CBR</td> </tr> <tr> <td>8.9. The prescription of antidepressants should take into account any past history of a treatment emergent affective switch (TEAS).</td> <td>CBR</td> </tr> </tbody> </table>	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.	CBR	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.	CBR	8.8. Antidepressant therapy should be avoided during 'mixed states' (mania with depressive features or depression with manic features).	CBR	8.9. The prescription of antidepressants should take into account any past history of a treatment emergent affective switch (TEAS).	CBR	p 2-3
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2015, 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).	p5										
2015, RANZCP states that underlying causes of bipolar disorder and mood instability need to be identified and treated (Malhi, 2015).	p6										
2017, 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, 2019)	p4.										
2017, United Nations; " Regrettably, recent decades have been marked with excessive medicalization of mental health and the overuse of biomedical interventions, including in the treatment of depression and											

<p>suicide prevention. The biased and selective use of research outcomes has negatively influenced mental health policies and services. Important stakeholders, including the general public, rights holders using mental health services, policymakers, medical students, and medical doctors have been misinformed. The use of psychotropic medications as the first line treatment for depression and other conditions is, quite simply, unsupported by the evidence. The excessive use of medications and other biomedical interventions, based on a reductive neurobiological paradigm causes more harm than good, undermines the right to health, and must be abandoned." (Dainius Pūras)</p>	
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The above is strong evidence. However, there will always be a voice looking for a way to say that this remains controversial. The only thing that should ever matter is the person sitting in front of the doctor, and how they responded to prescribed treatment. I attended over 150 appointments with psychiatrist in that ten-year period, I was unstable. Despite this, not once did my psychiatrist revert to the RANZCP clinical treatment guidelines.

Prof Whiteford asked me at the Hearing if my treatment was off-label (RANZCP,2018). I would like to clarify my response. It was not off label, as none of the following steps occurred: -

- Off-label would have required using standard treatment for my presentation first. Not once from 2006-2016 were antidepressants excluded in my treatment. "antidepressant therapy should be avoided during mixed state" (RANZCP,2015)
- Off-label treatment benefits would outweigh the risks. "antidepressants cannot be recommended and may be potentially hazardous" (WFSBP,2019).
- Identified risks were not discussed or consent signed. "previous reaction to serotonergic drugs" (Med Records).
- The off-label trial should have been stopped if risks were higher than benefits. "prescription of antidepressants should take into account past history of TEAS" (RANZCP,2015); including "lethal suicidal plan" (Med Records), TMS and "possibility of future course of ECT" (Med Records) to treat my drug reaction.
- Ongoing plans were:- "there is also the option of trialling or re-trialling an antidepressant"; "I cannot permanently exclude the option of antidepressants in the future" (Med Records).

My treatment was reckless, not off-label. I was vulnerable and had no choice but to believe the system that failed me. This does not need more than CPD on side effects to stop widespread entrenched treatment beliefs that if you add a mood stabilizer, then ongoing prescription of antidepressants are ok when **"There is insufficient evidence for treatment benefits with antidepressants combined with mood stabilizers"** (ISBD, 2013) The Government should be outraged that this common practice is still happening.

Table 2. Medical records.

<p>"Bipolar disorder type 1"; "genetic-weighted"; "mixed mood state"; "profound mood lability"; "rapid cycling"; "some psychotic symptoms"; "has auditory hallucinations"; "psychosis"</p>
<p>"limited response to antidepressant & mood stabilizer"; "her illness has worsened to the point that she is not able to function effectively"; "her recovery is seriously limited due to persisting symptoms of bipolar disorder".</p>
<p>"limited benefit from prescription medication and her mood instability persists"</p>
<p>"possibility of future course of ECT"</p>
<p>"despite long term and full compliance with treatment, she has been totally unable to return to her previous high level of functioning. She is unlikely to have any further recovery and therefore unfit for any paid employment"</p>
<p>"When I first saw her ... I felt she has a mixed mood state";</p>

"I believe that Christine remains in mixed mood state with more depressive features ... there is also the option of trialling or re-trialling an antidepressant"

"I wonder if she had a delayed reaction to it" (antidepressant)

"a history of notable sensitivity, side effects and adverse reactions to many of the serotonergic antidepressants"

"a complex history," "a history of ... adverse reactions to many of the serotonergic antidepressants"

"When she is depressed (including mixed states and rapid cycling on antidepressants), she has constant thoughts of suicide and images to do with death and dying. She has always been able to resist any suicidal thoughts."

"lethal suicidal plan" (ultradian cycling immediately after starting a further antidepressant).

*"Epilim has helped her, particularly in combination with gabapentin"
"the best I've ever seen Christine." I had ceased the last antidepressant*

"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)." Risks not discussed with me.

"I cannot permanently exclude the option of antidepressants in the future"

Given the number of healthcare providers I had contact with, and the duration this occurred over, I believe there is a significant healthcare crisis that needs an urgent Government response.

Investigated bipolar suicides by the Victorian Coroner found "60% had not reached benchmark standards in treatment, and 46% were taking antidepressants at their time of death." (Keks, 2009) (See attachment 2). BPAD is an easy entry point for the Government to address injury from antidepressants. Some data is already available to the Government. Consider these current and future data sources:-

- ICD codes. Diagnosis of bipolar with specifiers of mixed features, mania, or rapid cycling with a list of discharge medications.
- Deidentified research data, eg QIMR Berghofer Australian Genetics of Bipolar Disorder Study. They gathered information about my moods and medications.
- Deidentified data collected by Black Dog Institute Bipolar Clinic. This will have information about mood specifier and presentation medications.
- RCA (as above)
- MH illness specific rating scales (as above)

The evidence of ADRs is hard to identify in consumers with a sustained treatment-emergent affect switch. The answer is in reviewing those who have failed to achieve remission and on antidepressants. See Attachment 3, which discussed case studies of chronic mixed features where antidepressants are successfully withdrawn. (El-Mallakh, 2005).

Audits and RCAs are an accepted part of maintaining standards of care in specialties to prevent negative outcomes, e.g. surgery. My life should have been provided the same value as a surgical patient.

GOVERNMENT INQUIRY

A simple perimenopausal depression was grossly mismanaged, I found myself in a vulnerable situation with a serious mental health illness. The only person I trusted was my psychiatrist. Nobody knew they caused and sustained my illness.

You should be outraged that this is happening and scrambling for solutions to close gaps that leave future generations at risk. Consultants are not above treatment guidelines that were in place to protect me. Those who are still clinging onto old practices need to be identified and their patients protected.

The biggest domino effect on patient care into the future is to discuss with the current Government the need for an urgent Inquiry to investigate factors that still obstruct consumers receiving safe care. This will provide and immediate change for consumers who are unable to obtain stability because their treatment does not reach benchmark standards.

Mixed hope. I attended the International Society of Bipolar Disorder conference in Sydney last year. The use of antidepressants was barely mentioned, it seemed a given that it was detrimental in the treatment of at-risk bipolar patients. Several psychiatrists whom I spoke with who chose never to use antidepressants in the management of any of their bipolar patients. I was reassured and hopeful for the future.

Social media is sharing more consumers and their psychiatrist are aware of the risks of antidepressants. But too many still talk about current episodes of rapid cycling, mania or mixed features whilst on antidepressant therapy. Others are constantly having the antidepressant changed in hope that they will find the one that works for them. Lamotrigine seems to be the flavour of the month to manage bipolar depression, with good outcomes. Sadly, it is not on PBS, so out of the reach of many.

“The use of psychotropic medications as the first line treatment for depression and other conditions is, quite simply, unsupported by the evidence. The excessive use of medications and other biomedical interventions, based on a reductive neurobiological paradigm causes more harm than good, undermines the right to health, and must be abandoned.”

United Nations Human Rights High Commissioners Office.
(Puras, 2017)

**There exists complacency in following treatment guidelines by some clinicians;
complexity of diagnosing a drug reaction that mimics bipolar disorder;
a lack of tools to evaluate and monitor for neurotoxic drug reactions;
an inability of Government agencies to respond; and
outcomes of high-level dysfunction or medication-induced suicide from antidepressants.**

**Not one Australian should ever
be exposed to prescription
medications that sustain
a mental health illness.**

This is our basic health right.

ATTACHMENTS

1. Thase, et al. 2019. Impact of Pharmacogenomics on Clinical Outcomes for Patients Taking Medications with Gene-Drug Interactions in a Randomized Controlled Trial.
2. Keks, 2009. Evaluation of treatment in 35 cases of bipolar suicide.
3. El-Mallakh, Karippot, 2005. Antidepressant-associated chronic irritable dysphoria (acid) in bipolar disorder: a case series

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