From: Christine Newton [redacted]
Sent: Tuesday, 8 February 2022 9:22 AM
To: Mental Health Select Committee
Subject: RE: Automatic reply: Chris Newton - Submission
Attachments: Personal Accounts of Antidepressant-Induced (2).pdf; MHSC Qld 7.2.22.docx

Categories: Submission

Hi Amanda

Thank you for the extension in time.
Please find attached a word document with my submission for the MHSC's consideration.

There is one only attachment with Lived Experiences.
This has de-identified lived experiences of consumers from public and private MH systems.
*** The attachment is confidential, for the information of the MHSC, but the attachment MUST NOT be published.

I would still like the opportunity to speak at the hearing. I do not intend to discuss history, but to discuss the reforms that I have presented in my submission.

Kind Regards
Christine Newton

[redacted]

Sent from Mail for Windows

INQUIRY INTO THE OPPORTUNITIES TO IMPROVE MENTAL HEALTH OUTCOMES FOR QUEENSLANDERS

To the Mental Health Select Committee.

I shall address the following terms of reference: -

(c)	Opportunities to improve economic and social participation of people with mental illness through comprehensive, coordinated, and integrated mental health services: a. across the care continuum from prevention, crisis response, harm reduction, treatment and recovery; b. across sectors, including Commonwealth funded primary care and private specialist services, state funded specialist mental health services, non-government
(f)	How investment by the Queensland government and other levels of government can enhance outcomes for Queenslanders requiring mental health treatment and support;
(g)	Service safety and quality, workforce improvement and digital capability. Six priority areas for safety and reduction of potential and actual harms that may occur in MH care are:- - partnering for improved safety - enhancing responses to deterioration - providing trauma-informed care - improving medication safety - Reducing suicide and self-harm - increasing the safety of transitions

Thank you for the opportunity to provide this submission to the *'Mental Health Select Committee inquiry into the opportunities to improve mental health outcomes for Queenslanders'* (MHSC). I am a retired Registered Nurse and worked for Queensland Health for the most part of my 32-year career. I learnt never to turn my back on critical incidents. It was not until I was 45yo that I required the services of the mental health system.

I provide the MHSC with this submission regarding a mental health system that can compromise the well-being of Queenslanders when they needed you most. I am going to speak from my experience, but all reforms provided cross-over and benefit all Queenslanders with any mental health illnesses.

STATISTICS.

In bipolar disorder (BD), Adverse Drug Reactions (ADR) that cause treatment-emergent mood instability or suicidal deaths frequently go undiagnosed due to lack of effective monitoring or evidence. In any medical specialty these would demand investigation and coordinated implementation of solutions.

Bipolar disorder is a common disorder with poor outcomes. It is 12 years since there has been a review of treatment and outcomes in Australia. In this, the Victorian Coroner reviewed 35 bipolar suicides and concluded: -

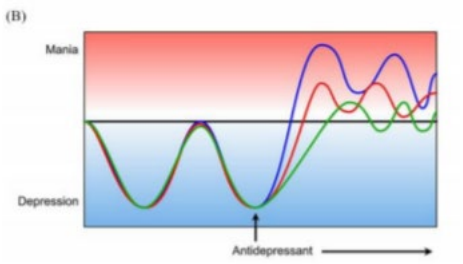
- only 34% had reached benchmark treatment standards the month before their death
- a staggering 60 % had failed to reach benchmark treatment, and
- 46% were on antidepressants at the time of death. (Keks, attach 1)

Despite Royal Australia and New Zealand College of Psychiatrist (RANZCP) *'mood disorder clinical practice guidelines'* in place to protect consumers the evidence remains that it is not reaching end users, see personal accounts (attach 1). This demands urgent Government intervention.

	Incidence	Approx lives at risk
Australians diagnosed with BD (a)	568,000	
Australians currently impaired with BD (a)	352,000	~ 352,000
BD suicides (b)	30-60 times general pop	
BD lifetime suicide attempts (d)	24 - 26%	~ 88,000 (of 352,000)
BD lifetime completed suicidal deaths (d)	3.4 – 14%	~ 12,000 – 49,000 (of 352,000)
Peak in bipolar suicide (d)	8.4 years after diagnosis	
BD with suicidal ideations	No data collected	No Data
Treatment-emergent suicidal deaths	No data collected	No Data

a. ABS, June 2016; b. Mahli 2021; c. Black Dog Institute; d. Schaffe, 2015

My History - A GP prescribed antidepressants for mild perimenopausal depression, I became suicidal and was placed under the care of a psychiatrist who prescribed off-label doses of antidepressants. New symptoms of melancholy with psychosis, irritability, suicidality, and agitation emerged. After 18 months I was diagnosed with bipolar disorder (Figure 1, RANZCP, Malhi 2020). But nothing changed, *nine* antidepressants were trialled over *ten* years, I was told I was treatment-resistant.



DSM-5 calls this Substance/Medication-Induced Bipolar Disorder. I had not taken illicit substances; this was prescribed for 3650 days by multiple specialists. When ceased I no longer had bipolar symptoms. I had suffered a serious neurotoxic adverse drug reaction that impacted every part of my life.

My **Clinical Records** showed that treating psychiatrists were fully aware: - of *"adverse reactions to many of the serotonergic antidepressants"*, including a "*suicidal plan (lethal OD)",* but despite the risks, they repeatedly chose the *"option of trialing or re-trialing an antidepressant"*. My treatment was: -

- Not clinically indicated,
- provided no benefit,
- sustained a life-threatening adverse drug reaction, and
- therefore, was not off-label therapy.

Failure to inform me that I had an adverse drug reaction breached my Health Rights for safe and informed treatment. This is not isolated and demands the attention of the MHSC to protect consumers.

I spoke at the **Productivity Commission Mental Health Inquiry, 2020** hearing. Due to the volume of public concerns about the pharmaceutical treatment the recommendations made were:-

Action 10.2 The Mental Health Related Prescribing
- The prescribing of mental health medications should be based on informed consumer choice and follow evidence-based guidelines.
- The Australian Government should commission a review into off-label prescribing of mental health medications in Australia.

REFORM 1
Off-label prescribing

The QMSC should recommend the Queensland Government review into off-label prescribing of mental health medications in Australia.

The **RANZCP** clinical practice guidelines (Figure 2, Mahli 2020) warned of antidepressant-induced mood switches and provided evidence-based options to protect consumers. The RANZCP 2004 treatment guidelines stated the same. Eighteen years on and consumers are still not protected by these. The MHSC must urgently identified why complacency goes unmonitored when there is significant injury.

Recommendation Box 5.	Administration of antidepressants in bipolar disorder	Grade
General considerations		
5.1	The use of antidepressants in the treatment of bipolar disorder should be overseen by a psychiatrist where possible.	CBR
5.2	The clinical risks versus benefits of antidepressants in treating bipolar depression should be determined on an individual basis.	CBR
Treatment		
5.3	Adjunctive antidepressant therapy should be used cautiously in the treatment of bipolar depression when there is a history of antidepressant-induced mania, current or predominant mixed features, or a history of rapid cycling.	EBR III
5.4	Antidepressant monotherapy should be avoided in bipolar disorder	EBR III
Treatment emergent affective switch (TEAS)		
5.5	Upon commencing antidepressants, patients with bipolar disorder should be closely monitored for symptoms of mania, and if these emerge then antidepressant therapy should be discontinued. Psychoeducation should be provided so that patients, family and friends can identify early warning signs of mania and/or mixed symptoms.	CBR
5.6	Antidepressant therapy should be avoided in bipolar disorder patients with a history of rapid cycling and/or a high level of mood instability.	CBR
5.7	The prescription of antidepressants should consider any past history of a TEAS.	CBR

CBR: consensus-based recommendation; EBR: evidence-based recommendation.

REFORM 2
ADDRESS KNOWING-DOING GAP

a. **RIGHT DOOR**. Expert Psychiatrists trained in mental health subspecialties should be identifiable and available to public and private patients.

Mental Health disorders are complex and have a high level of disability and suicidality. Current patterns display suboptimal treatment with poor outcomes. For these reasons, management should not be about accessing any psychiatrist, but the right psychiatrist. The current practice assumes that all psychiatrists are experts and current in all fields of mental health. This system fails consumers.

- Support methods that GPs and consumers can identify psychiatrists with this training.

B. **CONTINUING PROFESSIONAL DEVELOPMENT** (CPDs).

As part of the 'Registration Standard' health care professionals can only *provide "services that they are trained, qualified and competent to perform"*. There is no method to establish if a psychiatrist is current with RANZCP clinical practice guidelines. These are significant documents and must become mandatory CPDs to ensure evidence-based practice is provided.

In addition to this, CPDs for guidelines should attract an endorsement that remains valid until the next guideline is released. The endorsement would permit consultants to promote to GPs and consumers that they are current in subspecialties management. Not having an endorsement would not prevent them from practising; but ensures currency, accountability, and consumer confidence.

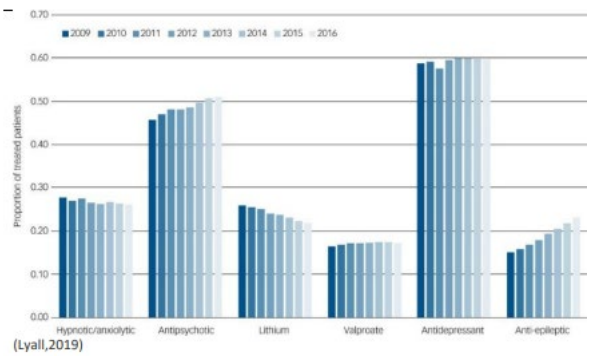
- All revised RANZCP Clinical Practice Guidelines are significant documents.
- Endorsement to identify RANZCP clinical practice guideline CPDs currency.

A task force from **The International Society of Bipolar Disorder** states *"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. …. there is insufficient evidence for treatment benefits with antidepressants combined with mood stabilizers"* (3). International bipolar academics, including Ghaemi state that *fewer than 20% benefit, but 60% of patients are taking them* (4). The World Federation of Societies of Biological Psychiatry said, *"the use of antidepressants (in mixed state) cannot be recommended and may be potentially hazardous"*.

Therapeutic Goods Administration warning of mania and suicide from antidepressants in *Product Information*. In June 2018 the *Medicine Safety Update* alerted of *"medicines associated with a risk of neuropsychiatric adverse events"*. They listed symptoms that mimic unstable bipolar presentations from psychotropic medication commonly prescribed to treat bipolar disorder (5).

Attempts to mask the drug reaction with more psychiatric medications instead of removing the cause is

beyond comprehension and potentially lethal. It is outside RANZCP treatment guidelines, has no place in the evidence-based medicine. But recent international studies are consistent with my experience.



(Lyall,2019)

Scotland:- "**The findings are concerning and represent a gap between treatment guidelines and clinical practice**." (Lyall,2019)

American:- "**Antidepressant prescriptions persisted despite a lack of evidence for their efficacy** in bipolar disorder and concerns about increasing the risk" (Rhee, 2020)

REFORM 3
DATA COLLECTION

The QIMR Berghofer Medical Research Institutes 'genetics of bipolar' research project obtained current pharmaceutical histories from 5000 participants. This data will provide the Government information to decide if Australia is following international trends.

If so, then the MHSC will be able to establish if treatment patterns have not changed since the Victorian Coroner of study of bipolar suicide; or if the attached lived experience from consumers reflects the knowing-doing gap in state and public mental health services.

https://www.qimrberghofer.edu.au/study/australian-genetics-of-bipolar-disorder-study/

I placed a complaint with the **Queensland Office of Health Ombudsman** who referred the investigation to the **Australian Health Practitioner Regulation Agency** (AHPRA) to investigated. They stated, *"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".* This is like saying penicillin use is common, whilst dismissing that the complaint was about repeated prescribing when they were allergic to it, not informing the patient of the cause, and not putting measures in place to protect the patient in the future.

The process advantaged the doctors. I was not permitted a copy of my medical records before I made my complaint. The doctors got to see my complaint and were asked to address key points. They were investigated based on their response and the selected parts of my medical record that they chose to quote. My medical record was not read, I did not get the opportunity to see their response or how they portrayed me. I was told that if it was only my word against theirs and a doctor is always considered to have a higher value. Once I gained access to my medical records the documentation was most consistent with my complaint, but I couldn't ask for the matter to be reconsidered as it was not new. I was healthy and had experience in health care and complaints to draw from; I have no idea how consumers who are unstable can be expected to have a voice in this domain.

REFORM 4
OHO / AHPRA

Consumers would benefit from a Lived-Experience representative to support them with: -

- Writing a complaint.
- A lived-experience representative within OHO / AHPRA to represent to sit on boards investigating mental health complaints.

Medication-induced suicide is not suicide! The Victorian Coroner concluded in his review of bipolar suicides that *"the present findings suggest that improvements in the treatment of bipolar illness will save lives."* (Keks, attach 1)

Data collected by the Queensland Suicide Registry fails to identify medication-induced suicides. This statistic would be lost amongst *Probable* suicides or "*Beyond reasonable doubt:* The available information suggests that the deceased had communicated verbally or in writing their intent to die by suicide."

In medical specialties severe drug reactions, near-deaths or deaths would demand investigation and coordinated implementation of solutions. In mental health medication-induced suicide is not even a target group for suicide prevention in 2022. The Government needs to find ways to monitor the deaths caused by treatment in mental health. The way MHSC can lead Queensland in this is through Root Cause Analysis.

REFORM 5

1. **Add Medication-Induced suicide** to the Queensland Suicide Registry

2. **ROOT CAUSE ANALYSIS**

Resilience to treatment-emergent suicidality will eventually fail when the cause is not removed. BP suicide peaks 8.4 years after diagnosis. A Coroner may not link such deaths to a protracted ADR; but RCA could.

Medication-induced suicidality is preventable. Underlying systemic causes in the public and private health systems that are preventing safe health care must be identified and addressed as a matter of urgency. RCA is a catalyst for the QMSC to achieve this.

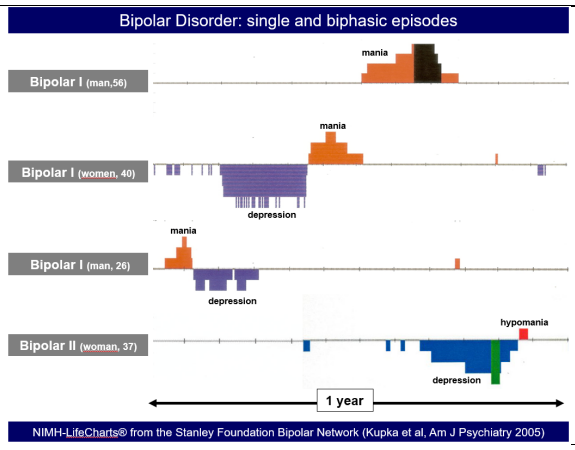
- BD consumers taking antidepressants who attempt suicide should be flagged as near misses,
- and completed suicides as sentinel events. Both must be investigated.

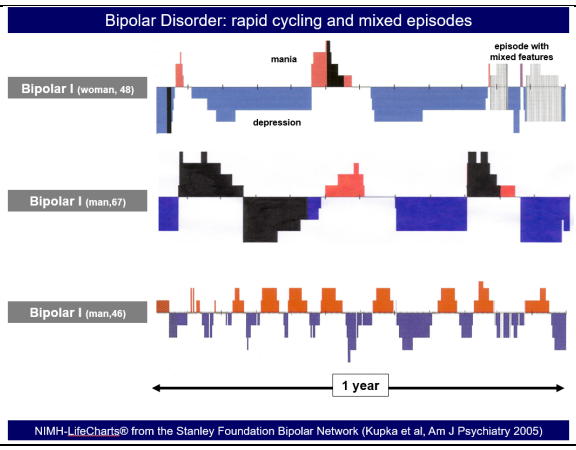
Measurement-Based Care. I was reviewed by psychiatrists 150 times over ten years as an outpatient. My records show no quantitative data, rating scales or subjective input. There were no targets, audits, or case conferencing to protect me.

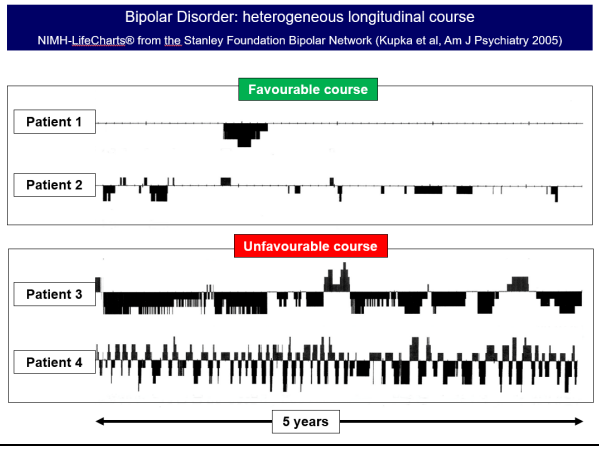
- Illness specific rating scales are a biomarker that can be used across mental health.
- They measure and evaluate the consumer's mental state, and their response to pharmaceutical and other interventions.
- When psychotropic medications can take weeks to cause benefits or adverse reactions there needs to be longitudinal charting to monitor these. This will help the clinician separate the natural course of the illness from treatment induced.

- Rating scales must be built into any new MH digital platforms.
- A lack of biomarkers in psychiatry is a fallacy supports a failure to guide treatment with any standardised tools.

Uniform quantitative data is the foundation of the healthcare system. "Measurement-Based Care (MBC) is not intended to replace clinical judgment. MBC by psychiatrists has the potential to improve the accuracy of diagnoses and improve the outcomes of care. In essence, MBC aims to get the diagnosis and management right as often and as quickly as possible." (Ahmed, 2018)







Illness specific longitudinal data collection in mental health provides meaningful information and has been proven to improve diagnosis and outcomes of care.

REFORM 6
Measurement-based care

International cohorts have already established longitudinal monitoring of mental health illness to improve patient outcomes. The MHSC should lead Australia be recommending this to be included in data collection.

REFORM 7
QUANTATATIVE RATING SCALES

National Rating Scales. National, illness-specific, rating scales will assist in monitoring: -
- Monitor natural course of illness;
- identify response to pharmaceutical/ psychological treatment;
- identify response to triggers;

- identifies treatment-emergent mood instability;
- support treatment choice;
- provide a uniform tracking scale that is shared between health care workers;
- graph illness over weeks, months, and years;
- flag consumers who do not reach targets for intervention;
- provide transparency and accountability; and
- provides digital data for national health monitoring.

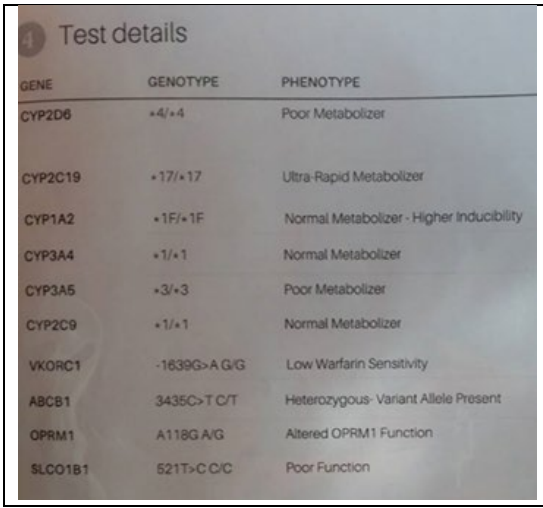
Targets. Setting safe parameters for rating scales will: -
- Support treatment changes.
- Identify the need for further investigation.
- Identify the need for referral to bipolar clinic, case conference, other services.
- A tool for clinical audits.
- A tool for AHPRA to evaluate practitioners.
- Government use of de-identified data to manage resources.

DIGITAL DATA SYSTEMS must provide for illness specific rating scales charting and targets.

NEUROTOXICITY If an ADR caused kidney (nephrotoxicity) or liver (hepatotoxicity) this 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 brain (neuropsychiatric toxicity) is not as clear cut and needs to be addressed. Pharmacogenomics is one tool.

In general medicine, a patient with chest pain would have blood tests, ECG and chest x-ray to establish the cause. One, two or all of these may come back normal, but normal results also provide information in diagnosis and treatment. **PHARMACOGENOMICS test** results showed that what I had told my psychiatrist was real. Antidepressants made me worse. The report, together with clinical assessment would have guided my treatment, and minimised risks, including suicidality.

> *"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 MDD with at least 1 prior medication failure."* (Thase, 2019)



Test details

GENE	GENOTYPE	PHENOTYPE
CYP2D6	*4/*4	Poor Metabolizer
CYP2C19	*17/*17	Ultra-Rapid Metabolizer
CYP1A2	*1F/*1F	Normal Metabolizer - Higher Inducibility
CYP3A4	*1/*1	Normal Metabolizer
CYP3A5	*3/*3	Poor Metabolizer
CYP2C9	*1/*1	Normal Metabolizer
VKORC1	-1639G>A G/G	Low Warfarin Sensitivity
ABCB1	3435C>T C/T	Heterozygous- Variant Allele Present
OPRM1	A118G A/G	Altered OPRM1 Function
SLCO1B1	521T>C C/C	Poor Function

These results showed multiple Pharmacogenomic phenotype variants.

1. Ultra-rapid metabolism of pharmaceuticals causes subtherapeutic treatment. Clinically presents unstable.
2. Poor metabolism of pharmaceuticals causes increase side effects and toxicity. Clinically presents unstable.
3. Normal metabolism of pharmaceuticals, the consumer can present unstable, but this is the natural course of their illness.

Clinically all present the same, but use of various antidepressants, mood stabilisers and antipsychotics would differ when the psychiatrist is guided by this report.

REFORM 8
PHARMACOGENOMIC TESTING

MHSC should write to PBS re the importance of this testing to protect Queenslanders from pharmaceutical mismanagement.
Key points: -

- Minimise risk by using pharmacogenomic guided treatment decisions,
- One-off cost ($197) by PBS for non-responding consumers, and
- Guide to future treatment decisions, including yet undiagnosed illnesses.
- Emerging research for phenotypes linked to suicidality.

DEPRESCRIBING.

This must not be left as the job of geriatricians. Psychiatrists and GPs must consider that every medication that is prescribed must at some time be deprescribed. With psychotropic medications, this can be complex. In Ontario, Canada they have led the way with resources for clinicians and consumers.

REFORM 9
DEPRESCRIBING STRATEGIES

Below are links to how Canada has implemented deprescribing to support care providers and protect consumers. This is an important safety tool for consumers and Queensland Government should consider how they can expand their service.

https://deprescribing.org/
https://www.ismp-canada.org/download/safetyBulletins/2018/ISMPCSB2018-03- Deprescribing.pdf
http://medstopper.com/

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

Nobody should be considered **treatment-resistant** without assessment by a multidisciplinary team with specialist knowledge in the consumer's presentation, e.g., Bipolar Clinic. These must be time-limited, like transition care, before the consumer returns to their own care provider.

Mental Health Clinics should provide a one-off opportunity to identify missed causes, optimise future treatment and provide consumer resources. With uniform rating scales and targets in place, a patient who fails to reach targets would generate a requirement to step away from silo management (both private and public).

Excluding all underlying causes should never be a sentence in mental health. This is the foundation of a MH clinic. They provide a 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. Reform 10 describes this time-limited clinic.

REFORM 10
Mental Health Time-Limited Specialty Clinics

1. MH Case Manager allocated: -
   - obtain a history from the patient, care providers, hospitals, carers;
   - complete subjective and clinical assessment ratings;
   - initiate relevant pathology (e.g. recommendations from Mood and Food Centre, hormones, inflammatory markers, pharmacogenomics);
   - make appointments with practitioners depending on identified needs.

2. One-off assessments completed by relevant health care professionals. e.g. psychiatrist, clinical psychologist, dietitian, social worker, and /or occupational therapist. If there are comorbidities then provisions could be made for further external consultations e.g. pharmacist, geriatrician, Integrative GP.
3. Case conferencing is used to develop a consumer tailored treatment plan.
4. A copy of the plan is provided to the psychiatrist, GP, and other relevant health care workers.
5. 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.
6. The consumer's progress can be reassessed to measure outcomes at intervals.
7. A list of illness-specific treatment options. To emphasise how bipolar disorder is different to other mental health disorders, a specialty clinic could provide 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.

Thank you for listening.

After reading my clinical records to facilitate their release to me, my treating psychiatrist said she will support me as required. My Clinical Psychologist offered to do the same. They are aware that I am advocating for change to protect prescribed psychotropic medications. Not only have they validated my experience but stated they are willing to speak directly with you. It is health care professionals like these and others in Queensland that give me hope.

A simple perimenopausal depression was grossly mismanaged leaving me with an adverse drug reaction that mimicked a serious mental health illness. I trusted my psychiatrists, but I had no way of knowing they caused and sustained my symptoms. There were no safety nets identified or protected me in crisis.

I am not alone. I have attached personal accounts which shows that despite "weak evidence base for the efficacy and safety of antidepressant drugs in bipolar disorder". These are commonly prescribed with devastating outcomes.

The implementation and training phases for the use of antidepressants in bipolar is over. The RANZCP, TGA and other Government bodies have failed to protect consumers over the past eighteen years. Queenslanders have Health Rights and need to know their treatment is both current and safe. The reforms I have provided extend beyond my experience and will protect anyone living with a mental health illness.

ATTACHMENTS

Personal accounts, de-identified. Not for publication.

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