SUBMISSION TO THE SENATE SELECT COMMITTEE ON MENTAL HEALTH

We commend the Inquiry and its very broad reference components. This submission, however, will focus on mood disorders, identifying several key current concerns and then note a number of strategies that could be of assistance in addressing these issues.

BACKGROUND

The key mood disorders are 'depression' and 'bipolar disorder'. The case has been well made elsewhere that these represent the most disabling conditions in the community, with their early age of onset being associated with ongoing high levels of morbidity and disability, stigma, economic cost (direct and indirect), and a high rate of suicide, as well as contributing to an increased rate of 'co-morbid' and secondary psychiatric conditions (e.g. anxiety disorders, excess drug and alcohol intake) and social consequences.

The issue of **DETECTION** is best considered in regard to depression and bipolar disorder separately. Over the last decade there have been tremendous advances in attempting to improve the detection of depression by health professionals and by the community. We argue, however, that the current simple model for conceptualizing 'depression'– while useful for destigmatization, for recognition and for encouraging depressed people to seek assessment – is limited in practice and leads to a range of major concerns. In reality, there are multiple depressive conditions, each with differing principal causes and benefiting from differing treatment priorities. However, there has been a general tendency to homogenize myriad depressive conditions into *non-specific* single diagnoses such as 'major depression' or 'clinical depression', and then initiating non-specific treatment.

MANAGEMENT

Such a non-specificity model encourages treatment largely being shaped principally by the practitioner's discipline, training or special interest. As a generalization, patients with 'major depression' consulting a general practitioner or psychiatrist are highly likely to receive an antidepressant drug, those seeing a psychologist are highly likely to receive cognitive behaviour therapy, and those (say) seeing a hypnotherapist are highly likely to receive hypnotherapy. In essence, the patient is 'fitted' to the therapist's paradigm, rather than the converse (ie a specific therapy being 'fitted' to nuances of the condition).

A MEDICAL ANALOGY

If we compare the current paradigm to a fairly simple medical analogy, immediate limitations to managing 'depression' can be identified. For example, if an individual became very breathless and consulted a doctor, receiving a non-specific diagnosis of 'major breathlessness' would (we hope) only be a first-stage consideration, and not regarded as sufficiently informative to determine treatment. The doctor – and the patient – need to know what has caused the breathlessness, with possibilities ranging across transient and spontaneously remitting states (eg excessive exercise), quite specific conditions (e.g. asthma, pulmonary embolus, pneumonia) which might be expected on a rational and empirical basis to respond to a disease-specific treatment, and also more

chronic conditions (eg emphysema) where rational treatment might need to focus as much on the ongoing disability as on symptom relief. We argue that depressed patients also benefit from detection and management strategies that adopt a similar model. In the same way that we would be concerned by a treatment paradigm that allowed *all* breathless individuals to receive antibiotics or anti-asthmatic drugs as a singleton approach by the practitioner – irrespective of cause – we should be concerned about the current superficial model (eg recommendations that 'depression is a disease' and all sufferers should receive an antidepressant, or that depression reflects poor thinking patterns and all sufferers should receive cognitive behaviour therapy). Our argument is not merely theoretical, as we have worked as clinician researchers (at our Mood Disorders Unit until 2002, and now the Black Dog Institute) for 20 years, and been required to address management paradigms that build to so-called 'treatment resistance' and disorder persistence.

Thus, our group has argued for the importance of sub-typing the depressive disorders, and for applying more logical and rational treatment algorithms, and having the treatment 'fit' the underlying cause or pathology rather than having the patient being 'fitted' to the therapist's training or discipline-based paradigm. As noted, we see the consequences of failure to adopt a more logical and rational model. The commonest examples are of individuals with 'biological' disorders who have failed to receive any appropriate physical treatment (eg antidepressant drug) or who have received narrow physical approaches and/or an array of ineffectual treatments, leading to ongoing suffering and impairment. Conversely, we see a sizeable percentage of patients who have conditions more reflecting an interaction between their personality and life-event stressors, where non-physical approaches have a greater relevance but where they receive an endless set of drug treatments without benefit. Most treatments address symptoms (like aspirin for pain) and do little do address underlying determinants and build to resilience. Such 'paradigm failures' dominate the referrals that we have seen over our twenty years of assessing severely and treatment-resistant depressed patients. However, the problems are not unique to these groups – and occur at the earliest stages of the condition for many people.

Thus, while there have been considerable improvements in detecting 'depression', there is a need to proceed beyond this first stage and ensure detection is made more sophisticated and management more logical.

The second **DETECTION** issue is in regard to bipolar disorder. Once called manic depressive illness, we now divide the bipolar disorders into Bipolar I and Bipolar II. Bipolar I (old term = manic depression) probably affects 0.5–1% of the population over their lifetime and has probably been fairly consistent in its prevalence across the decades. By contrast, Bipolar II seems to have increased dramatically over the last ten years, with a number of estimates suggesting that some 5%-6% of the population might experience Bipolar II over their lifetime, and with the increase being extremely high in adolescents and young adults. Here, the 'highs' are usually not too severe, but the depressive episodes (being 'biological' in their origin) are of major concern. Individuals are profoundly depressed, they lack energy and find it even difficult to get out of bed, have a

bath or shower, while their concentration is compromised, affecting work and other daily activities. These states drive suicidal preoccupations and, on occasions, violence. A recent review of Bipolar II disorder established that the suicide rate was at least as high for those with Bipolar II as for Bipolar I, and that such individuals spend more time in depressed states than those with Bipolar I disorder.

In 2003, we undertook an audit of out-patients seeing a psychiatrist for the first time with a depressive disorder. Some 55% had Bipolar II Disorder. Of those, 80% had not previously received that diagnosis, despite having the condition for an average of 15 years. Most had previously seen a psychiatrist (in fact, up to 7 psychiatrists) without the diagnosis being provided. Failure to make the diagnosis largely reflected failure to ask any screening questions in relation to bipolar disorder. Detection rates by general practitioners are even lower, largely because of a lack of awareness and education about the importance of this mood disorder.

The bipolar disorders are amongst the most disabling and worrying mood disorders that we have to manage but, if not detected, the consequences are gravid. Conversely, the management of a Bipolar II condition – once detected – is generally an optimistic situation, where most individuals can have their mood swings brought under control. This is less likely to occur if the condition is not detected or if it is homogenized within the broad rubric of 'major depression'.

OUR INSTITUTE'S CAPACITY TO ASSIST

We now consider the contribution that the Black Dog Institute might make to address such concerns. As noted, the Institute builds on its predecessor – the Mood Disorders Unit – which was established in a Sydney teaching hospital in 1985. The initial unit was a clinical research facility, with clinical observations shaping research findings and research findings shaping clinical management. We assembled a group of clinician researchers, and this group has progressively expanded and developed over time. The team was the first group of researchers in Psychiatry to receive an NHMRC Program Grant (re-awarded on two occasions) and, when an audit was made of the most highly cited international researchers in the discipline of Psychiatry/Psychology in 2002, 7 of the top 18 in that list were from the MDU. In 2002, the Black Dog Institute was launched, retaining the MDU research priorities, but we expanded the clinical focus, and developed two major new components. One focuses on teaching and education, and the other (the 'Consumer and Community Resource Centre') focuses on supporting those with mood disorders, their families and carers, as well as addressing community needs via our Resource Centre, our Website, and a range of publications.

The Institute now has recently refurbished purpose-built premises at the Prince of Wales Hospital in Sydney and has the capacity to address a number of the issues noted above at a practical and imaginative level. These will be briefly noted.

In relation to detection, we have developed a unique computerized Mood Assessment Program (the MAP) which acts as a comprehensive clinical aid.

The MAP requires the patient to enter a set of information and then a clinician to enter other data based on their clinical assessment. The questions and the derived algorithms build on the accreted wisdom of our clinical observations over two decades and result in a comprehensive report being generated. The report indicates whether the patient is likely to have a clinical depressive condition, its sub-type (both for depression and for the possibility of bipolar disorder are taken up), together with noting the prevalence of any anxiety disorder or predisposing personality style. It makes an assessment of risk (e.g. suicide, self-injury), considers distal background factors (e.g. family history of mood disorder, deprivational upbringing), organic factors (e.g. blood pressure, stroke), drug and alcohol intake, and the relevance of a set of common precipitating life events. It records all treatments (drugs or other) received and their judged usefulness, so generating a useful record for the practitioner. Broad-brush treatment guidelines are also provided.

We have tested the utility of the MAP in a number of contexts. Even for a well-trained psychiatrist, the MAP can provide a number of advantages – picking up on information that might have been missed or judged as irrelevant during the assessment, and in providing a printed treatment record. For general practitioners and for other health professionals, the MAP has the potential to advance detection and more appropriate management to a substantial degree. It 'value adds' by its sophistication and pluralism.

The MAP is best seen as a clinical aid and not dissimilar to a patient having a 'path test'. For example, a clinician may suspect anaemia in a patient but the path test offers advantages of confirmation, quantification and even possible identification of cause (eg low iron levels). Similarly, the MAP has the capacity to provide additional diagnostic information to the practitioner and assist shaping a pluralistic management plan. Such computerised, structured, diagnostic and treatment, algorithm systems have been developed in other areas of Medicine but have not been developed for mood disorders – as, and as previously noted, the current paradigm effectively homogenises all depression into pseudo-conditions such as 'major depression' or 'clinical depression' and assumes non-specific treatments.

Having moved through the 'proof of concept' phase, our challenge now is to determine an effective way to deploy the MAP on a widespread basis.

The second component that the Institute would like to bring to your attention relates to ***education and training***. Over the last eighteen months, we have developed a range of educational programs – giving the Institute model – for the detection and management of the differing mood disorders. We have a 6-hour general practitioner program that meets the Commonwealth's Better Health Outcome requirements and we are an approved provider. We have developed training programs for psychologists, with more than 600 completing a discipline-specific educational program last year. We are developing training programs for individuals with bipolar disorder and for other health workers. The Institute's sub-typing model excites the health professionals, who appreciate the logic and the richer model. It is not complicated to teach or to implement.

It is worth emphasising that the Institute's educational programs occur independently of the pharmaceutical industry and thus quite distinct in the Australian context. We believe that we have the capacity to become the 'preferred provider' for offering a more sophisticated and practical set of educational activities for a range of health professionals. A key issue therefore is to develop a mechanism to deliver these training solutions rapidly and extensively.

As noted, our organization is multi-faceted and we see the continuation of our clinical research activities as a vital component of the rich tapestry of activities needed to ensure the shaping of educational, training and clinical management components.

Thus, this submission has sought to focus on current issues of concern in regard to the detection and management of mood disorders, and we have identified two Institute strategies which we believe would go a long way to redressing the current issues, building on the track record long established by our Mood Disorders Unit.

We would be pleased to provide further information on these and related initiatives to assist advancing the aspirations of the Inquiry.

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