MHPN WEBINAR

Transcript

Identifying and treating panic disorder

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Panellists:

- Katie Dobinson (Clinical Psychologist, NSW)
- Dr Catherine Eltringham (General Practitioner, VIC)
- Dr John Lam-Po-Tang (Psychiatrist, NSW)

Facilitator: Professor Stephen Trumble (General Practitioner, Vic)

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Steve Trumble:

Good evening everybody, and welcome to tonight's webinar on identifying and treating panic disorder. MHPN would like to acknowledge the traditional custodians of the land, seas, and waterways across Australia upon which our webinars, presenters, and participants are located. We wish to pay our respect to the elders past, present, and future for the memories, the traditions, the cultures, and the hopes of Aboriginal and Torres Strait Islander Australia. Steve Trumble is my name. I'm on the land of the Wurundjeri people. I'm a GP by background, although I've been in medical education at University of Melbourne for more than 20 years. We've got a great panel for you tonight. I'm your facilitator, but the panel is who you're here to see and hear from. Their webinars, sorry, their biographies were disseminated with the webinar invitation, so I won't go through those again. But just to remind you who we have and to meet them, first of all is Catherine Eltringham. Hello Catherine. Welcome.

Dr Catherine Eltringham:

Steve.

Steve Trumble:

You're a GP educator, a clinical GP educator. What do you see as the biggest opportunity for improvement for clinicians when it comes to working with people who are experiencing panic disorder?

Dr Catherine Eltringham:

Well Steve, I think one of the things that I really try and get across to the GP registrars that I work with is that the GP needs to be listening and hearing the cues, and listening to what the patient isn't quite saying, and seeing some of the behaviours. And then, once we recognise patients have panic disorder or other mental health conditions, is validating that and supporting their lifestyle, health and their general wellbeing and that that's part of the management. It's a vital part of the management and it's something that we as GPs can do across time, and complementing all of the other management that might be happening.

Steve Trumble:

Fabulous, we'll certainly be hearing more about that very shortly. So, thanks for joining us. We also have Katie Dobinson who's a clinical psychologist, you can see there on your screens. Now Katie, you've been telling us in earlier meetings that you've been working on an evidence-based online treatment programme called This Way Up. Can you tell us a bit more about that programme?

Katie Dobinson:

Yeah, absolutely. Thanks Steve, and it's great to be here tonight. So, in one of my roles I work at St. Vincent's Public Hospital in Sydney, and that's a team called the Clinical Research Unit for depression and anxiety. And part of that involves an online CBT treatment programme, which is called This Way Up. So, that provides evidence-based cognitive behaviour therapy to patients that are wanting to access that online. Yeah, very happy to talk more about it later, but it's always interesting, and fun, and a nice way to provide some blended care treatment approaches for things such as panic disorder.

Steve Trumble:

Fabulous. Katie, there's been a lot of interest in the lead up to the webinar in evidence-based and accessible treatment options for people with panic disorders, so we'll certainly hear more about that from you. And we also have Dr. John Lam-Po-Tang, who's a psychiatrist. And John, you've been working in this area for a long time. It's 25 years I think, you've been working with people who have panic, or anxiety and obsessive compulsive disorders. What is it that's kept you engaged in this area for so much of your career?

Dr John Lam-Po-Tang:

So Steve, Katie is working at the clinical research unit for anxiety and depression, and that's where I did my advanced training in psychiatry 25 years ago. And so, it's a great service. I think people with anxiety disorder see a very rewarding bunch of people with whom to work. They're often very motivated to get better and engage in treatment. There are effective treatments that we can deliver both pharmacologically and psychologically, and certainly in Sydney there are surprisingly few psychiatrists who choose to specialise in this area. So for all those reasons, I think it's a great clinical area to focus on.

Steve Trumble:

Great to have you working, it's great to have all three people with us tonight. You can tell that each are experts in their field, and very keen to talk with you about what we can do to better improve our management of people in this area. Now, what's going to happen is that each of the panellists is going to give a short, discipline-specific presentation largely related to the case that's been circulated before the webinar, but also touching on some of the key issues in this area.

We do now just need to talk about the aim of the webinar and the learning outcomes. So, the aim of the webinar is to outline how health professionals can identify, assess, diagnose, and evaluate treatments for people experiencing panic disorder. You can see the learning outcomes there. This is an important topic for us to look at comorbidities, and Catherine will be largely talking about that, but making the diagnosis and then most importantly, figuring out which therapeutic approaches is going to be most suitable for that particular person. And as always with MHPN, there's the importance of collaboration, and making appropriate referrals in order to provide the best possible care. So, we'll now move into the

section of the webcast where we have presentations from each of our colleagues. The way the case is set up is that Kim, the person in the case, was left leaving hospital with an intent to visit the GP the next day. So, in that case we'll start with our GP. Catherine, over to you.

Dr Catherine Eltringham:

Great, thanks Steve. So, when I looked at this case, the thing as a GP that I thought was that, given the way that Kim presented, it's unlikely that he would've been to the GP very often given the demographic that he comes from. And if he had, then his previous worries and concerns probably wouldn't have even come up in consultation, because he said himself, he didn't consider himself to be an anxious person. And so, unless you were being really specific to find out that, he possibly still would've denied it anyway. There's some screening tools that we do use in general practise if you are listening to patient cues and hearing some statements from people that you think, oh, maybe there is some anxiety going on. And so we ask questions such as how often have you been worried? Do you describe yourself as a worrier? Do you use alcohol or other substances to cope with your worries?

And I just like to point out that chocolate doesn't count as a substance that we need to be concerned about. And, do you ever feel restless or fidgety? But because Kim didn't see himself as a worrier or an anxious person, then screening him may not have picked up any of these things. Next slide please. So, when you start to look at the history that we do know about Kim, and we don't know a lot about him, but there was a fair bit in the history that we do have that we can look at.

So, the types of things you might hear or that have come up from that summary that we get is that he's got a history of exam stress, dislikes speaking in groups, he talks about social anxiety, he talks about physical symptoms that could be physical symptoms of anxiety, that he has been a bit more worried lately, and that there's some escalation in his worry and been a little bit more over time.

And so, just clarifying those things with Kim would be really important in that first consultation. Next slide. So, for this first consultation after Kim has been to emergency, when he comes to see me, I'd get him to describe the event, tell me what happened, where were you, what were you doing, describe how it felt, what did it feel like, what physical symptoms can we remember. I think patients really like to tell us about those events, and it's important to give them the time and space to do that. And then the other thing is exploring further history. Has this happened before? Is this part of a panic disorder, or is this the first event? Exploring more about that history of anxiety, and worries, and concerns. And I think one of the things if Kim doesn't see himself as an anxious person, to use other languages, well what about a worrier?

Would you describe yourself as a worrier? Are there things you worry about now that you didn't use to? I'm also looking for medical causes. So, what other kind of medical symptoms might've been happening that could be accounting for this event, and also exploring a substance history. Next slide. So, as I'm talking to Kim and going through this history, I'm thinking about what is going on, what are the differential diagnoses? We're thinking is this a panic attack versus a panic disorder? What medical causes could there be? Is there substances that may have precipitated this event or these symptoms? Is there a thyroid disorder, some diabetes, a cardiac arrhythmia, heart disorder, a pulmonary embolism, so a blood clot in his lung, that make people feel suddenly short of breath. Some other more complicated things and uncommon things gratefully, I can't even say it today, pheochromocytoma and malaria.

So, other things that cause the types of symptoms, and then looking at whether this is part of a bigger anxiety disorder as well. And that's that how long has he been feeling more worried, and what's been

happening? Next slide. And with Kim, as we determine that maybe there isn't a medical cause, and there might be some further investigation that I as the GP need to do to exclude that, but I'm thinking how can I support Kim moving forward and what can we do? So, we know that if someone has got anxiety or panic attacks or panic disorder, that psychology and psychologist is really beneficial. And so flagging that early on is important to gauge where his thoughts are as far as accessing that type of assistance, whether he's looking for something that's online and easily accessible, whether he prefers to do that in person. And then thinking about whether medical management is required.

So, is there physical symptoms that require medical management? Is there a bigger anxiety that might need some medical management or a PRN as he needs some options, and it might be that this is significant enough that we need to engage a psychiatrist as well. But the thing that the GP can do is support Kim to manage these symptoms, through looking at his lifestyle factors and his general wellbeing. And so one of the ways to put this together is something that I've borrowed from a friend of mine who's a psychiatrist, Russell Golden, who talks about the ingredients for supportive management. And so, these are things like something to do. So, what does he do work-wise, what are his hobbies? How does he spend his time? Can he think of some distracting activities? So if he's feeling worried, what's a distractor he could do? Has he been involved in mindfulness?

Is that something that we can look at incorporating, so that he has somewhere for his brain to go when he wants to feel calm. Somewhere to go, so what are his routines? Where does he go? Does he spend time doing physical activity? Where does he go to enjoy himself? Where does he spend time outside the home and outside of work? Someone to talk to, so who does he talk to about his fears and joys and successes? Who would he tell that he was in emergency the other day, and who does he talk to when he's got concerns? Here, I think it's really important as a GP to say that I'm always available if you make an appointment with me, you can come and just talk to me about what's happening, and what's worrying you, and that's absolutely okay, and I even have tissues if you get upset, so it is no trouble to come and talk to me as your GP. And the other thing is something to look forward to. So, finding something to do for fun and enjoyment.

There's another thing on the list there that I've crossed out and the reason I've done that and that this point is not everyone, so for people who are very busy, who are always busy with work and lots of other things going on, they need some time to do nothing. So, some time out for themselves, some quietness in their life. But people who have got more negative mood symptoms who are spending a lot of time alone and not engaged with people, we don't want to encourage more time doing nothing. We want to encourage some time interacting with people, and with community, and doing some enjoyment activities. And so that's how the GP can support Kim across this time as well. Next slide.

Katie Dobinson:

That's already occurred by the time the client is sitting with me for some talk therapy or psychological therapy, but not always. So that is an important step in figuring out what's going on for Kim and considering some of the differential diagnoses. Now, when trying to differentiate between panic disorder and other mental health conditions, it can be confusing and tricky initially because panic attacks in and of themselves are extremely common, and they can co-occur with many other conditions that aren't panic disorder. The real key diagnostic criteria here is to understand the cognitions, or the fears and thoughts that are underlying those panic symptoms or panic attacks, and in panic disorder, it is all about the fear of having another panic attack, and or a fear of these symptoms that I'm experiencing are

harmful and dangerous to me, misinterpretation of those symptoms causing harm or threat to the individual.

Steve Trumble:

Hey, I'm just going to interrupt you for just a moment. My executive decision here, I'm really sorry, but it looks like some people lost sound at the beginning of your presentation. Just to give you lived experience of panic, can you please go back and just summarise quickly what you've already said?

Katie Dobinson:

Yes, absolutely. Feel free to interrupt if that happens again, it's good exposure therapy for me to manage my own anxiety symptoms. So yeah, I'll pick up again, let me know if you'd like me to repeat anything else Steve.

Steve Trumble:

Just a minute, a minute'd be great Katie, thanks.

Katie Dobinson:

Okay, no problem. So, as a psychologist when I'm receiving a referral or I've got some information on this case study or background for someone such as Kim, the first step would be to rule out the possibility that there might be some medical condition underlying these particular symptoms. So, assuming that's already been done by the excellent investigations that Catherine's just completed, I'd be then wanting to really speak with Kim, and assess the underlying fear or cognition around the panic symptoms and sensations that he's experiencing, and that's really going to guide me in understanding the differential diagnosis. This is important because panic attacks are really commonly occurring phenomenon that can happen in a range of mental health conditions. So, the key to understanding is this a panic attack occurring in a different condition, or is it specific to panic disorder, is looking out for a cognition and fear that is about the feared sensations of the panic attack itself.

So, a worry that I might be having a heart attack, a worry that I might be going crazy, and a worry about having another panic attack. I've tried to give some examples of thoughts or cognitions that might commonly occur with panic attacks that are present in other mental health disorders. So for example, a person with social anxiety is perhaps having panic attacks around how they're being perceived by others in social situations. So, they might have a thought that I look stupid to others.

In OCD, the panic fears might be around becoming unwell due to contamination. In specific phobia, panic attacks could be occurring due to thoughts and beliefs around that feared stimuli. So, I can't stop thinking about the spider crawling over me, and now my heart's starting to race and I'm hyperventilating. And then again in post-traumatic stress disorder and complex trauma type presentations, panic attacks are very common, but they're going to be triggered by reminders of the traumatic event or perhaps someone recalling an assault that has occurred. Thank you, next slide.

So, then moving more to understanding Kim's individual case formulation. These are just some tips that I find really helpful in that assessment formulation and treatment planning phase for panic disorder. So, I'm always considering the Five Different Ps for an individual client's case formulation. These include the presenting problem, so really looking out for what are the symptoms that Kim is presenting with, and

these are primarily those panic and anxiety symptoms. I'm going to be considering and unpacking with the client their predisposing factors, so there's some hints and clues in the case study here. Whilst Kim doesn't self-identify as an anxious person, if we sort of read between the lines, perhaps he's minimising a little bit, that there has been a bit of an anxious temperament throughout his life, and has he always felt a bit of a worrier.

I'm then going to be trying to consider the precipitating factors, so what might have triggered his recent panic attacks, so we can sort of hypothesise that it may have been around the interview he was involved in, and some underlying work stress.

Perpetuating factors are what we're really going to be targeting in the treatment for panic disorder, so this is understanding how Kim's symptoms of panic as well as his interpretation of these symptoms, and how he's acting or how he's coping with that are maintaining ongoing anxiety and fear as well as panic symptoms.

And importantly, I'm also going to want to consider his protective factors. So, who are his supports within his personal life, but also other health professionals, and other protective factors for Kim include, he's curious, he's wanting to get some support, he's going to go to his GP, so these are all good signs. Thank you, next slide.

So, moving on, building a little bit on this case formulation, I thought it might be helpful to show the cognitive behavioural model of panic disorder in relation to Kim. So, this really shows again that pattern of triggers, thoughts, feelings, and behaviours that are driving a panic attack cycle. Now when we think of Kim's case study, he's got some external triggers which is like, the job interview that he's just conducted, but also some internal triggers. So, these are those panic symptoms he lists such as his racing heart, feeling quite clammy, shortness of breath, all these kind of things. He's going to experience that and then in terms of his thinking patterns but also his physiology and his behaviours, he's going into a state of threat and apprehension, where his fight and flight system is activated. This then kicks off those bodily sensations of more racing heartbeats, more breathlessness, and the key to panic disorder again is what's happening for Kim, is likely he's misinterpreting those symptoms as being very dangerous and very catastrophic.

So, he speaks of worrying about his dad, who's begun having angina in the last year. Perhaps he's worrying about his own mortality, which is a really common thought in panic disorder that maintains those impairing symptoms. Thank you, next slide please. Okay, so I did just want to touch on treatment from a psychologist perspective, but also lots of other health professionals and mental health professionals that can provide cognitive behaviour therapy, which is the gold standard evidence-based treatment for treating panic disorder, and it is a really effective and luckily relatively short-term intervention.

Another point that I'd like to highlight is cognitive behaviour therapy for panic disorder can be delivered in person, it can also be delivered online through programmes such as the one that I mentioned earlier called This Way Up, or a little bit of both. So, we call that blended care and really I'd be considering what are Kim's needs, what are his preferences, but it's just a helpful point to know that in the treatment guidelines for anxiety disorders, they're both found to be equally effective, so whether it's online or in person, which is a helpful thing to know when you're thinking about accessibility and cost options as well, for people that are seeking treatment. Now the core components of cognitive behaviour therapy for panic disorder, there's a little bit more to it than this, but this is really the bread and butter of what

Kim would be receiving if he would've come to see me for some treatment of his panic attacks and panic disorder.

First, I'd want to take him through, similarly like that model of panic that I just showed you earlier, I'd want to draw this out with Kim together collaboratively, and help him understand how those interpretations of his symptoms as dangerous, when in fact they're very uncomfortable and distressing but not physically harmful or threatening, how that maintains his difficulties. I'd then be wanting to teach Kim some de-arousal skills, so a common one for treatment of panic attacks is learning how to do some slow, controlled breathing. We'd then be looking at challenging and understanding more helpful balanced ways of thinking, and challenging those misinterpretations of his physical symptoms as being harmful, and then getting stuck into some exposure therapy, which is one of the most important parts of treatment for panic disorder where we're actually asking people to bring on some of those feared sensations deliberately, and learn that they can cope with them and tolerate them, and that they're not harmful. Thank you, please. Next slide.

And this final slide of mine really just reiterates two of those very core components of treatment for panic disorder, one being controlled breathing. So, whilst this isn't essential for people who are experiencing panic disorder, it can be really helpful to have a way to calm down that fight and flight system. We don't have to calm it down because it's not actually going to physically harm us, but it is very uncomfortable and distressing, and can also help someone shift their attention onto their breathing. Secondly, interoceptive exposure. So, what this term means is relating to the body, we're trying to bring on feelings of panic sensations specific to that individual's formulation. So for Kim, if it's about breathlessness, I might be trying to get him to do some interoceptive exposure through deliberately breathing pretty quickly and deeply, and bringing on a feeling of hyperventilation. Yes, it is pretty uncomfortable, which is why developing a good therapeutic relationship and rapport is important, but he will eventually learn that he can cope with those symptoms, and the panic disorder is reduced, and over time with more exposure practise, is often treated pretty effectively. Thank you.

Steve Trumble:

Great, thanks Katie. That's been really helpful, and it's been interesting looking in the chat box that certainly your Five Ps have hit the mark, a lot of people use a very similar approach. There was also a wave of relief swept through the group when Catherine said the chocolate was okay, so it's really good to see people focused on the big issues. There's a number of things that we will talk about when we get to the conversation part also, so looking forward to that. But before we get there, really important that we hear now from John with the psychiatrist's perspective. Thanks John.

Dr John Lam-Po-Tang:

Thanks Steve. Just before we move on to the role of a psychiatrist in the clinical team helping someone with panic disorder, I thought I'd just provide some basic epidemiology about this condition. Anxiety disorders as a group are one of the most common groups of psychiatric disorders we have. So, according to Australian data, we have very good quality Australian data, around 12% of the population will report having an anxiety disorder within the last 12 months, and over the course of a lifetime it's thought to be about 20%. But the other two major groups of psychiatric diagnosis, other mood disorders and alcohol and other drug disorders, and by contrast, for example, with mood disorders, it's about 5.8% of the population are thought to have a mood disorder within any 12 month period, and around 5.1% of the population are thought to have an alcohol and other drug disorder in the last 12 months.

I've put information here about agoraphobia, because agoraphobia is a very common development or a very commonly related condition to panic disorder. Panic disorder, as Katie explained, was very random and out of the blue unexpected panic attacks occur, and people develop fear around having further panic attacks. Agoraphobia often develops later on, where people experience recurrent panic attacks and then they start to experience what we call situationally cued anxieties. That is, they start to associate panic attacks with certain types of situations such as lifts, crowded trains, being long distances from home, and they develop avoidance of certain situations in relation to these panic attacks. And again, it's very understandable. People don't want to experience panic attacks, so people take measures to mitigate or avoid experiencing them. You can see from this data that these conditions are common in the Australian community, and Australian figures are pretty similar to those say, of our New Zealand cousins or populations in other parts of the world. You can also see that the median age of onset of both panic disorder and agoraphobia is quite young, and you can also see that there's a female preponderance, which is typical across the anxiety disorders. Next slide please.

It might seem strange that a psychiatrist is going to talk about the role of a general practitioner, but this is what I firmly believe, that sometimes I think we think of general practitioners as a referral source, and certainly in Australia it's necessary to obtain a referral from a GP to see a psychiatrist or a psychologist, but a GP is so much more important than that. First of all, in many cases GPs will have known people presenting with panic and other anxiety disorders for many years. They'll be able to understand in great detail the longitudinal history of that individual. They often can tell me about not only the longitudinal history of that individual, but the parents and siblings and so on, which gives me great contextual information. I worked in regional Australia for about 14 years, and often the GPs would then tell me what was happening in the local school or the local community, which gave extra information about why certain people were presenting in certain ways. GP is crucial to be able to provide physical examination and undertake observations, as well as organise, interpret, and convey the results of those investigations. Because people with panic attacks are prone to misinterpreting the significance of their physical sensations, it's utterly crucial that we deliver that information in very clear and unambiguous terms.

People with panic attacks may fear they're hypoglycemic or hypotensive and it's really, really important that we clarify that their blood pressure, for example, is normal or their blood glucose is normal.

The role of a GP will also be to identify, if they haven't already, and manage the existence of any comorbid medical conditions that may be causing symptoms of anxiety or contributing to it. They should review all medications, not just psychotropic medications. And as everyone knows, they play an enormously important role in the coordination of care, and it's important that this role isn't just seen as a point of entry coordination, that is at the start when someone like Kim presents to emergency, but to actually act as an advocate and review how that coordinated care plan is going. So, over the next few months, to say to themselves and to Kim, how are things going? Are we making progress? If not, why not? Are there any things we can do about that to get the better health outcomes? I won't talk to the interventions, the lifestyle ones, because that's already been addressed. So next slide please.

Okay, the role of a psychiatrist, what can a psychiatrist offer? I guess I would see, and people have different opinions obviously, but I would see one of the key roles as a psychiatrist is to be able to provide a comprehensive biopsychosocial assessment of the individual, especially when it comes to diagnostic clarification. So, it is important to remember that people with anxiety disorders, and that includes people with panic disorder and agoraphobia, commonly have more than one psychiatric condition and hence they have psychiatric comorbidity. The most common comorbid groups of disorders would

include major depressive disorder, substance use disorder, and the other anxiety disorders. But people may also then have other psychiatric disorders, and it's important that a psychiatrist be able to help tease out which other disorders may be present, and also assist with identifying and prioritising a structured treatment plan to address those conditions that the patient feels is important. Psychiatrists are well-versed in the prescription and review of psychotropic medication, and we'll talk about this in a second. And also a psychiatrist may be very helpful in providing an opinion where individuals do not appear to be responding to evidence-based treatments, such as evidence-based cognitive behaviour therapy delivered at appropriate frequency, or a person doesn't appear to be responding to standard protocols for medications when that's appropriate. Next slide please.

When, I think another thing just, this is not necessarily the role of a psychiatrist, but I think the aim of mental health professionals and our GP colleagues, is to really help work with the patient to deliver best outcomes for that patient, as defined by them. And I think we shouldn't, shouldn't not think about when we might need to consult, or confer, or refer to another health professional. Again, to facilitate getting the best outcomes for that patient. Depending on what the professional background happens to be, obviously there'll be a range of healthcare professionals involved in dealing with someone like Kim. Today, or tonight rather, we have a GP, a clinical psychologist and a psychiatrist, but there are also other healthcare professionals that do work with people with anxiety disorders and panic disorder. So, for example, one might, depending on one's background and experience, one may have to refer to another psychologist, even if one is a psychologist.

If a person presents at risk, for example, one may have to refer them to after-hours or emergency community mental health services. If a person has a difficult-to-control alcohol and other substance use, referral to specialised drug and alcohol services may be appropriate. These might be embedded within a health service. They may also include peer led organisations such as AO or Smart Recovery in New South Wales, or a psychiatrist may be useful depending on the clinical background of the healthcare professional providing initial and subsequent care, and at times referral to other specialised service providers may be necessary. Next slide please. Okay, I put the slides on medication towards the end because I thought, I feared rather, that if I put them up front it would just reinforce people's thoughts about that psychiatrists just provide medication. And what I'd like to do, is reinforce the two earlier speakers, to say that first line recommendations for the treatment of panic disorder and agoraphobia is cognitive behaviour therapy.

That's Australian clinical practise guidelines, but they're also clinical practise guidelines in the UK, Canada, and to a lesser extent the US. So, most peak bodies around the world in psychiatry firmly and continue to recommend cognitive behavioural therapy first. Now, some people might be saying, is there nothing new? And I think it's great in some ways that David Clark's model, that Katie showed, still holds true. This was a model from 1986, and as we say, a good theory should explain the past and predict the future, and I think it's very good in some ways that models of symptom development, that were developed in the 1980s, still remain relevant today.

Anyway, on to medication. A psychiatrist should facilitate review of all medications, again, not just psychotropic medications, and consider their potential contribution to the person's anxiety. Psychoeducation is relevant in two levels as far as psychiatrist is concerned, not just with the diagnosis, or diagnoses in question, in this case panic disorder, but also psychoeducation regarding medication I think is very important, and often overlooked.

Modification of lifestyle factors such as caffeine intake, alcohol consumption, exercise, and diet should also precede discussion about medication. And I think these shouldn't be just done once at the start, they should be reviewed over the course of time as well. Like I said, ideally a trial of CBT should precede a trial of medication. I would say, maybe even a discussion about medication should come after a discussion about CBT. However, it is important to understand that there are accessibility issues when it comes to CBT delivery. There are, or there were, geographical accessibility issues until relatively recently. However, with services that deliver CBT online, this hopefully will be reduced. There are cultural and linguistic barriers to accessibility. It's really important that CBT is delivered in a language that the person understands well. And being realistic, there are financial barriers for some individuals when it comes to accessing either psychiatric or psychological care.

Where there's sort of psychiatric and medical comorbidity, sometimes there is a need to implement antidepressant medication, or other psychotropic medications to allow stabilisation of psychiatric comorbidity before a person can actively engage in CBT. For example, if someone is profoundly depressed, we do not recommend jumping straight into CBT because the person may not be able to engage in that therapy and it may become a challenging, and in some ways unhelpful, process for that person. Next slide please. Okay, in terms of medication recommendations, drawing from Australian guidelines, Katie did put up the reference for those guidelines. They're freely available on the internet. You can just Google them, and download the PDF, and they cover a range of anxiety disorders, not just panic disorder and agoraphobia, but looking at tonight's topic, the first line in medications we recommend, again after CBT, would be the SSRI antidepressants. I tend personally not to prescribe the SSRI antidepressant paroxetine in any woman of childbearing age.

And another group of first-line antidepressants would be the SNRI antidepressants such as venlafaxine, fluoxetine, and desvenlafaxine. Now in that group of first-line antidepressants, the doctors in the audience will all know that that represents nine different antidepressants. So, that's a big chunk of the available antidepressants in this country. There are a lot to choose from. The second-line grouping would be the tricyclic antidepressants. But in saying this, I don't want people to take the message that you try one of the first-line antidepressants, then you move on to the second-line. We wouldn't recommend that at all. For example, if someone doesn't tolerate or doesn't respond to an optimised dose of one SSRI, then we would typically recommend the trial of a second SSRI. Then we'd recommend a trial of at least one SNRI, and then we maybe consider other options. And again, I would be saying, looking not just at the medication but also holistically, lifestyle factors, external stressors and psychological intervention as well as medication.

Next slide please. Benzodiazepines, these are not recommended as first-line treatment. This is one of those areas where the clinical trial data does say they work, but then the clinical practise guidelines, the statements and the opinions of peak bodies around the world, do not recommend them as first-line treatment. And that's because of the risk of dependence and side effects, including sedation, and some cognitive side effects as well. I should also point out that we don't recommend them as routine medications to use at the initiation of antidepressants. It's, you'll see that talked about, and certainly when I attend conferences in the US, our US counterparts seem to be far keener on concomitant prescription of benzodiazepines whilst initiating antidepressant. And, I think with good psychoeducation about the medication, starting at a low dose, titrating it up slowly, in fact giving the patient control about when they can titrate the dose up, we often don't need to.

Benzodiazepines are obviously not recommended in individuals with current comorbid alcohol and substance use disorders. And I guess there's some other things as well. Concomitant use of

benzodiazepines may interfere with the efficacy of CBT, especially habituation to fear situations. Finally, there's also a really, really high risk of dependency with a high potency benzo such as alprazolam, commonly referred to, well one of the brand names is Xanax or Kalma; clonazepam, a common brand name of which is Rivotril; and lorazepam, a common brand name of which is Ativan. There's no doubt these are effective sedative medications, but because they work so potently and so quickly they have a high risk of dependency formation, and this can then last, this can then create more problems that may persist for months if not years. That's the end of mine.

Steve Trumble:

Great, thanks John. There have been a number of questions too about beta blockers John, and I'm old enough to remember colleagues at medical school who had to do their oral exams in the recumbent position because they'd pilfered some beta blockers, and then couldn't stand up because they'd dropped their blood pressure so much. I'm presuming that beta blockers are not playing a role in modern management of anxiety?

Dr John Lam-Po-Tang:

Look, there's no doubt that beta blockers do reduce some of the somatic symptoms of anxiety, namely tremor and tachycardia or racing heart, but they typically don't address the actual emotional or cognitive symptoms of panic disorder or other anxiety disorders. That said, for example, and it's maybe a bit off topic to talk about social anxiety disorder, but there are some circumstances in social anxiety disorder where the person is very sensitised to appearing tremulous, for example, and there might be a role for as-needed use of beta blockers. In and of themselves, they're not necessarily going to change much. They're a very short-term option and I don't think they should be used in preference to say, the first-line medications listed.

Steve Trumble:

Alright, well thank you for that and thank you to all three panellists for your presentations. We've had a good number of questions that have been posted during the presentations. A couple have come up on the impact of the Covid pandemic, the early stages of the Covid pandemic, which of course it's continuing, and whether any panellists had any thoughts about what happened to the prevalence of panic disorder during the pandemic. Katie or Catherine maybe, did you want to start?

Katie Dobinson:

I'd be happy to contribute some. I can't speak precisely to the prevalence of panic disorder specifically during the pandemic, though I know across the board there's been a massive rise in anxiety disorders, and through where I was working at the time, and I'm still working, at CRUfAD and This Way Up, we saw a significant increase, particularly in the online anxiety disorder treatment programmes. I think it was up to about 500% during that time. I think also it's important to consider, it was somewhat adaptive to develop a bit of health anxiety and a bit of staying at home at that time. However, unfortunately that sort of exacerbated things, perhaps into a full panic disorder or full agoraphobia or full health anxiety disorder for many people who might've been predisposed to that, and then the pandemic, understandably, has pushed things over the edge. One thing that I think has been helpful, not trying to look at a silver lining from something that was and continues to be incredibly challenging for society, but

the accessibility of telehealth kind of options means that we've got other ways to meet people who are struggling with things like panic and agoraphobia stuck at home.

Steve Trumble:

Thanks for that. Any other thoughts, Catherine or John?

Dr Catherine Eltringham:

Yeah, absolutely agree with Katie with the increase. And I think what we saw in general practise was that over time, as people were exposed to more and more uncertainty with the pandemic, is that people who previously had developed some strategies and routines around managing their fears and their anxieties, and what caused panic type events had that all undone by the ongoing uncertainty and the change in routines, and they lost their somewhere to go, and they lost their someone to see, and they lost their thing to look forward to. And that continued ongoing difficulty in contacting people's support networks just meant that not only were people having to speak to their GP on the phone rather than come in, but nearly everyone over a period of time, it felt like every second patient came with their presenting complaint plus a mental health worry, because a lot of people who managed before would just say, why can't I manage this now? Why am I so worried now? Why am I so anxious? And it was very common, and we're just starting to see that unravel, and sort of normalise back to people who have got their strategies and can get back into those routines. And like Katie said, the access to online resources and telehealth options has been amazing for management and mental health patients in general practice in particular.

Steve Trumble:

Right. And I'm thinking that Kim, our case, I mean, it is fairly early in the piece for Kim. I would imagine that it'd be possible to maybe head him off at the pass and prevent him from progressing the whole way to panic disorder? There are lots of other counsellors who might be able to help him make sense of what's going on in his world. Is that reasonable?

Dr Catherine Eltringham:

Yeah, I think so. If we look at this, he's had one event that we are aware of, so he doesn't present with diagnosis, and John would be able to mention more about the diagnosis than me, but he's had one event, so he hasn't met the criteria of any of the anxiety particularly or with a panic disorder. And so, that interaction with people who he feels understand and can support him and work through things would be really good, and might just actually be able to help him to manage and not develop into something that becomes more impactful on his work and everyday life.

Steve Trumble:

And if he's in HR, he may well have good connections that he can refer himself to. So, that's always a possibility. So, thank you for your comments on that. John, did you have anything to add to what we've just been talking about?

Dr John Lam-Po-Tang:

Yeah, look, I think technically to meet a diagnosis of panic disorder, one needs to have symptoms for a month. I think that's a long time to wait, especially where Kim has been proactive in seeking treatment. So, jumping in and starting to talk about lifestyle modification, assessing alcohol consumption, caffeine, is very, very helpful. Giving good, evidence-based advice about the nature of panic attacks is also very helpful. And in particular, making sure that Kim is aware that these are frightening, they are distressing, but they're ultimately not dangerous once the person has had medical conditions ruled out. And importantly, that Kim shouldn't avoid doing anything, or going anywhere because of his anxiety, would be very useful advice to give at the point of contact, whether that be an emergency or in GP, in a GP setting.

Steve Trumble:

Thanks for that.

Katie Dobinson:

I'll just briefly add to that, I think to completely agree with everything that John's just said, and that I can think of quite a few people that I've seen with panic who really, it's just that psychoeducation that they need, and they actually improve very, very quickly with understanding that even though these symptoms are very uncomfortable, distressing, frightening, they're not actually harmful to you. Sometimes people really kind of take that on, and then without avoiding further scenarios, they get better very, very quickly.

Steve Trumble:

Alright, well thank you so much for that. I've been watching the questions coming in and there have been a number of questions from people asking about people who are neurodivergent, people with intellectual disability, people on the autistic spectrum, and whether there are particular approaches that work better with that group, or which need to be avoided in that group, I suppose a very diverse group. People have also been talking about EMDR and whether that has a place, particularly with people who might be on the autistic spectrum. Any thoughts about that from any of the panellists?

Dr John Lam-Po-Tang:

In terms of dealing with individuals with neurodivergence? I think it's important that, I think contextually, people should be adapting and modifying their treatment approach according to the specific needs of the individual, whether that person have neurodivergence or another modifying condition. I'll get Katie to maybe speak to the CBT, my clinical experience has been that, certainly in the case of panic disorder and agoraphobia, individuals certainly can benefit from CBT - it does need to be modified at times, but I think the protocols can be implemented and adapted. But yeah, I think the evidence is, from my experience, the evidence is pretty good for intellectual impairment and neurodivergent populations.

Katie Dobinson:

Yeah, I would echo everything that John has just said. It's still CBT, still the evidence-based intervention, of course we need to consider someone, anyone's comorbidities, and with neurodivergence and

intellectual disabilities that's on such a spectrum that that can mean significant modifications, or very minor modifications. Some examples that I can think of, particularly for say, people with autism spectrum disorder or intellectual, mild intellectual disabilities, just in thinking about each of your treatment interventions, what's this person's cognitive abilities and how can I modify my treatment to support that? How are there other support people that I can involve in treatment? So, who does my client feel comfortable having involved? Perhaps there's a family member, partner, support person that can assist in implementing things like regular exposure practise. So yeah, it's really like with any individual, understanding their comorbidities and tailoring treatment to their needs, but I think the core components would still in most cases be really appropriate.

Steve Trumble:

And Katie, one of the approaches you mentioned was PMR, or progressive muscle relaxation. I guess that's something that would be able to be done by people with a disability most of the time?

Katie Dobinson:

Yeah, I think it would depend on the particular disability. PMR, or progressive muscle relaxation, is essentially a range of different tensing, and then relaxing and releasing different muscle groups of the body. So, maybe it would be tailoring that intervention to that person's individual abilities. It might not be the whole body that they're doing PMR exercises for, but they could still use that skill. And also, PMR isn't for everyone. Some people much prefer breathing exercises over something that's more physically involving different muscle groups. So, it's an individual kind of approach and see what works best, but where possible, I like to introduce both of those strategies and see what feels better for the client.

Steve Trumble:

Okay, great. Thank you very much indeed. Look, there's been a lot of talk tonight about the multidisciplinary team, and obviously it's very important to MHPN about teamwork, and getting the most out of that team. I'm really struck by a question that's come in from Andy, who's asked about what they can do as a psychologist in order, I guess, to connect better with the GPs and psychiatrists with whom they work in particular. Thinking of the three professions that we've got with us tonight, and what each of those professions, I guess the GP and psychiatrists in particular, are looking for in communications from the psychologist that actually makes things work best. Is there something in particular that John, or Catherine, you really look for in your communications with psychologists such as Katie to make things work well for the client?

Dr Catherine Eltringham:

I think, first of all I just wanted to say, I read the letters. Thank you very much for writing them. There isn't always a lot of time, and so if a letter or any correspondence is as point form as possible, so you can skim-read it, that's really useful because I will be scanning it, and then go back and read in more detail. And so I guess that's one of the things is, correspondence being, having enough in it but not too much so we've got time to look at it. And it's really useful then when anyone in the treating team says, oh, have you thought about this? Or, what's happening here? That's really valuable. And I think when I reflect on that, I possibly do take that information from your letters, but I honestly probably don't tell you what comes of it, because I have my medical hat on, and then I have my referring to the

psychologist mental health care plan hat on, and unfortunately they don't tend to talk to each other when I'm writing the letters back to the psychologist.

So, that's probably an oversight that happens a lot in general practise, because we're sort of doing things, and then moving on to the next part of the consultation, and working on that part of it, and often when a patient comes in to review a mental health care plan, that's what that appointment's for, and we don't, the things about sleep apnea, or their thyroid, or whatever else we might've done medically has been at previous appointments and not front of mind at that particular point in time. And so I guess that's where that medical/ mental health disconnect appears from the outside, whereas on the inside of the consultation room in general practise, it's happening across a long period of time. So yeah, I'm sorry if we don't write that back to you, but it's certainly valuable to get anyone's insights into what might help us to work out what's going on and what can support any patients better. Hopefully that helps.

Steve Trumble:

Yeah, thanks Catherine. Any thoughts from the other panellists about that particular issue?

Dr John Lam-Po-Tang:

Look, I think I'm also guilty of being one of those psychiatrists who may not include all stakeholders in correspondence. Look, I think there's a few things I'd say. First of all, I echo Catherine's comment about time, and I think most of us are very time poor. I do read the letters, I have to say. And also, quite frankly, I do echo your own concerns. I do sometimes wonder, how much information should be put in. I tend to have an older style, what we call a Maudsley approach to an initial letter, which often extends to say, four or five pages. And I do sometimes wonder, do GPS actually want all of that or do they want a summary version? Often psychiatrists write letters for ourselves. They are our summary of the record that is in a tight fashion, so we can actually read them. But I do, sometimes I do wonder, well, maybe shorter or briefer sort of forms might be better read.

Some things you can do in clinical practice would be, give a copy of your letter to the patient so that they know what has been said and they can chase it up with the psychiatrist and the GP in those consultations, and get them to try and say, write notes, here's a copy of the letter, write notes if you have anything, we'll discuss them again. I also think in terms of what can you do, I think, in terms of cultivating a relationship with trusted psychiatrists, people who work either nearby, or in a similar area may get, I guess, I would say more responsive reactions from the other members of the treating team. That obviously takes time, obviously depends on local resources, other factors like how much you like them, so on and so forth, or their potential disposition. Yeah, some doctors aren't particularly communicative, even though especially in the case of psychiatrists, communication is meant to be one of our core skills.

Dr Catherine Eltringham:

John, I just wanted to respond with you, how you should write your letters. My favourite letters are the ones that have, so you've written back, and at the very top you put a summary of what your management is, and what your thoughts are, and what your questions might be. So, that's a short summary that might just be dot points or a brief paragraph, and then the whole rest of your amazing letter can be after that. So I can read the summary, and then come back when I've got time to go through all of the more detail. Sometimes other health professionals have spent more time delving in

more deeply with patients than often the GP might have time to do. We've got time over 20 or 30 years, but we don't have time over one hour to go in depth as far as sometimes other people do. But if the summary is right at the start, then that's where the money is. And so that's really helpful as well, to put here's my summary of what we've been doing, and what I'm worried about, and what I'm thinking, and then the rest of the letter after that. That's my tip from GPs, but that's only my opinion.

Steve Trumble:

Well, you've mentioned money Catherine, which has led us to the elephant lurking in the corner that Jody has named, which is the way the system works, and that not every GP is as engaged with mental health as perhaps you are, and unfortunately, a lot of people's experience, and I'm looking at Jody's question here, particularly young people; to the GP, straight on medication, mental health care plan with a diagnosis required by the legislation to get access to the five subsidised visits. Any thoughts about that? I mean, what can we do to not pathologize people like poor old Kim?

Dr Catherine Eltringham:

Yeah, and I think there's been a big transition even in the time I've been a medical educator, in GPs recognising that a lot of the management is not medication, and that's further down the list. And so, that it's coming through and it's happening and that experience is there, but we need to recognise, and we teach the GP registrars that yes, a mental health care plan needs a diagnosis. You have to have a diagnosis to have the care plan. And so, if a patient has a diagnosis, then fantastic, we can get you this assistance to care you need with a Medicare rebate for psychology. But if you don't have a diagnosis, then let's take our time to make sure that we are calling it the right thing. Is it a symptom of something that's happening? Is it stressors? Can we access the type of help you need some other way, so that we are not giving you a diagnosis you don't have?

And I think that distinction between if you are seeking care for a diagnostic condition, that's fantastic, and that should be applauded, and people should not have anything come from that that's negative, and that's a whole separate discussion. But if people don't have a clear diagnosis, that having a conversation with patients of, well, this is what's required to do the plan, at the moment I can't tell you what I think your diagnosis is, or I don't think you meet those criteria. Let's meet a few times. Let's have a talk about it. Let's do some other things in the interim, and see what else we can do. We also talk about accessing things like EAP through the workplace. Is there someone that can support you in the short-term for this short-term stressor? And then we reassess over time whether it is something a bit more prolonged.

Steve Trumble:

Yeah thanks, Catherine. And John, I'm going to go to you. I think you wanted to talk a bit about medication that you mentioned earlier?

Dr John Lam-Po-Tang:

Absolutely. But before I jump into medication, I'm just going to add something to Catherine's comment, that with respect to panic disorder, the criteria, a strict application of the criteria is a month. So in Kim's case, it would be a month from when he presented to the emergency department, not a month when he presented for you. So even one or two consultations may get very, very close to that month. And it may

well be that by the time he gets in to see a psychologist, it's well over the month. So, you're fulfilling the criterion of a specific diagnosis by the time he actually gets in front of the psychologist. I should have clarified this when I was giving my information about medication, and that is that the first and second line recommendations are for people over the age of 18. We do not recommend routine use of antidepressants for panic disorder or agoraphobia in people under 18 due to the risk of agitation, restlessness, and suicidal ideation. And for individuals between the age of 18 and 25, there is less of a risk than the younger population, but there's still more of a risk than say, the age population aged 25 and above. So those recommendations should be understood to be, shall we say, adults only and not the population as a whole. Just thought I'd better jump in and clarify that.

Steve Trumble:

Thanks John. And there's actually been a question from Sue specifically about Mirtazapine, which is a bit of a GP go-to for the older patient with anxiety or depressive symptoms. She's asked about changing from Mirtazapine if it becomes tolerated. You've talked quite a bit about initiating treatment, but obviously we've got to be on our toes about looking for it stopping working, and the therapeutic inertia of not making a change. Is there any thoughts you have about monitoring patients to see when we might need to change to something?

Dr John Lam-Po-Tang:

Sure. Look, the phenomenon of medications seeming to work for a period of time and then seeming to lose some or all of their effect is not uncommon. You see this referred to in the literature as tachyphylaxis, or the Americans often refer to it as the "poop-out" phenomenon. It's commonly understood that this happens with almost all of the antidepressants for almost all of the indications for which antidepressants are used, not just panic disorder and agoraphobia. If an individual is on a therapeutic dose of an SSRI or an SNRI and the individual appears to start losing some of that effect, it would be appropriate to titrate the dose upward first. So for example, if the person's on 10mg a day of escitalopram given in the morning, that's something I didn't say as well, but SSRIs, we conventionally give in the morning, not at night, it would be appropriate for the dose to be titrated up to 15mg and possibly even to 20. I wouldn't recommend changing to another antidepressant unless one had optimised the dose of the antidepressant they happen to be on. Of course, if an individual experiences intolerable side effects as designated and defined by the patient, not by me, then it obviously would be appropriate to move on to another medication.

Steve Trumble:

Thanks so much for that. There's actually also been a question asked, which I think is quite interesting, from David Poon who's asked about any evidence for peer support groups being part of treatment for panic disorder, and I'm thinking particularly Katie, about your online programme. Is this something that people can interact with each other through the online medium, or do they just talk to the machine?

Katie Dobinson:

Well, I guess the This Way Up programme, there isn't a component where you can directly talk to other people that are doing the same programme as you, though I've certainly, lots of people that I work with with panic disorder, or with other forms of anxiety, speak their own lived experiences is huge helpfulness and huge utility to peer support, whether that's with an individual peer support worker, or

whether that's really building up more social connections and community with people who understand what it's like to experience what you're experiencing. An excellent organisation based in New South Wales is called Wayahead, they used to be called the Mental Health Association New South Wales, but I think now it's Wayahead. They run free support groups, certainly throughout Sydney and I think through other parts of the state, for people with OCD-specific support groups and then anxiety groups that people with anxiety, but also their support persons and family and friends and loved ones, can attend. I actually used to run them for a long time and yeah, I think it's an excellent way to boost a cognitive behavioural intervention because you're getting out there and active, you're avoiding less, you're probably learning more about anxiety and getting tips from other people as to how to manage. So yes, I think that's an invaluable resource for a lot of people.

Steve Trumble:

Great, thanks Katie. And unfortunately, we're at the stage of the webinar where we need to have final comments from each presenter. We ask people to please hang on for this final part. Often there's some really useful things said, so no pressure Catherine, but we'll start with you.

Dr Catherine Eltringham:

Certainly. So, I think one of the things to remember is there's a lot that your GP can do, and if patients don't have a GP that they see, really encourage them to find someone that they can speak to because it's that extra support in between visits with their psychologist, or to talk through what they're working on online, or while they're initiating medications or waiting to see someone. It's those other things that GPs can do to support lifestyle, health, and general wellbeing, as well as checking in and seeing how people are going, and I think that's really important.

Steve Trumble:

Great, thank you so much, and concise as well. Katie, what are your final thoughts?

Katie Dobinson:

Yeah, I'm just reflecting on a couple of things. I think there's two key points from me. One would be, particularly for people who haven't seen a psychologist before, especially someone like Kim who may not be self-identifying with something like panic disorder, where it's likely that that is a condition he's dealing with and suffering from, letting people know that the intervention is a short-term, practical, skills-based intervention. Understandably, people may have views of seeing a psychologist as, they're going to ask me about all my deep dark secrets, and going to go into my past, and it's going to take three years and I'm going to have to lie on a couch. If you don't want to do that, that's okay. This is actually a short to medium term evidence-based treatment, and it's really effective. The other point I'd like to make is around accessibility. So, I think the role of psychology, and CBT treatment for panic disorder, yes, psychologists can do that really well. That's what we're trained to do. But so too are lots of other health and mental health professionals, counsellors, social workers, many, many more, and that things like online treatment programmes are a nice way to provide accessibility at a low or no cost option where that's a barrier for people who might be struggling financially or living in rural and remote areas.

Steve Trumble:

Fabulous. Katie, thanks so much. And the final word to John.

Dr John Lam-Po-Tang:

So, regardless of the comprehensive treatment approach that should be tailored to a patient that you as the healthcare provider choose to implement, I'd strongly advise reviewing the progress of your patient or client at the eight week mark, if not earlier, to make sure they're getting better. If they're not getting better, as evidenced by frequency of panic attacks, concern about future panic attacks, or avoidance behaviour, you should be sitting down and thinking, is there something I'm missing? Are we implementing the plan as appropriately? Is there anything differently I should be doing? So don't keep on doing the same thing without really reflecting on what's happening at the patient level.

Steve Trumble:

Thanks John, and thank you to all three of you. That's been an absolutely fabulous evening. So, thank you for the effort you put in to the presentations and your willingness to discuss lots of questions, which you can get to, I say this every time, I'm so sorry about that, but it's really good to see the engagement that people have with the topic as it comes up. I've just glanced at myself and seen the image on the screen, I should remind us as we head into summer, if you're going sailing, please wear sunscreen or you too will look like this. So, a little bit of GP skin health on the side there. So thanks everybody for participating and being part of tonight. We do ask you to fill out the exit survey. It's really important to us that we hear from you feedback about what we can do to make these webinars better.

So, click on the banner above the top of the screen or scan the QR code that's there on the screen, or will be on the screen there shortly, or go to the SurveyMonkey address that's provided there. There you go, there's the screen. The recording, now please do, if you've missed any of tonight's presentation because of sound issues, whatever it might be, NBN, then when you do get the email saying the recording's been released, we can guarantee you that the soundtrack will be whole on that. So, please listen again, if you found us talking too fast, then you can slow it down, or speed us up, which is what my students do to my lectures, so there you go. There are a few webinars coming up. There's the MHPN Special Event, a hypothetical case scenario. They're fabulous, hypotheticals, and that's on Tuesday, the 21st of November, which is next Tuesday, and that'll start at 7:00 PM rather than 7:15 is a bit of difference.

So, get your dinner heated up quickly. There's also on Monday the 11th, Primary health strategies for working with children who present with ADHD concerns, it's part of the Emerging Minds series. You can see that's on Monday, the 11th of December. There's a new podcast episode out now, and I'm thinking there should be a podcast on how to communicate better between mental health professionals online or in letters. That was a great discussion, but this podcast is really topical. It's a conversation about climate change and mental health. So, definitely one to listen to. So, thanks again everybody for finding time on a busy Wednesday to hear our panellists, and interact with them as best we can. Before I close, I would like to acknowledge the lived experience of people and carers who have lived with mental illness in the past, and those who continue to live with mental illness in the present. Thank you to everyone for your participation this evening, and please do fill out the evaluation. Have a good evening. Good night.