with consideration of the patients’ clinical circumstances, their preferences and attitudes. The RANZCP mood disorder guidelines aim to support the implementation of evidence-based research findings into clinical practice by improving understanding, specifically providing an up-to-date summary of evidence regarding the benefits and risks of pharmacological interventions and highlighting current areas of uncertainty.

However, one may debate as to whether these are clinical guidelines as they purport to be. I would contend that these are not simply clinical guidelines but rather an amalgamation of clinical guidelines, clinical care pathways and clinical algorithms. They consist of decision points linked to represent the logic and flow of clinical practice. Additionally, they provide a systematic review of the pertinent evidence and recommendations for action that specify the necessary steps to assure consistent clinical decisions. Furthermore, they provide a standard of practice summarised in the form of an algorithm. Thus, these guidelines set the clinical standard for daily practice encouraging clinicians to advance and refine their care process.

Although the clinical mood disorder guidelines provide great directives for the clinical care of varied individuals with different mood disorders, challenges still remain. These guidelines primarily focus on the majority of the population in Australia. Although these guidelines provide some consideration of special, minority population segments, it should be recognised that more needs to be done. For example, Aboriginal and Torres Strait Islander peoples, in particular, have distinct presentations that are currently less well understood and require urgent detailed examination. Another major challenge pertains to how often the guidelines are updated with a plethora of new research emerging in the time period between the publications. Thus, there is scope for adopting an online version of dynamic guidelines that could be updated as research and clinical care findings change, accordingly providing the most informed and up-to-date care for individuals with mood disorders. The guidelines could also be further refined, for instance, by the inclusion of specifiers corresponding to the course of the illness – for example, the role of valproate in treating mania in bipolar disorder specified by early and later episodes of mania. Furthermore, in addition to the guidelines providing the recommended course of action, the guidelines could also seek to include what is not recommended.

In addition to the above challenges, the clinical guidelines could also address contemporary challenges, those specifically pertaining to bipolar disorder such as the role of antidepressants in bipolar disorder, when to withdraw antipsychotics in a manic episode and the complexity of comorbidity. Another contemporary challenge relates to cognition, specifically how to minimise and manage cognitive impairment. Although challenges remain, the RANZCP clinical practice guidelines are accessible, pragmatic and comprehensive, providing directives for the provision of care for individuals with varied mood disorders concomitantly meeting the needs of a range of clinicians.

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See RANZCP Guideline by Malhi et al. 50(12): 1087–1206

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This is extraordinary. But will it prove worth the wait?

It is becoming increasingly apparent that our understanding of mood disorders as captured by current classificatory systems is rudimentary and that our zeal for reliability of diagnoses may have caused us to overlook several important aspects of the fabric of mood disorders.

First, by their very nature, it seems that mood disorders do not appear to lend themselves to categorical definition. Therefore, we need to return to dimensional concepts and to formulate emotional symptoms and syndromes along a spectrum (Ghaemi and Dalley, 2014). This dissonance between taxonomy and clinical reality is reflected empirically and explains the day-to-day difficulty clinicians face in identifying arbitrary cut-offs to make diagnoses (Malhi and Porter, 2014).

Second, the half-hearted attempts by DSM-5 to rectify this situation have possibly made matters worse. For example, DSM-IV mixed episodes have been supplanted in DSM-5 by a mixed features specifier, supposedly to lower the threshold for capturing mixed mood states (Malhi et al., 2015). Ironically, instead of providing clarity, this fundamental change in mixed states classification has further complicated the diagnostic process, and mixed episodes are no longer codable per se. Instead, the mixed features specifier allows for myriad combinations of symptoms to qualify as mixed. But the horse has bolted, and the key question now is whether ICD-11 will remedy matters.

So what needs to be done? Recent research clearly shows that any definition of mixed states must include core mixed features, such as distractibility, irritability and psychomotor agitation (Malhi et al., 2016). Furthermore, in order to make any future classification of mixed states meaningful and useful for clinicians, it needs to separate mixed mania (Renaires et al., 2015) and mixed depression and allow for both of these ‘states’ to be coded separately as episodes. This is critical because without this it is difficult to see how even basic epidemiological information regarding mixed states will be captured.

When put simply in straightforward language, these suggestions for improving the classification of mixed states seem reasonable and logical. However, in practice, this will require some bold decisions to be made by any ICD-11 committee overseeing these changes. First, they would need to depart from the template that DSM-5 has adopted. Second, they would need to create a definition that has a greater level of specificity than ICD definitions have hitherto employed, and do so on the basis of very modest evidence. The easiest position to adopt, for the sake of harmonization between the two taxonomies, would be to follow DSM-5. But this would make ICD-11 as redundant as DSM-5, and despite being a revision, it would offer nothing new. In other words, it would be instantly viewed as ‘old’.

Naturally, we hope that ICD adopts a bold position and not only completely revises the classification of mood disorders but also addresses the many other inconsistencies in our current classificatory systems.

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