Depression – A Medical and Legal Problem

by

Professor Graham D. Burrows
and
The Honourable Justice Frank Vincent

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The Chairman of the meeting was Dr. John Marum.

PROFESSOR BURROWS. Depression is an interesting issue for us and I know in an audience like this where I have both lawyers and doctors that we have to learn to talk the same language. Depression in some ways is a Pandora's box or, as Justice Frank Vincent might say, it's a bag of worms that we have to look at when we're looking at the cross-relationship between the medical profession and the legal profession. We tried to do something about that of recent times by educating doctors, the community and this is just to highlight the Depression Awareness Journal of the Mental Health Foundation of Australia which theoretically should go to all GPs. I suspect it probably should go to all lawyers as well.

Depression is an interesting problem for the legal profession. I've tried to look at it from their point of view as well as the medical point of view by pointing out that there are 22 different classifications in the world literature of depression. So it's not surprising that people have problems with that. However, we in Australia take the bio-psycho-social theory of medical psychiatric conditions. There are biological features, there are psychological features and there are social features and we spend a lot of time debating how much biological, how much psychological, how much social. One of the messages that I want to give is that there is a disorder called "clinical depression" which in fact has as a sub-group a group who have a biological disorder. They have chemistry which they have genetically inherited, they have a disorder which they're not responsible for and, when you talk to them, it's like saying, "You have diabetes, I won't give you insulin, I'll just talk about it and perhaps you'll feel better", and you wouldn't, would you?

The global burden of disease is a summary of a major study from the World Health Organisation and Harvard University which pointed out that by the year 2020, of the top medical conditions that exist in the world, five of them will be psychiatric, and the Top of the Pops will be depression. In fact we now know that lawyers and doctors have got to know something about depression. One in four women will have a depressive disorder in her life and one in six men.

Now there is a true difference between male and female but it may be that the male goes off to the publican while the woman goes off to the doctor. But it's a very common disorder. At the moment we know from recent epidemiological studies in Australia that one in five has a significant emotional problem tonight. There are about 100 of you here, 20 of you have a problem and I'll talk to you after the lecture if you like.

Why are we interested in depression? There are many reasons, but one of the reasons of course is that suicide is the result of depressive disorder. I've had a role on the Coroner's Suicide Committee for a number of years. Yesterday I talked at Monash Medical Centre where we looked at depression and the suicide problem that's occurred. Australia's suicide rate in 15 to 24 year olds ranks very highly, just between Finland, New Zealand and Switzerland. Finland has 41 suicides per 100,000 of population; New Zealand 39 and we have 26 or near enough in that age group. Australia and New Zealand run very closely together.

In young people depression is the commonest disorder in Australia and New Zealand and if I gave you a lecture on youth suicide I will tell you that the caricature of the youth suicide is a 21 year old male who kills himself by a violent method. If I look at female suicide rates per 100,000 of course the figures are slightly different, although Australia is still 5 - remember the other was 26. So females don't kill themselves as much as men do. Females are nowhere near as violent as the male. The female has a better brain than the man does in all sorts of ways

If you look at the external causes of death in Australia in 1997, homicide rates are pretty low. I say often provocatively, the newspaper reports motor traffic accidents and homicides but perhaps it should report suicide. Perhaps we need to change society's attitudes to that. The commonest cause of suicide by far is depressive disorder; unrecognised, untreated. And the best treatment - and the best treatment, I repeat, for prevention of suicide is treating depression. And the best treatment for treating depression is anti-depressants and the best anti-depressant which will control suicide, believe it or not, is lithium - lithium carbonate - which in fact was discovered by the late John Kaye here in Melbourne, Australia in 1948, reported in the Medical Journal in 1949.

Looking at rates of suicides by gender in 1997, you will notice of course the males are far greater and they vary throughout the states. The Northern Territory, no guesses what that is, aboriginal mental health. If we look at suicide across the life spans you will notice the age that really worries me is 25 to 34. You will notice there is a drop in males and then as we get older it goes up.

Now, gentlemen, as you get older there's a greater chance you're going to have a depressive disorder and that's a reality. If we look at suicide rate across the years you will notice the male is going up. Females are very consistent; it hasn't really altered much at all.

So the typical suicide - male, violent method, leaves a suicide note, has psychiatric problems and worthlessness is the best predictor of suicide. If you're going to look at anything at all you look at worthlessness and hopelessness. And the interesting thing is that they really ask for help before suicide.

We did a study in 1992/3/4 and we studied a major group of suicides here in Victoria and the thing that really worried me was that 50 per cent of them who suicided had been nowhere near a doctor. It was not the doctor's responsibility. He hadn't missed it. It was the community and the parents. And that's what led us into the depression initiative and so on.

Now what causes depression? Well, there's a combination of the biological, genetic, psychological and social factors. Some people are born with malfunctioning genes. They will become depressed even if they think their personality is very healthy. They will become depressed. You can follow it through the grandfather, the father et cetera. I'm not only saying males - grandmother, mother and daughter. General medical illnesses are extremely important. There are many medical illnesses, if you work in a general hospital like I do at the Austin, where depression is present. Other psychiatric illnesses such as schizophrenia can have depression and so on. If we look at the primary diagnosis of those that suicide, 70 per cent have a primary depressive disorder. Some medications cause depression. How many of you are getting older and taking joint-type medications because you've got arthritis and so on. They're notorious. Other medications are used for hypertension, blood pressure control and so on. And of course one of the commonest causes of depression of course is alcohol. One of your good group here, Dr David Marsh referred me a man recently who was depressed, he'd been on anti-depressants for a long time but he was drinking a hell of a lot of grog. Stop his grog, dry him out, he doesn't need the anti-depressant, he doesn't need the grog either.

Low sunlight levels. We're interested in that and we use a form of therapy called phototherapy or light therapy and that's why some of you feel very depressed during winter, not because it's raining, not because it's cold but because of the effect of light on your eye, the light through your optic nerve going to your pineal gland which creates something called melatonin. Melatonin causes your nice brown skin in summer but is also needed for the synthesis of serotonin which is an anti-depressant drug.

Pregnancy. That's why women of course have a major role Professor Lorraine Denerstein and her team have done a lot of study on post-natal depression. Extreme stress, grief and isolation. Stress causes the legal profession some problem because I stand up and say if you're under a lot of stress you'll go on to becoming anxious, you'll go on to becoming depressed and the initial issue may have been stress.

We in psychiatry and medicine have classifications highlighting the symptoms of depression. Depressed mood most of the day nearly every day. Subjective experience, of course, feeling sadder, empty. You can observe them being tearful or slowed down, retarded. Markedly diminished interest or pleasure in all or almost all activities most of the day nearly every day. It's not Mondayitis; it is arbitrary over a number of weeks. Significant weight loss when not dieting or weight gain, change of more than 5 per cent of body weight. Sleep disturbance.

Can I ask you, for the non-medicos anyway, are you the sort of person who gets into bed, tosses and turns at the end of the night, spends a long time saying "If I had that conversation again I would tell him or her what to do. I know what I'd really do" and eventually you go off to sleep and just as you go off to sleep the alarm goes and it's time to get out of bed and you, like a very active person, say "I've got to do my exercise", so you stretch in the bed, you wiggle your toes, you go back to sleep, you wake up and you're running late for the rest of the day. That's one form of sleep disturbance.

The other one, of course, is we go to sleep perfectly, asleep within 10/15 minutes and then wake at 2, 3 or 4 o'clock in the morning, get up and go to the toilet, raid the fridge, but then you feel dreadful. How many have the first type of sleep disturbance, can I ask you that? Get into bed, toss and turn. You lying devils. There's much more than that. That's normal neurotic depression. How many of you have the second type of sleep disturbance, you awake at 2, 3, and 4 o'clock in the morning. Come and see me after this will you, you have a real problem. Psychomotor agitation or retardation of the every-day fatigue or loss of energy nearly every day. Feelings of worthlessness. Inappropriate guilt. There are a lot of people out there who go around guilty about everything. Diminished ability to think or concentrate, indecisiveness, et cetera. Recurrent thoughts of death, recurrent suicidal ideation. I can't miss a group like this without saying people who have suicidal ideation will talk about it, like feel relieved if you feel comfortable to talk about it. The only people who have trouble talking about it is not

the patient, not the person, not the sufferer, it's the other person. Talk about it.

There's obviously an overlap between anxiety and depression, if you like, and that's not madness, it's major affective disorder. There's a role between the two. I've seen many anxious people who are not depressed but I've never seen a depressed person who's not anxious. They go together.

The initial episodes of depression are preceded by psychosocial stresses and subsequent episodes. So you may be stressed initially at the age of 16, 18, or 19 which leads to you becoming depressed. Okay, that's fine. We're fully charged. But later on, of course, the episodes aren't so important really. The initial episodes of depression are preceded by more psychosocial stresses but depressive episodes transmutate from the triggered episodes to spontaneous ones. So though you may go back and find a cause for the initial depression, the second episode or the third episode you can't because episodes become more treatment resistant. We know that the type and magnitude and frequency of the stressor are important in the first time but have an effect on the long term. The quality and context of the stressor may be important in determining the outcome. We know over time the role of the stressor in triggering episodes becomes less important and we know which is the important issue, that depressive episodes themselves act as a stressor. In other words, episodes beget episodes. So when you try and find a cause of this person's depression when they've been depressed for the third time you won't find it.

What are the implications of this for treatment of depression? The response to treatment may differ as a function of the stage of the illness, so what occurred when you were 16 or 17 may not when you're 60. Sensitisation effects may be prevented by vigorous early treatment and I get very concerned about therapists at all levels who say "It's good for you to talk your way through this depression. It may take two years but you'll be stronger later." That's boloney. It's scientifically not true and in fact if these people have a true depression and aren't treated vigorously they'll have greater problems later in life.

Longer-term prophylaxis is recommended today. When I started in psychiatry most people were treating their depressed people for six weeks. Now we say a year to two for the first episodes. The second episode we say three to five. I'm saying five. And for the third episode we're saying for life. Depression is a chronic disorder and if you don't treat it soon enough you'll get what we can call malignant

transformation and that's a very important thing. We are now seeing people of 50, 60, and 70, who should have been treated much more vigorously earlier on and they weren't. We know that now.

What is the course of the depression? 70 per cent of patients with a first episode of a depression will have a second depression. Almost all bi-polar disorders, those that have the ups and downs, are recurrent. There are longer intervals between the earlier episodes and there's a progressive shortening of intervals of remission with recurrent episodes.

How do we treat depression? This is a slide given to me years ago by an American psychiatrist - social manipulation. And I thought in a group of legal people I should use that word. We are social manipulators in many ways and it's not necessarily malignant. We have to find the treatment that is important. Psychotherapy, talking therapies, there are many different types, supportive, cognitive, inter-personal. There are 200 different schools of psychotherapy in the literature. They all think they've got something different but they haven't really. Behavioural treatments and biological treatments. And for people with the clinical depression that I'm talking about here tonight, they need medication.

So anti-depressants are important and so is expert personal counselling. There are people in our community who call themselves counsellors I wouldn't send a sick chook to. Combination of medicines and counselling. And in severe depression, ECT.

We have many different anti-depressant drugs. The new one, Metazapine or Remeron. Avanza has just been launched but we've been using it for some time. And of course we have ECT. That's the one treatment which causes more controversy than anything else. Psychiatrists are head shrinkers, they use ECT, and they do dreadful things to you. When I'm depressed and have my true unipolar or major depression, heaven forbid, I hope my clinicians will give me ECT.

However, if you look at the probabilities of recovery of depression under various conditions, there is a group up to 20 per cent that may get spontaneous recovery, some that respond to placebo, those are the neurotic depressions, anti-depressants up to 85 per cent and then through to ECT. There are problems with drugs and I'm not denying that and for the medicos amongst you, some of the problems are the cardio-toxicity. If any of you are prescribing tricyclic anti-depressants today, shame on you. You should not be prescribing a tricyclic today. I'm campaigning against them. Burrows, Voira, Sloman and others

years ago showed that tricyclics were very toxic drugs. We have very effective drugs.

The prophylaxis of depression is important, of course, because suicide or para-suicide is always a risk in depression and if somebody says they're going to kill themself I always take it seriously. Drug overdose is the common way of doing it. There are also problems in prophylaxis because these drugs have problems such as sexual side effects. The SSRIs which are the common ones today, there are five of them here, Zoloft, Prozac et cetera, cause sexual side effects.

Now depression may lead to problems in the legal situation. We see people who are depressed who go shoplifting. Why do they go shoplifting when they're depressed? We see people who have drug-taking behaviour because they're depressed. We see people who have gambled because they're depressed. They may have been depressed before they went gambling; they become depressed after gambling too, some of them. Homicide is very infrequent, but there is a group of people who are depressed who kill others and the homicide/suicide connection is not uncommon to us psychiatrists.

Shoplifting. These people are depressed. You notice guilt was one of the symptoms. They feel they need punishment. They need to be found out. For example, the middle-aged female who shoplifts who is depressed, she takes things she doesn't need, she can afford and she takes them and she doesn't even know why she takes them.

Drug-taking behaviour, of course. The depressed, they take it to lift their mood. The commonest cause of people taking drugs, the younger group too, is that they're depressed. They take the marijuana, the heroin, and the other drugs because they're depressed and they take them because they give them highs. Of course that leads to violence, motor vehicle accidents and so on.

Gambling. If you're depressed and you gamble too much, and I've seen a few of these people from those who've gambled $35, and a pensioner can't afford that, to a gentleman who will be before the court soon who's gambled $10 million and a solicitor who gambled one and a half million dollars. Theft, embezzlement, financial and family breakdown; you've seen that on the TV recently.

Homicide. The person kills because they're depressed. They have disturbed perception. They have delusions. They have guilty feelings. It's a wicked world. "I've got to kill you to save you. I've got to kill others." They save the loved ones from a bad world. The homicide/suicide, the person who kills their loved one and then kills themself

because they're saving this person, the bad, the wicked, the hopeless, helpless, no future, the illness of now and they can't be saved.

For those who really want to read about it, that's all of you, there's an excellent report "Understanding Depression" and, guess what, a Burrows happens to be there.

JUSTICE VINCENT. Professor Burrows has, in his inimitable fashion, presented us with an image of the prevalence of depressive illness in this community and the manner in which depression can impact upon the lives of those who are unfortunate enough to suffer from it.

I have spent many years in the law and something like 40 years in the area of the criminal law. That experience has given me a powerful impression of the significance of depression in affecting the lives of a huge number of people with whom I've come into contact in that system. I have worked with them as a barrister, as a chair of the Parole Board and as a trial judge.

The sense of hopelessness possibly accompanied by related feelings of anger frequently provides the background for anti-social and self-destructive activities. Commonly, when the history of the offender is explored, a picture emerges of childhood abuse and neglect, followed by some type of acting out behaviour. There is early alcohol and drug abuse, early state intervention, possibly in the form of incarceration and, finally, an acceptance by the individual of the inevitability of failure attended by the consequences of that acceptance.

In the law we tend not to use the word "depression." What we speak about is lack of self-esteem. But frequently that is a term which is being employed in place of and masking a very substantial level of depression, a form of clinical depression or some serious effective mood disorder that is influencing the individual in every aspect of his or her life. Self-medication by the use of illegal drugs or the abuse of prescription drugs is, of course, well recognised.

While these patterns have long been identified, I think it would be fair to say that their significance in the area of the criminal law with which I've been involved for the major part of my adult life, has received minimal attention. We do not talk about these conditions in terms of mental states. We use a whole variety of other expressions sometimes because of the problems with which we're confronted once we acknowledge their origin.

There are a number of reasons why I suggest that we do not deal with these issues appropriately. First, in only a very small percentage

of the cases with which I have been concerned over the years was there any demonstrable history upon which a diagnosis of depression could be made. The issues would arise in an adversarial system in the context of a particular type of possibly reprehensible behaviour and in a framework in which a full exploration of the individual's backgrounds or problems would often have been perceived - and correctly perceived - as having adverse consequences to the person concerned. So much material is not, by reason of the proceeding and the character of the activity in which we're engaged, brought into the open.

Frequently, and it is disturbing to see it, you can look at a criminal history and you can read the social development, you can read the state of mind of the person from it without anything else. You can see the transition from the scared kid who is acting out in a particular way into a very nasty young teenager who is rebelling and hurting himself and others around him and then you can see the hardening which develops as a consequence of the responses of the very system itself, until eventually - and this has been my experience on a large number of occasions - the individual with whom you are confronted is very badly damaged indeed and probably almost completely resistant to any kind of intervention or treatment.

It is difficult to know what to do from the legal perspective in that circumstance. You may well understand the origin of the problem. You may well perceive the development of a depressive illness or the development of what we tend to call "this lack of self esteem", but ultimately what you are confronted with is an individual who engages in very anti-social behaviour of a kind which has a potential to hurt others in the community and you may ultimately be left - as we are sometimes left - with nothing other than the power of the state to attempt to control that situation by incarceration.

The courts acknowledging this kind of framework and these kinds of issues are on many occasions suspicious of these kinds of diagnoses. Sometimes for good reasons. They are regularly made *ex post facto*. The material upon which they're based cannot be tested and they are often perceived as devices for the avoidance of responsibility rather than being explanations of conduct in which individuals have engaged. Even the very diagnosis of the presence of a depressive illness can be problematic in a great many cases. There is more than one definition, of course. The term is used as loosely by medical practitioners as it is by lawyers and the community generally. It encompasses everything from sadness to very severe states of being. When one has to look at

the extent to which regard is to be had to it in a criminal law context, you can appreciate that it is difficult indeed.

Given that you are dealing with a situation in which it can be said that an individual acted in a particular fashion and that person was at that stage suffering from some level of depression, the question then arises as to the relationship between that depressive state and the behaviour in which the individual engaged and that can pose extremely difficult issues from the perspective of the law. What impact has that state of depression had upon the individual concerned and to what extent can it be seen to have contributed to his or her engagement in the behaviour with which the court is concerned.

Generally speaking, the law attributes responsibility for involvement in serious crime on the foundation of "knowledge" and "intention." Take, for example, the crime of murder. This offence is committed when a person of "sound mind" causes the death of another through the performance of a conscious, voluntary and deliberate act, which act is carried out with the specific intention of either killing the victim or of causing really serious physical injury to the victim. An individual suffering from a quite significant level of depression would nevertheless almost certainly be able to carry out the deliberate and intentional act of killing another. It is not a situation normally in which one would anticipate that it could be said in argument that the individual did not act at all in a conscious and deliberate sense, as we understand it.

The person may also - although this is perhaps more debatable - be able to reason about the moral wrongness of the act as perceived by the general community. In other words, this would render any approach by way of a defence of mental impairment not appropriate in most cases, I would suspect, of depressive illness. As I understand the situation with respect to the effect of such an illness, it is not that one does not perform the act consciously or that one does not understand the significance and meaning of that act, in the sense that I have described, but the relationship between the performance of that act, and the external world and the circumstances perceived by that individual, are distorted in a very serious way.

In Victoria a person charged with murder in the situation that I have described would encounter great difficulty in presenting a defence or an argument in mitigation based upon an accepted state of clinical depression. I used "an argument in mitigation" because I was adverting to the notion of provocation which we have in our law.

It might be possible - and I don't know that this would be sound in terms of the medical understanding - to conceive an extreme situation in which a person was so depressed that he or she could be argued to be in some kind of dissociative state and therefore there be no conscious voluntary act in the legal sense. This would give rise to a question of possible mental impairment impacting upon the legal responsibility of the person. But I suspect such occasions would be very rare indeed and I would also suspect that there would be very considerable resistance to the acceptance of that position in a legal context.

If a person was, however, able by reference to the presence of a state of clinical depression to avail himself or herself of the defence of mental impairment under our law then, as many of those who are present tonight would be well aware, the consequences would be uncertain and may, indeed, be quite horrific as far as the individual is concerned and have very little to do with the actual mental state of the individual at the time of the trial or, indeed, the management of that mental state subsequently.

Supposing, however - and I now refer to this aspect of provocation - the person was suffering from clinical depression and he or she reacted to a perceived provocative act committed by another. There is doubt, in my mind as to the extent to which this could be taken into account in our law at this stage. I note that the House of Lords quite recently decided that it was a factor to which regard could be had in consideration of the question of provocation.

In Victoria this would operate in a curious fashion. Our High Court has said that the test to be applied in a case of provocation is that of the possible reaction of an "ordinary" person. Now perhaps for those who have no understanding of all this exotica of the law, I need to provide a general, albeit loose description of the fashion in which the law operates. The legal system accepts that an ordinary person can under certain kinds of pressures commit the extraordinary act of killing another; that there can be provocative behaviour of a kind which might cause an ordinary person to lose self-control to the extent that a killing can occur.

Now the test we apply, as I have said, is that of an "ordinary" person and let me tell you, that as a test it is a nightmare. One of the aspects that has been debated for years is who on earth is an "ordinary" person for this purpose? And we have had a lot of different ways of looking at, until at one stage it was decided that the ordinary person might be, for example, the "ordinary" person with all the characteristics of the

individual concerned. It was decided that as an objective standard for the operation of our law this really presented a problem. So the High Court eventually said that the "ordinary" person for this purpose had to be a person of ordinary firmness of mind.

Now we've got our individual who has got clinical depression. The one thing we can say with a reasonable degree of confidence about that person is that he or she probably does not have ordinary firmness of mind. Nevertheless the individual in our example has responded to the provocative behaviour of another, so in our wisdom, in order to accommodate that person's position, we would now have to argue that "Ah, but you see, we're talking about a person of ordinary firmness of mind who also suffers from clinical depression." We have, through this process, created a circular situation.

In some jurisdictions in this country it is possible to have regard to the presence of depressive illness in the context of diminished responsibility. We do not have that notion in the law in Victoria. It is the position in New South Wales and permits some flexibility to operate which accommodates a little more satisfactorily the variety of conditions which are not encompassed by McNaghten Rules and which really do need to be addressed in any sensible structure.

At the sentencing level the position is a little simpler. A judge or magistrate can have regard to the presence of a depressive state for a number of purposes. It can, of course, impact on the level of personal culpability or responsibility attributed to the individual. It has relevance to whether or not the application of a principle of general deterrence would be regarded as just in the circumstances and the extent to which other sentencing principles can operate. However, you must remember that judges and magistrates, as a practical proposition, have only a limited level of discretion when sentencing, despite what you may have been led to believe by the media and the talkback commentators. We have only a limited range of options available and must have regard to many factors of which the personal culpability of an individual is only one. Regrettably, there are occasions on which it is necessary to impose deterrent sentences or retributive sentences on people who are seriously disturbed in this way.

Even if it established that there has been some depressive illness present that has contributed to the conduct that has brought the individual before the court, it should not necessarily follow that the matter will be appropriately addressed at that point. Regularly there will have been a long history of criminal activity which will limit

significantly the options that are available to the sentencer. I've already adverted to the problem presented to a sentencer in the case of someone who is badly damaged, whose underlying social and mental problems may never have been appropriately addressed and who has reached the point where almost no real prospect seems to exist for any change in the situation.

If a non-custodial option is being considered, difficulty will be encountered in securing the appropriate services to address these sorts of problems. They are just not present in our community in sufficient numbers and particularly in the regional areas. Within the prison system the services are also extremely limited although I will say, in fairness, that over the last decade or so a considerable effort has been made to improve that situation.

From the legal perspective, the emergence of depression as a modern plague is likely to have an increasing effect upon our community. Our reasoning with respect to criminal responsibility and our responses to anti-social behaviours that have already been exposed as relatively primitive in a number of respects will almost certainly need to adapt. We ought to be looking at a wider range of options and a far more basic analysis of the origins of the criminal behaviour with which we are concerned. Sometimes I think our approach to these matters is similar to that of the individual who believes that he can bridge a language barrier by shouting even more loudly at the person who doesn't understand him. I am concerned that we are approaching the problem from that perspective but are placing greater reliance on stricter law enforcement; the application of greater levels of force.

Before I finish I would like to mention something that I was looking at today in this context. Recent figures provided by the Bureau of Justice in the United States are alarming and represent the same kind of path along which we are proceeding. 25 per cent of the individuals in the prison system in the United States are self-reported as having received treatment for some emotional or mental illness. One in three report that they have had difficulties of that kind. I suspect that if one explored the histories of inmates in greater depth it would be found that the percentage of people who actually suffered from some form of disorder would be considerably higher.

I noted also that there are over 2 million people in custody in the United States at the present time, that 9 percent of black adult males were presently in custody, that 28.5 per cent of black males could, on the current sentencing practices, be expected to undergo a prison

sentence at least once in their lifetime and that one in every 32 people in the United States is currently subject to some form of corrections order; a probation, parole, prison or gaol sentence.

I don't want to see us proceeding down that path. It would be far better to consider far more carefully the relationships between social disadvantage, mental illness generally and criminal responsibility. Our primary objective ought to be to reduce the incidence of anti-social behaviour and to reduce the level of pain and distress in the community that anti-social behaviour causes and can be seen to be manifested in a variety of ways.

QUESTION: In view of this problem of sentencing someone of sound mind but who is depressed, how does that equate with you psychiatrically, Graham?

PROFESSOR BURROWS. This is really a Pandora's box or a bag of worms. In 1967/68 I was in Ararat and I used to oscillate between the Ararat Prison and the Ararat Mental Hospital and what His Honour said is quite true. I could have gone over there and taken a third of the people out of the prison and put them in the mental hospital and vice versa. And that's part of the dilemma really.

I feel sympathy for the legal system because what I'd be saying about depression that would give me a defence would be that those who we would consider had severe depression where they had delusions, hallucinations and they believed things which are false, they were truly of unsound mind. I would be very concerned. I haven't actually been to court on the defence of depression. Never.

JUSTICE VINCENT. It almost never happens.

PROFESSOR BURROWS. I've been to the court on many times in the defence of other things, such as social disorders and so on, but never on depression. I thought of the number of people that I've seen that are severely depressed who have committed a crime; it's really not large. You do see them in the Magistrates' Court with shoplifting and gambling and those sorts of things but not in the Supreme Court. I was being provocative about post-traumatic stress disorder; it's over-diagnosed. It's actually getting ridiculous. You get post-traumatic stress disorder because the boss fired you, or you get post-traumatic stress disorder because you almost got run over as you crossed the road. The famous case of post-traumatic stress disorder is the one where somebody had, in clowning, put an artificial penis on her desk and after that she was a real wreck.

I think His Honour is quite correct. I didn't find myself disagreeing with anything he said in this sort of regard. I think he's right in the end when he said we have to look much more at the humanistic aspects and not the punitive aspects, when we're sentencing. I worry about those American figures also.

QUESTION: DR NAVE. Rob Nave, eye specialist. I'm quite concerned about the apparent difference in the definition of depression between the medical profession and the legal profession. Professor Burrows presented a whole series of signs and symptoms of depression whereas the legal profession take it as a loss of self-esteem. Now a lot of people who commit crimes have got low self-esteem and so they should have, but it just seemed to me that there's fundamentally an enormous difference there between these two.

JUSTICE VINCENT. The legal system does not have definitions for these notions at all. That's one of the features that separates us by a very long way. I was not suggesting that we were equate clinical depression with "lack of self-esteem." What I was saying, was that it was pitifully obvious to me in a large number of cases that people who have simply been referred to as lacking self-esteem were deeply depressed and had been so for a very long time. Their condition would never have been recognised as a state of depression by the legal system at all.

PROFESSOR BURROWS. I think I pointed that out with my 22 different classificatory systems. Having said that, I will tell you that the majority of psychiatrists can spend 99 per cent of their time arguing about one per cent of problems and they can agree about the others. So that if we take the area of depression we do have two major classificatory systems, the ICV10 and the DSM4 and one from Europe and one from America and we actually do agree most of the time and we would certainly agree on what was called moderate or severe depression. We might argue about the mild or the borderline-type areas.

Now what His Honour sees commonly, of course, is not depression; he sees major personality disorders most of the time and that's quite different. That's not to say that a person with a personality disorder can't suffer from a depressive disorder but it's not really the depressive disorder which created most of the problems. However, I do think the legal profession is going to have to learn a little bit more in that area, just as we have to learn a bit more about the legal profession.

QUESTION: Is there a pattern to spontaneous recovery or is every case peculiar to itself? You said that after three depressive episodes

a person should be under treatment for life but at what point do you accept that maybe the treatment was a failure? Have you ever satisfied yourself that there was actual evidence that supported a recovery without medical intervention?

PROFESSOR BURROWS. You've opened the Pandora's box. And, in brief, I'm not talking about the mild depressions, the Mondayitises, the people who get depressed because they've been rejected by a lover or their job or their mother and so forth. I'm talking about "clinical depression" quite deliberately. I was being provocative because you won't find a classificatory system which says there's a thing called "clinical depression" but we clinicians know what it is because we see it all the time.

Having said that, when I'm talking about the need for ongoing treatment after one or two or three episodes, I'm talking about moderately severe depression, I'm not talking about the psychological depressions, I'm talking about the so-called biological depressions. Most clinicians know the difference between what is mild neurotic depression in a reactive situation to loss of some perceived kind and a true major illness. And that's the problem because we're really saying, "How long is a piece of string?

QUESTION: You talked about anti-depressants and everyone has heard about Prozac in the media. But what about the community responsibility towards treatment of depression? Isn't it all about trying to give someone a purpose in life and to feel supported and valued in the community. I think that's what we should all be looking at doing rather than just examining the quite narrow medical and legal elements of the whole problem.

PROFESSOR BURROWS. I couldn't agree with you more. In 1994 we relaunched the National Depression Awareness Campaign because we wanted the community to take notice. We went into 300 schools, we ran prevention programs and it would be fair to say that in the field of psychiatry and psychological medicine we haven't done enough in the area of early detection, early prevention and health promotion. But that's what the Mental Health Foundation and other groups we're involved in are about.

Yes, I think depression is a community problem and as I pointed out when we looked at our young people who suicide, 50 per cent of them had never been near a doctor and if we'd actually been able to educate their families, their community. What started me on this was a young boy who went to one of our better schools. For two months before his

VCE results came out he was becoming more and more withdrawn, he wasn't sleeping so well, he was losing his appetite, he was withdrawing completely, he wasn't communicating and all his parents could think was that he was in adolescent turmoil. The morning before his results came out he killed himself. The day his results arrived he passed with flying colours. And what was true about this young lad - and I've done autopsies on all sorts of people - is that he had a depressive disorder as recognised by clinicians which could have responded to treatment.

And when I talked about the medications, I was talking about the severe group down the other end. Down the mild end, if the patient believes it and you believe it, it probably works, whether it's colour therapy, flat earth therapy, or touchy-feely therapy, whatever it is. But we clinicians and scientists would like to discuss and look at the major end.

QUESTION: MR MOLONEY. Your Honour, Stephen Moloney, barrister. Your Honour adverted to the sentencing principle of deterrence. I was wondering whether if there's a point with an accused where they're short of a finding of insanity but they're suffering from a serious mental illness, then the extent and the serious nature of that mental illness is able to cancel out some imposition of deterrence in the sentence?

JUSTICE VINCENT. Yes, of course. We attribute responsibility on the basis of knowledge and intention. Underneath our terminology there is a foundation of morality. An individual is considered to be responsible for controlled behaviour, in the sense that he or she has chosen to act in a particular way, or has whilst possessing an actual or constructive awareness of the potential significance of being engaged in conduct that is regarded as socially damaging and deserving of punishment. This underlies much of our law. As I indicated earlier, this notion is challenged once questions are asked about these concepts of knowledge, intention, and the moral culpability that underpins the system. We have a lot of difficulty at that level in the legal system. It is reflected in an area like the one under discussion.

How can one sensibly attribute moral culpability in the same way to an individual who is in a deeply depressed state at the time a particular action is undertaken as one might to an individual who is not so depressed? We have developed a system which has given a superficial clarity to these terms but that system has been under increasing stress as other disciplines have developed. Other methods of analysis of the very same behaviour are becoming available using

different kinds of modelling processes and using different techniques for information gathering of the kind to which Professor Burrows has adverted.

From the practical viewpoint of a sentencing judge, I would obviously not regard someone who was suffering from a level of depression as being in precisely the same situation as someone who was not, for a number of reasons. Clearly it would not be appropriate to use an individual as an example to deter others when that individual has acted whilst suffering from some kind of impaired function as a consequence of a disorder of that kind.

We grapple with these difficult problems all the time. They are inherent in the exercise of sentencing discretion

QUESTION: Graham, last year I was examining in great detail a small number of very tragic suicides that occurred on tricyclics and I compliment you for bringing up, not only for the medical but the legal people present, just how dangerous in over-dosage tricyclics are. When I went through what had actually happened, part of the problem was that they had gone back and refilled the repeat prescriptions the very next day and it amazed me that they could do that in a country town where there's only one pharmacy and it must have been realised that it had been filled the day before. I'm just wondering what can be done to prevent that sort of situation?

PROFESSOR BURROWS. Yes, good question. I wish I had a simple answer and I know you know there isn't one. You can get a printout of every drug that's ever been written by every doctor and for every patient and sometimes that's an interesting exercise to do. I think you highlighted the problem in that town because it was one pharmacist; he should have known. I think the answer to all this is education in the long run and we have to educate, as you've said, why prescribe a tricyclic when we have better drugs, but that's controversial. We have to educate the pharmacists, as we are trying to do. We have to educate the community. We have to educate the legal profession and I suppose that is what this meeting is all about in some ways. That would be my standard. I think progress throughout the world has always happened through education and the wider you can spread that education the better.